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Summary of updates to the *National health data dictionary (NHDD)* since version 14

This section summarises the updates made to the *National health data dictionary* (NHDD) version 15, published in August 2010. This reflects changes to national health data standards between July 2008 and June 2010. During this time, 13 data set specifications, 33 data clusters, 122 data elements, 1 classification scheme and 1 glossary item have been added to the NHDD. Other changes include the revision of 20 national minimum data sets, 8 data set specifications, 6 data clusters, 84 data elements, 7 classification schemes and 1 glossary item. As a result of these revisions, 86 data elements, 20 national minimum data sets, 8 data set specifications, 6 data element clusters, 7 classifications and 1 glossary item have been superseded. No national standards have been retired since version 14 of the NHDD was published.

These new standards have been agreed and endorsed by the members of the National Health Information Standards and Statistics Committee (NHISSC) and the National Electronic Health Information Principal Committee (NEHIPC).

Table 1: Summary table of updates to the NHDD since version 14

Registration status	National minimum data sets	Data set specifications	Data clusters	Data elements	Classifications	Glossary items
Standards (new)	Nil	13	33	122	1	1
Standards (revised)	20	8	6	84	7	1
Superseded	20	8	6	86	7	1
Retired	Nil	Nil	Nil	Nil	Nil	Nil

Table 2: Revised national minimum data sets

National minimum data set	Description of change	Data elements revised	Data elements added	Data elements removed
Admitted patient care NMDS 2009–2010	Revision of two data elements due to version change of related classifications	Area of usual residence Country of birth (SACC 2008)	Nil	Nil
Admitted patient care NMDS 2010–2011	Revision of seven data elements due to version change of related classifications	Activity when injured Additional diagnosis Area of usual residence External cause (admitted patient) Place of occurrence of external cause of injury (ICD-10-AM) Principal diagnosis Procedure	Nil	Nil

(continued)

Table 2 (continued): Revised national minimum data sets

National minimum data set	Description of change	Data elements revised	Data elements added	Data elements removed
Admitted patient mental health care NMDS 2009–2010	Revision of two data elements due to version change of related classifications	Area of usual residence Country of birth (SACC 2008)	Nil	Nil
Admitted patient mental health care NMDS 2010–2011	Revision of data elements due to version change of related classifications	Additional diagnosis Area of usual residence Diagnosis related group Major diagnostic category Principal diagnosis	Nil	Nil
Admitted patient palliative care NMDS 2009–2010	Revision of two data elements due to version change of related classifications	Area of usual residence Country of birth (SACC 2008)	Nil	Nil
Admitted patient palliative care NMDS 2010–11	Revision of three data elements due to version change of related classifications	Additional diagnosis Area of usual residence Principal diagnosis	Nil	Nil
Alcohol and other drug treatment services NMDS 2010–2011	Revision of two data elements due to version change of related classification	Area of usual residence Country of birth (SACC 2008)	Nil	Nil
Community mental health care NMDS 2009–2010	Revision of two data elements due to version change of related classification	Area of usual residence Country of birth (SACC 2008)	Nil	Nil
Community mental health care NMDS 2010–2011	Revision of two data elements due to version change of related classifications	Area of usual residence Principal diagnosis	Nil	Nil
Elective surgery waiting times (census data) NMDS 2009–	Addition of one data element	Nil	Indigenous status	Nil
Elective surgery waiting times (removals data) NMDS 2009–	Addition of one data element	Nil	Indigenous status	Nil
Government health expenditure NMDS 2009–2010	Revised scope statement which provides information about the purpose of the NMDS Data cluster separated into three component data clusters Revision of two data elements	Capital consumption expenses Health industry relevant organisation type	Nil	Nil

(continued)

Table 2 (continued): Revised national minimum data sets

National minimum data set	Description of change	Data elements revised	Data elements added	Data elements removed
Mental health establishments NMDS 2009–2010	Addition of two data elements	Nil	Average available beds for overnight-stay patients Average available beds for residential mental health patients	Nil
Mental health establishments NMDS 2010–2011	Revision of one data element due to version change of related classification	Geographical location of establishment	Nil	Nil
Non-admitted patient emergency department care NMDS 2010–2011	Revision of four data elements to clarify time spent in the emergency department. Revision of two data elements due to a version change of related classifications	Area of usual residence Country of birth (SACC 2008) Emergency department date of commencement of service event Emergency department time of commencement of service event Emergency department waiting time to service delivery Triage category	Nil	Nil
Perinatal NMDS 2010–2011	Addition of four data elements. Revision of two data elements due to a version change of related classifications	Area of usual residence Country of birth (SACC 2008)	Number of tobacco cigarettes smoked per day, first 20 weeks of pregnancy Pregnancy duration at the first antenatal care visit Tobacco smoking indicator, after 20 weeks of pregnancy Tobacco smoking indicator, first 20 weeks of pregnancy	Nil
Public hospital establishments NMDS 2009–2010	One data element replaced by two new data elements	Nil	Average available beds for overnight-stay patients Average available beds for same-day patients	Number of available beds for admitted patients
Public hospital establishments NMDS 2010–2011	Revision of one data element due to version change of related classification	Geographical location of establishment	Nil	Nil

(continued)

Table 2 (continued): Revised national minimum data sets

National minimum data set	Description of change	Data elements revised	Data elements added	Data elements removed
Residential mental health care NMDS 2009–2010	Revision of two data elements due to version change of related classifications	Area of usual residence Country of birth (SACC 2008)	Nil	Nil
Residential mental health care NMDS 2010–2011	Revision of three data elements due to version change of related classifications	Additional diagnosis Area of usual residence Principal diagnosis	Nil	Nil

Table 3: Revised data set specifications

DSS	Description of change	Data elements revised	Data elements added	Data elements removed
Acute coronary syndrome (clinical) DSS	Revised scope statement clarifying the data collection timeframe of the data set Revisions to 29 data elements, 70 new data elements	ECG – change location ECG – change type ECG – heart rhythm type Functional stress ischaemic and perfusion outcome result Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre Laboratory standard – upper limit of normal range for troponin assay, total micrograms per litre Person – acute coronary syndrome procedure type Person – acute coronary syndrome related medical history Person – acute coronary syndrome risk stratum Person – bleeding episode status Person – chest pain pattern Person – cholesterol level (measured)	ECG – Bundle-branch block status ECG – lead V4R presence indicator ECG – new Q waves indicator ECG – ST-segment-elevation in lead V4R indicator ECG time Electrocardiogram (ECG) date Isoenzyme, total units per litre Laboratory standard – upper limit of normal range for creatine kinase Person – acute coronary syndrome symptoms onset date Person – acute coronary syndrome symptoms onset time Person with ACS – instrumented bleeding location Person with ACS – acute coronary syndrome related clinical event time Person with ACS – lifestyle counselling type Person with ACS – non instrumented bleeding location Person with ACS – other cause of acute coronary syndrome	Nil

(continued)

Table 3 (continued): Revised data set specifications

DSS	Description of change	Data elements revised	Data elements added	Data elements removed
		<p>Person – clinical evidence status (acute coronary syndrome related medical history)</p> <p>Person – clinical procedure timing</p> <p>Person – creatine kinase myocardial band isoenzyme level (measured), total micrograms per litre</p> <p>Person – creatine kinase myocardial band isoenzyme level (measured), total units per litre</p> <p>Person – creatinine serum level, micromoles per litre</p> <p>Person – fibrinolytic drug administered Person – intravenous fibrinolytic therapy date</p> <p>Person – intravenous fibrinolytic therapy time</p> <p>Person – low-density lipoprotein cholesterol level (calculated)</p> <p>Person – primary percutaneous coronary intervention date</p> <p>Person – primary percutaneous coronary intervention time</p> <p>Person – reason for readmission following acute coronary syndrome episode</p> <p>Person – triglyceride level (measured)</p> <p>Person – troponin assay type</p> <p>Person – troponin level (measured), total micrograms per litre</p> <p>Stress test element</p>	<p>Person with ACS – pharmacotherapy type prescribed (in hospital)</p> <p>Person with ACS – pharmacotherapy type taken post discharge from hospital</p> <p>Person with ACS – type of acute coronary syndrome related clinical event experienced</p> <p>Person with acute coronary syndrome (ACS) – acute coronary syndrome related clinical event date</p> <p>Stress test – assessment of cardiac perfusion</p> <p>Stress test date</p> <p>Stress test intensity</p>	
<p>Cancer (clinical) DSS (Version Standard from 6/3/2009 and Superseded on 22/12/2009)</p>	<p>Revision of eleven data elements</p>	<p>Cancer staging—M stage code</p> <p>Cancer staging—N stage code</p> <p>Cancer staging—T stage code</p> <p>Cancer staging—TNM stage grouping code</p> <p>Histopathological grade</p> <p>Morphology of cancer</p>	<p>Nil</p>	<p>Nil</p>

(continued)

Table 3 (continued): Revised data set specifications

DSS	Description of change	Data elements revised	Data elements added	Data elements removed
Cancer (clinical) DSS (Version Standard from 22/12/2009)	Revision of 3 data elements due to version change of related classification.	Number of regional lymph nodes examined Oestrogen receptor assay result Primary site of cancer (ICDO-3 code) Regional lymph nodes positive Tumour size at diagnosis (solid tumours) Cancer treatment—target site (ICD-10-AM) Primary site of cancer (ICD-10-AM code) Surgical treatment procedure for cancer	Nil	Nil
Cardiovascular disease (clinical) DSS	Revision of one data element due to version change of related classification.	Country of birth (SACC 2008)	Nil	Nil
Health care client identification DSS	Revision of one data element due to version change of related classification.	Country of birth (SACC 2008)	Nil	Nil
Health care provider identification DSS	Revision of one data element due to version change of a related classification	Country of birth (SACC 2008)	Nil	Nil
Computer Assisted Telephone Interview demographic module DSS	Revision of one data element due to version change of related classification.	Country of birth (SACC 2008)	Nil	Nil
Injury surveillance DSS	Revision of three data elements due to version change of related classifications.	Activity when injured External cause (admitted patient) Place of occurrence of external cause of injury (ICD-10-AM)	Nil	Nil

Table 4: New data set specifications

Name	Description
Breast cancer (cancer registries) DSS	The breast cancer data set enables 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.
Registered chiropractic labour force DSS	All chiropractors listed with the Australian Health Practitioner Regulation Agency during the reference period. Chiropractors included in this DSS may be currently registered or they may be listed but not currently registered.
Registered dental and allied dental health professional labour force DSS	All dental and allied dental health professionals listed with the Australian Health Practitioner Regulation Agency during the reference period. Dental and allied dental health professionals included in this DSS may be currently registered or they may be listed but not currently registered.
Registered health labour force DSS	All health professionals listed with the Australian Health Practitioner Regulation Agency during the reference period. This encompasses health professions that require registration under the National Registration and Accreditation Scheme. All health professionals listed with the Australian Health Practitioner Regulation Agency during the reference period. This encompasses health professions that require registration under the National Registration and Accreditation Scheme.
Registered medical professional labour force DSS	All medical professionals listed with the Australian Health Practitioner Regulation Agency during the reference period, including: <ul style="list-style-type: none"> • medical practitioners • medical specialists • medical specialists-in-training. Medical professionals included in this DSS may be currently registered or they may be listed but not currently registered.
Registered midwifery labour force DSS	All midwives listed with the Australian Health Practitioner Regulation Agency during the reference period. Midwives included in this DSS may be currently registered or they may be listed but not currently registered.
Registered nursing professional labour force DSS	All nursing professionals listed with the Australian Health Practitioner Regulation Agency during the reference period, including: <ul style="list-style-type: none"> • enrolled nurses • registered nurses • nurse practitioners. Nursing professionals included in this DSS may be currently registered or they may be listed but not currently registered.
Registered optometry labour force DSS	All optometrists listed with the Australian Health Practitioner Regulation Agency during the reference period. Optometrists included in this DSS may be currently registered or they may be listed but not currently registered.
Registered osteopathy labour force DSS	All osteopaths listed with the Australian Health Practitioner Regulation Agency during the reference period. Osteopaths included in this DSS may be currently registered or they may be listed but not currently registered.
Registered pharmacy labour force DSS	All pharmacists listed with the Australian Health Practitioner Regulation Agency during the reference period. Pharmacists included in this DSS may be currently registered or they may be listed but not currently registered.
Registered physiotherapy labour force DSS	All physiotherapists listed with the Australian Health Practitioner Regulation Agency during the reference period. Physiotherapists included in this DSS may be currently registered or they may be listed but not currently registered.
Registered podiatry labour force DSS	All podiatrists listed with the Australian Health Practitioner Regulation Agency during the reference period. Podiatrists included in this DSS may be currently registered or they may be listed but not currently registered.
Registered psychology labour force DSS	All psychologists listed with the Australian Health Practitioner Regulation Agency during the reference period. Psychologists included in this DSS may be currently registered or they may be listed but not currently registered.

Table 5: New data clusters

Name	Description
Acute coronary syndrome clinical event cluster	The acute coronary syndrome (ACS) related clinical events are those which can negatively impact on the outcomes of a person with ACS. Information on the occurrence of these events in people with ACS is required due to an emerging appreciation of their relationship with late mortality. The clinical event cluster collects information on the timing and type of clinical events experienced during the current hospitalisation.
Acute coronary syndrome pharmacotherapy data cluster	<p>The pharmacotherapies collected in this data cluster are recommended for the management of acute coronary syndromes (ACS) in the national guidelines. The following pharmacotherapies are collected as part of this data cluster:</p> <p>Aspirin</p> <p>Angiotensin converting enzyme (ACE) inhibitor</p> <p>Angiotensin II receptor blocker</p> <p>Antithrombin</p> <p>Beta-blocker</p> <p>Clopidogrel</p> <p>Fibrinolytic</p> <p>Glycoprotein IIb/IIIa receptor antagonist</p> <p>Statin</p> <p>The pharmacotherapy cluster collects information on the type of pharmacotherapies prescribed and the timing of each prescription.</p>
Coronary artery cluster	<p>This cluster collects information on the characteristics of and interventions performed for the coronary arteries during the current hospitalisation. The coronary arteries included in this cluster are:</p> <p>Left anterior descending coronary artery</p> <p>Inferior surface artery</p> <p>Left circumflex coronary artery</p> <p>Diagonal coronary artery</p> <p>Left main coronary artery</p> <p>Posterior descending artery</p> <p>Right coronary artery</p>
Electrocardiogram cluster	<p>An electrocardiogram (ECG) measures the electrical activity of the heart over time. The evaluation of an ECG provides important diagnostic information relevant to the risk stratification, diagnosis and management of acute coronary syndromes. The electrocardiogram cluster collects information on the timing of each ECG and specific diagnostic characteristics determined from the ECG:</p> <ul style="list-style-type: none"> • ECG change type and location • Bundle-branch block status • Q waves status • ST-segment elevation in lead V4R
Functional stress test cluster	A functional stress test evaluates arterial blood flow to the heart muscle during increased cardiac work through physical exercise or pharmacological methods. The functional stress test cluster collects information on the timing, characteristics and results of a functional stress test performed during the current hospital presentation.
Government health expenditure organisation expenditure capital consumption data element cluster	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting of consumption of fixed capital (depreciation). These are all either health and health-related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.

(continued)

Table 5 (continued): New data clusters

Name	Description
Government health expenditure organisation expenditure employee related data element cluster	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, and workers compensation premiums and payouts. These are all either health and health-related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.
Government health expenditure organisation expenditure purchase of goods and services data element cluster	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting mainly of purchases of goods and services. These are all either health and health-related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.
Labour force status cluster	All health professionals renewing their registration with the Australian Health Practitioner Regulation Agency.
Main job of registered chiropractor cluster	The main job of registered chiropractors who were employed in the profession during the reference week. The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.
Main job of registered dental and allied dental health professional cluster	The main job of registered dental and allied dental health professionals who were employed in the profession during the reference week.
Main job of registered medical professional cluster	The main job of registered medical professionals who were employed in the profession during the reference week.
Main job of registered midwife cluster	The main job of registered midwives who were employed in the profession during the reference week.
Main job of registered nursing professional cluster	The main job of registered nursing professionals who were employed in the profession during the reference week.
Main job of registered optometrist cluster	The main job of registered optometrists who were employed in the profession during the reference week.
Main job of registered osteopath cluster	The main job of registered osteopaths who were employed in the profession during the reference week.
Main job of registered pharmacist cluster	The main job of registered pharmacists who were employed in the profession during the reference week.
Main job of registered physiotherapist cluster	The main job of registered physiotherapists who were employed in the profession during the reference week.
Main job of registered podiatrist cluster	The main job of registered podiatrists who were employed in the profession during the reference week.
Main job of registered psychologist cluster	The main job of registered psychologists who were employed in the profession during the reference week.
Second job of registered chiropractor cluster	The second job of registered chiropractors who were employed in more than one job in the profession during the reference week. The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.
Second job of registered dental and allied dental health professional cluster	The second job of registered dental and allied dental health professionals who were employed in more than one job in the profession during the reference week.
Second job of registered medical professional cluster	The second job of registered medical professionals who were employed in more than one job in the profession during the reference week.

(continued)

Table 5 (continued): New data clusters

Name	Description
Second job of registered midwife cluster	The second job of registered midwives who were employed in more than one job in the profession during the reference week.
Second job of registered nursing professional cluster	The second job of registered nursing professionals who were employed in more than one job in the profession during the reference week.
Second job of registered optometrist cluster	The second job of registered optometrists who were employed in more than one job in the profession during the reference week.
Second job of registered osteopath cluster	The second job of registered osteopaths who were employed in more than one job in the profession during the reference week.
Second job of registered pharmacist cluster	The second job of registered pharmacists who were employed in more than one job in the profession during the reference week.
Second job of registered physiotherapist cluster	The second job of registered physiotherapists who were employed in more than one job in the profession during the reference week.
Second job of registered podiatrist cluster	The second job of registered podiatrists who were employed in more than one job in the profession during the reference week.
Second job of registered psychologist cluster	The second job of registered psychologists who were employed in more than one job in the profession during the reference week.
Ventricular ejection fraction cluster	The ventricular ejection fraction is the fraction of blood pumped out of a ventricle with each heart beat. Impaired ventricular ejection fraction can be indicative of damage to the heart muscle, such as that sustained during myocardial infarction. The ventricular ejection fraction cluster collects information on the timing, measurement type and results of a ventricular ejection fraction measurement during the current hospital presentation.
Work setting hours cluster	Registered health professionals listed with the Australian Health Practitioner Regulation Agency who were employed in the profession during the reference week. They may be an employee or they may be self-employed.

Table 6: Revised data clusters

Data cluster	Description of change	Data elements revised	Data elements added	Data elements removed
Government health expenditure organisation expenditure capital consumption data element cluster	Revision of two data elements. One revision due to the revision of the data element concept name, and the second due to an addition of a permissible value.	Capital consumption expenses Health industry relevant organisation type	Nil	Nil
Government health expenditure organisation expenditure data element cluster	Revision of two data elements. One revision due to the revision of the data element concept name, and the second due to an addition of a permissible value.	Capital consumption expenses Health industry relevant organisation type	Nil	Nil
Government health expenditure organisation expenditure employee related data element cluster	Revision of one data element, due to the addition of a new permissible value.	Health industry relevant organisation type	Nil	Nil

(continued)

Table 6 (continued): Revised data clusters

Data cluster	Description of change	Data elements revised	Data elements added	Data elements removed
Government health expenditure organisation expenditure purchase of goods and services data	Revision of one data element, due to the addition of a new permissible value.	Health industry relevant organisation type	Nil	Nil
Government health expenditure organisation revenue data element cluster	Revision of one data element, due to the addition of a new permissible value. Addition of information to the collection methods.	Health industry relevant organisation type	Nil	Nil
Government health expenditure organisation function revenue data element cluster	Scope statement added, conditionality updated to mandatory	Nil	Nil	Nil

Table 7: Revised data elements

Short name	Technical name	Description of change
Activity when injured	Injury event—activity type, code (ICD-10-AM 7th edn) ANNNN	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Acute coronary syndrome procedure type	Person—acute coronary syndrome procedure type, code NN	Additional information added to Collection methods and Guide for use regarding timing of ACS procedures.
Acute coronary syndrome related medical history	Person—acute coronary syndrome related medical history, code NN	Definition revised for clarification. Collection methods revised to clarify use of supporting data elements. Insertion of new references.
Acute coronary syndrome stratum	Person—acute coronary syndrome risk stratum, code N	Definition revised for clarification. Guide for use includes additional information for ACS symptoms. Comments provide rationale for collection.
Additional diagnosis	Episode of care—additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Address—country identifier (person)	Person (address)—country identifier, code (SACC 2008) NNNN	Revisions are a result of the release of the Standard Australian Classification of Countries 2008.
Area of practice – dental	Registered health professional—principal area of practice, dental code NN	The former data element was revised and replaced with four specific and targeted data elements based on the previous permissible values.
Area of practice – midwifery	Registered health professional—principal area of practice, midwifery code NN	The former data element was revised and replaced with four specific and targeted data elements based on the previous permissible values.
Area of practice – nursing	Registered health professional—principal area of practice, nursing code NN	The former data element was revised and replaced with four specific and targeted data elements based on the previous permissible values.

(continued)

Table 7 (continued): Revised data elements

Short name	Technical name	Description of change
Area of practice – psychology	Registered health professional—principal area of practice, psychology code NN	The former data element was revised and replaced with four specific and targeted data elements based on the previous permissible values
Area of usual residence	Person—area of usual residence, geographical location code (ASGC 2008) NNNNN	Value domain uses updated ASGC 2008 classification.
Area of usual residence	Person—area of usual residence, geographical location code (ASGC 2009) NNNNN	Revisions are a result of the release of the ASGC 2009.
Available bed—overnight-stay admitted care, average number of beds N[NNN.N]	Average available beds for overnight-stay patients	Value domain has been revised to 5 numeric characters in length. The object class has been revised to reference available beds and the property revised to clearly reflect the scope as overnight-stay patients.
Bleeding episode using TIMI criteria (status)	Person—bleeding episode status, Thrombolysis in Myocardial Infraction (TIMI) code N	Data element now uses specific TIMI value domain. Value domain Guide for use clarifies acceptable ranges for bleeding episodes.
Cancer staging—M stage code	Person with cancer—distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX	Value domain updated to 6 th edition of UICC TNM Classification of Malignant Tumours. Guide for use updated to clarify that TNM staging applies to solid tumours, excluding brain tumours.
Cancer staging—N stage code	Person with cancer—regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX	Value domain updated to 6 th edition of UICC TNM Classification of Malignant Tumours. Guide for use updated to clarify that TNM staging applies to solid tumours, excluding brain tumours.
Cancer staging—T stage code	Person with cancer—primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX[X]	Value domain updated to 6 th edition of UICC TNM Classification of Malignant Tumours. Guide for use updated to clarify that TNM staging applies to solid tumours, excluding brain tumours.
Cancer staging—TNM stage grouping code	Person with cancer—extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XXXX{[X]XX}	Value domain updated to 6 th edition of UICC TNM Classification of Malignant Tumours. Guide for use updated to clarify that TNM staging applies to solid tumours, excluding brain tumours.
Cancer treatment—target site (ICD-10-AM)	Cancer treatment—target site for cancer treatment, code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Capital consumption expenses	Organisation—capital consumption expenses, total Australian currency NNNNN.N	Property changed from Depreciation expenses for consistency with definition, therefore changing the data element concept and data element.
Chest pain pattern category	Person—chest pain pattern, code N	Value domain Guide for use expanded to provide additional information about chest pain.

(continued)

Table 7 (continued): Revised data elements

Short name	Technical name	Description of change
Cholesterol—LDL (calculated)	Person—low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N	Definition revised for clarification. Collection methods updated to reflect changes in clinical practice. Origin for information included.
Cholesterol—total (measured)	Person—cholesterol level (measured), total millimoles per litre N[N].N	Definition revised for clarification. Comments and references updated.
Clinical evidence of acute coronary syndrome related medical history	Person—clinical evidence status (acute coronary syndrome related medical history), yes/no code N	Five separate data elements for clinical evidence status consolidated into one data element.
Clinical procedure timing (status)	Person—clinical procedure timing, code N	Value domain modified to refer to a clinical procedure relating to the current hospital presentation, rather than an episode of admitted patient care.
Complication of labour and delivery	Birth event—complication, code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Complications of pregnancy	Pregnancy (current)—complication, code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Congenital malformations	Person—congenital malformation, code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Country of birth	Person—country of birth, code (SACC 2008) NNNN	Revisions are a result of the release of the Standard Australian Classification of Countries 2008.
Creatine kinase MB isoenzyme level (micrograms per litre)	Person—creatinine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNN]	Guide for use modified to refer to hospital presentation rather than admission. Change to supplementary codes in value domain.
Creatine kinase MB isoenzyme level (units per litre)	Person—creatinine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN]	Value domain name changed to reflect appropriate unit of measurement – previously international units. Guide for use modified to refer to hospital presentation rather than admission. Change to supplementary codes in value domain.
Creatine kinase MB isoenzyme—upper limit of normal range (units per litre)	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN]	Value domain name changed to reflect appropriate unit of measurement – previously international units.
Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre)	Laboratory standard—upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN]	Correction to definition.
Creatinine serum level (measured)	Person—creatinine serum level, total micromoles per litre NN[NN]	Data element name and definition revised for clarification. Additional information added to comments.
Date of intravenous fibrinolytic therapy	Person—intravenous fibrinolytic therapy date, DDMMYYYY	Definition revised for clarification.
Date of primary percutaneous coronary intervention	Person—primary percutaneous coronary intervention date, DDMMYYYY	Name and definition changed to reflect Percutaneous coronary intervention date rather than first angioplasty balloon inflation or stenting date. Guide for use provides information about PCI.

(continued)

Table 7 (continued): Revised data elements

Short name	Technical name	Description of change
Diagnosis related group	Episode of admitted patient care—diagnosis related group, code (AR-DRG v 6) ANNA	Revisions are a result of agreement to collect version 6 of the Australian Refined Diagnosis Related Groups (AR-DRG v 6).
Electrocardiogram change location	Electrocardiogram—change location, code N	Definition no longer specifies a 12 point ECG. Guide for use revised for clarity.
Electrocardiogram change type	Electrocardiogram—change type, code N	Object class changed. Collection methods contain additional information. Value domain codes have been changed to double digits.
Emergency department date of commencement of service event	Non-admitted patient emergency department service episode—service commencement date, DDMMYYYY	Revised to ensure greater consistency of collection and reporting.
Emergency department time of commencement of service event	Non-admitted patient emergency department service episode—service commencement time, hhmm	Revised to ensure greater consistency of collection and reporting.
Emergency department waiting time to service delivery	Non-admitted patient emergency department service episode—waiting time (to service delivery), total minutes NNNNN	Revised to ensure greater consistency of collection and reporting.
Employment status - health professional	Registered health professional—labour force status, registered health professional code N	Data element updated to refer to registered health professionals. Permissible values condensed.
External cause (admitted patient)	Injury event—external cause, code (ICD-10-AM 7th edn) ANN{N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Fibrinolytic drug used	Person—fibrinolytic drug administered, code N	Definition revised for clarification.
Functional stress ischaemic and perfusion outcome result	Functional stress test—iskaemic and perfusion outcome result, code N	Object class changed. Definition changed to include perfusion outcome. New value domain used.
Functional stress test element	Functional stress test—stress test element, code N	Object class changed. Definition revised for clarification.
Geographical location of establishment	Establishment—geographical location, code (ASGC 2009) NNNNN	Revisions are a result of the 2009 release of the Australian Standard Geographical Classification (ASGC 2009).
Geographical location of establishment	Establishment—geographical location, code (ASGC 2008) NNNNN	Value domain uses updated ASGC 2008 classification.
Geographical location of service delivery outlet	Service delivery outlet—geographic location, code (ASGC 2008) NNNNN	Value domain uses updated ASGC 2008 classification.
Geographical location of service delivery outlet	Service delivery outlet—geographic location, code (ASGC 2009) NNNNN	Revisions are a result of the release of the ASGC 2009.
Gestational age	Product of conception—gestational age, completed weeks N[N]	Revised to clarify the existing definition.
Health industry relevant organisation type	Health industry relevant organisation—main activity type, code NNN	Addition of category '204 Residential age care' to value domain and associated guide for use changes.
Heart rhythm type	Electrocardiogram—heart rhythm type, code N[N]	Object class changed.

(continued)

Table 7 (continued): Revised data elements

Short name	Technical name	Description of change
Histopathological grade	Person with cancer—histopathological grade, code N	Revision to definition for clarity. Guide for use expanded to clarify coding rules including breast cancer. Collection methods updated to provide information about cancer registries.
Hours worked in health profession - clinical	Registered health professional—hours worked in clinical role, total hours NNN	Data element scope has been generalised to apply to all registered health professional, rather than simply medical practitioners. As a result the object class, property and data element concept have been changed
Hours worked in health profession - total	Registered health professional—hours worked in health profession, total hours NNN	Revision has consolidated two data elements into one data element. The scope has been generalised to capture all registered health professionals.
Major diagnostic category	Episode of admitted patient care—major diagnostic category, code (AR-DRG v 6) NN	Revisions are a result of agreement to collect AR-DRG v 6.
Maternal medical conditions	Female (pregnant)—maternal medical condition, code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Morphology of cancer	Person with cancer—morphology of cancer, code (ICDO-3) NNNN/N	Collection methods updated to provide more comprehensive information for cancer registries.
Neonatal morbidity	Admitted patient (neonate)—neonatal morbidity, code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition (ICD-10-AM-7 th edition).
Number of regional lymph nodes examined	Person with cancer—number of regional lymph nodes examined, total code N[N]	Additional information added to the Guide for use, including a reference to TNM Classification of Tumours, 6th Edition.
Oestrogen receptor assay result	Person with cancer—oestrogen receptor assay result, code N	Information about coding rules added to Guide for use. Collection methods updated to provide information about cancer registries. Additional information added to value domain clarifying use of supplementary codes.
Place of occurrence of external cause of injury (ICD-10-AM)	Injury event—place of occurrence, code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Postpartum complication	Birth event—complication (postpartum), code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Primary site of cancer (ICD-10-AM code)	Person with cancer—primary site of cancer, code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.
Primary site of cancer (ICDO-3 code)	Person with cancer—primary site of cancer, code (ICDO-3) ANN{.N[N]}	Information about cancer registries and coding rules added to Guide for use.
Principal diagnosis	Episode of care—principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]}	Revisions are a result of the release of the ICD-10-AM-7 th edition.

(continued)

Table 7 (continued): Revised data elements

Short name	Technical name	Description of change
Principal role – health profession	Registered health professional—principal role, health profession code N	The definition has been revised. The value domain has been revised to condense three permissible values into an 'other' category. The object class has also been revised to clarify it refers to registered health professionals only
Procedure	Episode of admitted patient care—procedure, code (ACHI 7th edn) NNNNN-NN	Revisions are a result of the release of the ACHI 7 th edition.
Reason for readmission—acute coronary syndrome	Person—reason for readmission following acute coronary syndrome episode, code N[N]	Guide for use revised to clarify conditions under which this data element should be collected i.e. if they have been discharged from an episode of admitted patient care for acute coronary syndrome within the last 28 days.
Recurrent expenditure—Department of Veterans' Affairs funded	Establishment—recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)]	Revised to clarify the existing definition and remove perceived ambiguities.
Regional lymph nodes positive	Person with cancer—number of positive regional lymph nodes, total N[N]	Additional information added to the Guide for use, including a reference to TNM Classification of Tumours, 6th Edition. Data element now using a generic value domain which is reused across a number of cancer data elements.
Specialised mental health service—supported public housing places	Specialised mental health service—number of supported public housing places, total N[N(5)]	Revised to clarify the existing definition and remove perceived ambiguities.
Surgical treatment procedure for cancer	Cancer treatment—surgical procedure for cancer, procedure code (ACHI 7th edn) NNNNN-NN	Revisions are a result of the release of the Australian Classification of Health Interventions (ACHI) 7 th edition.
Time of intravenous fibrinolytic therapy	Person—intravenous fibrinolytic therapy time, hhmm	Additional information added to comments.
Time of primary percutaneous coronary intervention	Person—primary percutaneous coronary intervention time, hhmm	Name and definition changed to reflect Percutaneous coronary intervention time rather than first angioplasty balloon inflation or stenting time. Guide for use provides information about PCI.
Triage category	Non-admitted patient emergency department service episode—triage category, code N	Revised to ensure greater consistency of collection and reporting.
Triglyceride level (measured)	Person—triglyceride level (measured), total millimoles per litre N[N].N	Collection methods modified to reflect that new information relating to the calculation of the low-density lipoprotein - cholesterol (LDL-C).
Troponin assay type	Person—troponin assay type, code N	Value domain revised: permissible value '3 Not taken' has been removed.
Troponin assay—upper limit of normal range (micrograms per litre)	Laboratory standard—upper limit of normal range for troponin assay, total micrograms per litre N[NNN]	Correction of grammatical error in definition.
Troponin level (measured)	Person—troponin level (measured), total micrograms per litre NN.NN	Guide for use revised to remove reference to the admission, and correction of typographical error.

(continued)

Table 7 (continued): Revised data elements

Short name	Technical name	Description of change
Tumour size at diagnosis (solid tumours)	Person with cancer—solid tumour size (at diagnosis), total millimetres NNN	Guide for use expanded to include detailed information about reporting standards and coding rules.
Work setting – registered health professional	Registered health professional—work setting, code ANN	The definition, object class and value domain have been revised to reflect the work setting of a registered health professional. The property has been revised to change the scope to work setting

Table 8: New data elements

Short name	Technical name
Acute coronary syndrome related clinical event type	Person with acute coronary syndrome—type of acute coronary syndrome related clinical event experienced, code N[N]
Angina status	Person—angina status, Canadian Cardiovascular Society code N
Area of practice - dental	Registered health professional—principal area of practice, dental code NN
Area of practice - midwifery	Registered health professional—principal area of practice, midwifery code NN
Area of practice - nursing	Registered health professional—principal area of practice, nursing code NN
Area of practice - psychology	Registered health professional—principal area of practice, psychology code NN
Average available beds for hospital-in-the-home patients	Occupied bed—hospital in the home care, average number of beds N[NNN.N]
Average available beds for residential mental health patients	Available bed—residential mental health care, average number of beds N[NNN.N]
Average available beds for same-day patients	Available bed—same-day admitted care, average number of beds N[NNN.N]
Average available neonatal cots (non-special-care)	Available bed—neonatal admitted care (Non-special-care), average number of beds N[NNN.N]
Bundle-branch block status	Electrocardiogram—bundle-branch block status, code N
Coronary artery bypass graft location	Person—coronary artery bypass graft location, code N
Coronary artery stenosis location	Person—coronary artery stenosis location, code N
Country of employment in registered profession	Registered health professional—country of employment in registered profession, Australia/other country code N
C-reactive protein level (measured)	Person—C-reactive protein level (measured), total milligrams per litre N[NN].N
Creatine kinase isoenzyme—upper limit of normal range (U/L)	Laboratory standard—upper limit of normal range for creatine kinase isoenzyme, total units per litre N[NNN]
Creatine kinase level (U/L)	Person—creatinine kinase isoenzyme level (measured), total units per litre N[NNN]
Date C-reactive protein level measured	Person—C-reactive protein level measured date, DDMMYYYY
Date creatinine serum level measured	Person—creatinine serum level measured date, DDMMYYYY

(continued)

Table 8 (continued): New data elements

Short name	Technical name
Date of acute coronary syndrome related clinical event	Person with acute coronary syndrome—acute coronary syndrome related clinical event date, DDMMYYYY
Date of coronary artery bypass graft	Person—coronary artery bypass graft date, DDMMYYYY
Date of diagnostic cardiac catheterisation	Person—diagnostic cardiac catheterisation date, DDMMYYYY
Date of electrocardiogram	Electrocardiogram— electrocardiogram date, DDMMYYYY
Date of functional stress test	Functional stress test—test date, DDMMYYYY
Date of implantable cardiac defibrillator procedure	Person—implantable cardiac defibrillator procedure date, DDMMYYYY
Date of intra-aortic balloon pump procedure	Person—intra-aortic balloon pump procedure date, DDMMYYYY
Date of most recent stroke	Person—most recent stroke date, DDMMYYYY
Date of non-invasive ventilation administration	Person—non-invasive ventilation administration date, DDMMYYYY
Date of onset of acute coronary syndrome symptoms	Person—acute coronary syndrome symptoms onset date, DDMMYYYY
Date of pacemaker insertion	Person—pacemaker insertion date, DDMMYYYY
Date of rescue percutaneous coronary intervention	Person—rescue percutaneous coronary intervention date, DDMMYYYY
Date of revascularisation percutaneous coronary intervention	Person—revascularisation percutaneous coronary intervention date, DDMMYYYY
Date of ventricular ejection fraction test	Ventricular ejection fraction test—test date, DDMMYYYY
ECG - Q waves indicator	Person—electrocardiogram Q waves indicator, yes/no code N
Electrocardiogram - new Q waves indicator	Electrocardiogram—new Q waves indicator, yes/no code N
Electrocardiogram - lead V4R presence indicator	Electrocardiogram—lead V4R presence indicator, yes/no code N
Electrocardiogram - ST-segment-elevation in lead V4R	Electrocardiogram— ST-segment-elevation in lead V4R indicator, yes/no code N
Extended leave status in registered profession	Registered health professional—extended leave status in registered profession, code N
Field of medicine - medical practitioner	Registered health professional—principal field of medicine, medical practitioner code N
Functional stress test assessment of cardiac perfusion	Functional stress test—assessment of cardiac perfusion, code N[N]
Functional stress test intensity	Functional stress test— stress test intensity, code N
Functional stress test performed indicator	Person—functional stress test performed indicator, yes/no code N
Hours worked in health profession - clinical	Registered health professional—hours worked in clinical role, total hours NNN
Hours worked in health profession - non-clinical	Registered health professional—hours worked in non-clinical role, total hours NNN
Hours worked in health profession - private sector	Registered health professional—hours worked in private sector, total hours NNN
Hours worked in health profession - public sector	Registered health professional—hours worked in public sector, total hours NNN
Hours worked in health profession - total	Registered health professional—hours worked in health profession, total hours NNN

(continued)

Table 8 (continued): New data elements

Short name	Technical name
Human epidermal growth factor receptor-2 test result	Person with cancer—human epidermal growth factor receptor-2 test result, code N
Human epidermal growth factor receptor-2 test type	Person with cancer—human epidermal growth factor receptor-2 test type, code N
Instrumented bleeding location	Person with acute coronary syndrome—bleeding location, instrumented code N(N)
Intended years in health profession	Registered health professional—intended years in profession, total years NN
Jobseeker status in registered profession	Registered health professional—jobseeker status in registered profession, code N
Length of employment in health profession	Registered health professional—length of employment in profession in Australia, total years NN
Lifestyle counselling type	Person with acute coronary syndrome—lifestyle counselling type, code N
Lymphovascular invasion	Person with cancer—lymphovascular invasion, code N
Maximum stenosis coronary artery	Person—maximum stenosis coronary artery, percentage N[NN]
Month and year of birth	Person—date of birth, MMYYYY
Neo-adjuvant therapy	Person with cancer—neoadjuvant therapy indicator, code N
Non-instrumented bleeding location	Person with acute coronary syndrome—bleeding location, non-instrumented code N(N)
Number of coronary artery lesions attempted	Person—count of coronary artery lesions attempted, total number N[N]
Number of coronary artery lesions successfully dilated	Person—count of coronary artery lesions successfully dilated, total number N[N]
Number of coronary artery stents	Person—count of coronary artery stents, total number N[N]
Number of episodes of angina in last 24 hours	Person—angina episodes count (24 hours preceding hospital presentation), total number NN[N]
Number of positive sentinel lymph nodes	Person with cancer—number of positive sentinel lymph nodes, total code N[N]
Number of sentinel lymph nodes examined	Person with cancer—number of sentinel lymph nodes examined, total code N[N]
Number of tobacco cigarettes smoked per day after 20 weeks of pregnancy	Female (pregnant)—number of cigarettes smoked (per day after 20 weeks of pregnancy), number N[NN]
Number of tobacco cigarettes smoked per day first 20 weeks of pregnancy	Female (pregnant)—number of cigarettes smoked (per day first 20 weeks of pregnancy), number N[NN]
Other/Underlying cause of acute coronary syndrome	Person with acute coronary syndrome—underlying cause of acute coronary syndrome, code N
Percutaneous coronary intervention procedure type	Person—percutaneous coronary intervention procedure type, code N
Person—Australian state/territory of birth, code N	Person—Australian state/territory of birth, code N
Pharmacotherapy type prescribed for acute coronary syndrome in hospital	Person with acute coronary syndrome—pharmacotherapy type prescribed in hospital, code N[N]
Pharmacotherapy type taken for acute coronary syndrome post discharge	Person with acute coronary syndrome—pharmacotherapy type taken post discharge from hospital, code N[N]
Postcode—Australian workplace	Workplace (address)—Australian postcode, code (Postcode datafile) {NNNN}
Pregnancy duration at the first antenatal care visit	Pregnancy—estimated duration (at the first visit for antenatal care), completed weeks N[N]

(continued)

Table 8 (continued): New data elements

Short name	Technical name
Principal role – health profession	Registered health professional—principal role, health profession code N
Reason for non prescription of pharmacotherapy	Person—reason for non prescription of pharmacotherapy, code N
Residual expenditure (mental health service)—Mental Health Act Regulation or related legislation	Specialised mental health service—residual expenditure (Mental Health Act Regulation or related legislation), total Australian currency N[N(8)]
Residual expenditure (mental health service)—service development	Specialised mental health service—residual expenditure (service development), total Australian currency N[N(8)]
Retirement status in registered profession	Registered health professional—retirement status in registered profession, code N
Suburb/town/locality name (workplace)	Workplace (address)—suburb/town/locality name, text [A(50)]
Time C-reactive protein level measured	Person—C-reactive protein level measured time, hhmm
Time of acute coronary syndrome related clinical event	Person with acute coronary syndrome—acute coronary syndrome related clinical event time, hhmm
Time of diagnostic cardiac catheterisation	Person—diagnostic cardiac catheterisation time, hhmm
Time of electrocardiogram	Electrocardiogram— electrocardiogram time, hhmm
Time of implantable cardiac defibrillator procedure	Person—implantable cardiac defibrillator procedure time, hhmm
Time of intra-aortic balloon pump procedure	Person—intra-aortic balloon pump procedure time, hhmm
Time of non-invasive ventilation administration	Person—non-invasive ventilation administration time, hhmm
Time of onset of acute coronary syndrome symptoms	Person—acute coronary syndrome symptoms onset time, hhmm
Time of pacemaker insertion	Person—pacemaker insertion time, hhmm
Time of rescue percutaneous coronary intervention	Person—rescue percutaneous coronary intervention time, hhmm
Time of revascularisation percutaneous coronary intervention	Person—revascularisation percutaneous coronary intervention time, hhmm
Time of ventricular ejection fraction test	Ventricular ejection fraction test—test time, hhmm
Timing of ACE-inhibitor prescription	Person—timing of ACE-inhibitor prescription, code N
Timing of angiotensin II receptor blocker prescription	Person—timing of angiotensin II receptor blocker prescription, code N
Timing of antithrombin therapy prescription	Person—timing of antithrombin therapy prescription, code N
Timing of aspirin prescription	Person—timing of aspirin prescription, code N
Timing of beta-blocker prescription	Person—timing of beta-blocker prescription, code N
Timing of clopidogrel prescription	Person—timing of clopidogrel prescription, code N
Timing of glycoprotein lib/IIIa inhibitor prescription	Person—timing of glycoprotein lib/IIIa inhibitor prescription, code N
Timing of statin prescription	Person—timing of statin prescription, code N
Tobacco smoking indicator, after 20 weeks of pregnancy	Female (pregnant)—tobacco smoking indicator (after twenty weeks of pregnancy), yes/no code N
Tobacco smoking indicator, first 20 weeks of pregnancy	Female (pregnant)—tobacco smoking indicator (first twenty weeks of pregnancy), yes/no code N
Total blood units transfused	Person—units of blood transfused, total N[NNN]
Underlying cause of death	Person—underlying cause of death, code (ICD-10 2 nd edn) ANN-ANN

(continued)

Table 8 (continued): New data elements

Short name	Technical name
Ventricular ejection fraction measurement indicator	Person—ventricular ejection fraction test performed indicator, yes/no code N
Ventricular ejection fraction test result (percentage)	Ventricular ejection fraction—test result, percentage N[N].N
Ventricular ejection fraction test result (code)	Ventricular ejection fraction—test result, code N
Ventricular ejection fraction test type	Ventricular ejection fraction test—test type, code N
Visa type - health professional	Registered health professional—visa type, code AANNN
Work sector - health professional	Registered health professional—work sector in health profession, code N
Work setting - chiropractor	Registered health professional—work setting, chiropractor code ANN
Work setting - dental	Registered health professional—work setting, dental code ANN
Work setting - medical practitioner	Registered health professional—work setting, medical practitioner code ANN
Work setting - midwife	Registered health professional—work setting, midwife code ANN
Work setting - nurse	Registered health professional—work setting, nurse code ANN
Work setting - optometrist	Registered health professional—work setting, optometrist code ANN
Work setting - osteopath	Registered health professional—work setting, osteopath code ANN
Work setting - pharmacist	Registered health professional—work setting, pharmacist code ANN
Work setting - physiotherapist	Registered health professional—work setting, physiotherapist code ANN
Work setting - podiatrist	Registered health professional—work setting, podiatrist code ANN
Work setting - psychologist	Registered health professional—work setting, psychologist code
Work setting - registered health professional	Registered health professional—work setting, code ANN

Table 9: Revised classification schemes

Name	Description of change
Australian Classification of Health Interventions (ACHI) 7th edition	Revisions are a result of the release of the ACHI 7th edition.
Australian Refined Diagnosis Related Groups version 6	Revisions are a result of agreement to collect AR-DRG v 6.
Australian Standard Geographical Classification 2008	Australian Standard Geographical Classification 2008 replaces Australian Standard Geographical Classification 2007.
Australian Standard Geographical Classification 2009	Revisions are a result of the release of the ASGC 2009.
International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition	Revisions are a result of the release of the ICD-10-AM 7th edition.
International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition replaces TNM Classification of Malignant Tumours 5th edition.
Standard Australian Classification of Countries 2008.	Standard Australian Classification of Countries 2008 replaces Standard Australian Classification of Countries 1998.

Table 10: New classification schemes

Name
International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, (2nd edition)

Table 11: Revised glossary items

Name	Description
Residential mental health care service	Revised to clarify the existing definition and remove perceived ambiguities.

Table 12: New glossary items

Name
Average for the counting period

National health data dictionary version 15

Data elements

Accrued mental health care days

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – accrued mental health care days, total N[N(7)]
<i>METeOR identifier:</i>	286770
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The total number of accrued mental health care days provided by admitted patient care services and residential mental health care services within the reference period (from 1 July to 30 June inclusive).
Data Element Concept:	Establishment – accrued mental health care days

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[N(7)]
<i>Maximum character length:</i>	8
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The days to be counted are only those days occurring within the reference period, i.e. from 1 July to the following 30 June for the relevant period, even if the patient/resident was admitted prior to the reference period or discharged after the reference period.</p> <p>A day is measured from midnight to 2359 hours.</p> <p>The following basic rules are used to calculate the number of accrued mental health care days:</p> <ul style="list-style-type: none">• Admission and discharge on the same day is equal to one mental health care day.• For a patient/resident admitted and discharged on different days all days are counted as mental health care days, except the day of discharge and any leave days.• If the patient/resident remains in hospital or residential care facility from midnight to 2359 hours count as a mental health care day.• The day a patient/resident goes on leave is not counted as a mental health care day, unless this was also the admission day.
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- The day the patient/resident returns from leave is counted as a mental health care day, unless the patient/resident goes on leave again on the same day of return or is discharged.
- Leave days involving an overnight absence are not counted as mental health care days.
- If a patient/resident goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one mental health care day.
- If the patient/resident remains in a hospital or residential care facility from 1 July to 30 June (the whole of the reference period) count as 365 days (or 366 days in a leap year).
- If the patient/resident remains in a hospital or residential care facility after the end of the reference period (i.e. after 30 June) do not count any days after the end of the reference period.

The following additional rules cover special circumstances and in such cases, override the basic rules:

When calculating accrued mental health care days for the reference period:

- Count the mental health care days of those patients/residents separated during the reference period. Exclude any days that may have occurred before the beginning of the reference period.
- Count the mental health care days of those patients/residents admitted during the reference period who did not separate until the following reference period. Exclude the days after the end of the reference period.
- For patients/residents admitted before the reference period and who remain in after the reference period (i.e. after 30 June), count the mental health care days within the reference period only. Exclude all days before and after the reference period.

Examples of mental health care day counting for a reference period 1 July 2004 to 30 June 2005:

Patient/resident A was admitted to hospital on 4 June 2004 and separated on 6 July 2004. If no leave or transfer occurred counting starts on 1 July. Count would be 5 days as day of discharge is not counted.

Patient/resident B was admitted to hospital on 1 August 2004 and separated on 8 August 2004. If no leave or transfer occurred counting starts on 1 August. Count would be 7 days as day of discharge is not counted.

Patient/resident C was admitted to hospital on 1 June 2005 and separated on 6 July 2005. If no leave or transfer occurred counting starts on 1 June. Count would be 30 days as patient/resident was not discharged on 30 June, so every day up to and including 30 June would be counted.

Patient/resident D was admitted to hospital on 1 August 2003 and has remained continuously in hospital to the present time. If no leave or transfer occurred counting starts on 1 July 2004 and concludes on 30 June 2005. Count would be 365 days as there is no day of discharge.

Collection methods:

To be reported for admitted patient care services, including services that are staffed for less than 24 hours, and non-government organisation services where included.

NOTE: These data need to be disaggregated by Specialised mental health service setting (excluding Ambulatory care settings). For admitted patient care settings these counts also need to be disaggregated by Specialised mental health service program type and Specialised mental health service target population.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Activity and participation life area

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – activity and participation life area, code (ICF 2001) AN[NNN]
<i>METeOR identifier:</i>	320125
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The life area in which a person participates or undertakes activities, as represented by a code.
<i>Context:</i>	Human functioning and disability
<i>Data Element Concept:</i>	Person – activity and participation life area

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	AN[NNN]
<i>Maximum character length:</i>	5

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept ‘Disability’ and gives an indication of the experience of disability for a person.</p> <p>The activities and participation codes are a neutral list that covers the full range of life areas in which a person can be involved. The domains can be used to record positive or neutral experience of functioning as well as limitations and restrictions.</p> <p>Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both ‘Self care’ (chapter level) and ‘Looking after one’s health’ (3 digit level) as the former includes the latter.</p> <p>The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with respective qualifiers (Activity difficulty level, Activity Need for assistance, Participation extent and Participation satisfaction level) will use the codes as indicated.</p> <p>CODE d1 Learning and applying knowledge CODE d2 General tasks and demands CODE d3 Communication CODE d4 Mobility</p>
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CODE d5 Self-care
CODE d6 Domestic life
CODE d7 Interpersonal interactions and relationships
CODE d8 Major life areas
CODE d9 Community, social and civic life

Data collected at this level will provide a general description of functioning for the person and can only be compared with data collected at the same level.

Each chapter contains categories at different levels ordered from general to detailed. For specific more detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter. The full range of permissible values is listed in the **Activities** and **Participation** component of the ICF.

An example of a value domain at the 3 digit level from the Self-care chapter may include:

CODE d510 Washing oneself
CODE d520 Caring for body parts
CODE d530 Toileting
CODE d540 Dressing
CODE d550 Eating
CODE d560 Drinking
CODE d570 Looking after one's health

An example of value domains at the 4 digit level from the Mobility chapter may include:

CODE d4600 Moving around within the home
CODE d4601 Moving around within buildings other than home
CODE d4602 Moving around outside the home and other buildings
CODE d4701 Using private motorized transportation
CODE d4702 Using public motorized transportation

The prefix *d* denotes the domains within the component of *Activities and Participation*. At the user's discretion, the prefix *d* can be replaced by *a* or *p*, to denote activities or participation respectively.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>

- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.cfm>

Data element attributes

Collection and usage attributes

Guide for use:

This metadata item, in conjunction with Activity difficulty level code N, enables the provision of information about the presence and extent of activity limitation for any given life area; with Activity need for assistance code N, the provision of information about the need for assistance with the given life area.

The extent of, and level of satisfaction with, participation in a given area are indicated by the use of this metadata item with the qualifiers Participation extent code N and Participation satisfaction level code N.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also [Person – need for assistance with activities in a life area, code N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also [Person – level of difficulty with activities in life areas, code \(ICF 2001\) N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also [Person – extent of participation in a life area, code \(ICF 2001\) N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also [Person – level of satisfaction with participation in a life area, code N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

[Activities and Participation cluster](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Activity when injured

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Injury event – activity type, code (ICD-10-AM 7th edn) ANNNN
<i>METeOR identifier:</i>	391320
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	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

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANNNN
<i>Maximum character length:</i>	5

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Admitted patient: External cause codes V00 to Y34 must be accompanied by an activity code.
<i>Comments:</i>	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

<i>Origin:</i>	National Centre for Classification in Health National Injury Surveillance Unit
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Relational attributes

<i>Related metadata references:</i>	Supersedes Injury event – activity type, code (ICD-10-AM 6th edn) ANNNN Health, Superseded 22/12/2009
<i>Implementation in Data Set Specifications:</i>	Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009 <i>Implementation start date:</i> 01/07/2010 Injury surveillance DSS Health, Standard 14/12/2009

Activity when injured (non-admitted patient)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Injury event – activity type, non-admitted patient code N[N]
<i>METeOR identifier:</i>	268942
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of activity undertaken by the non-admitted patient when injured, as represented by a code.
Data Element Concept:	Injury event – activity type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																				
<i>Data type:</i>	String																																				
<i>Format:</i>	N[N]																																				
<i>Maximum character length:</i>	2																																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Sports activity</td></tr><tr><td>00</td><td>Football, rugby</td></tr><tr><td>01</td><td>Football, Australian</td></tr><tr><td>02</td><td>Football, soccer</td></tr><tr><td>03</td><td>Hockey</td></tr><tr><td>04</td><td>Squash</td></tr><tr><td>05</td><td>Basketball</td></tr><tr><td>06</td><td>Netball</td></tr><tr><td>07</td><td>Cricket</td></tr><tr><td>08</td><td>Roller blading</td></tr><tr><td>09</td><td>Other and unspecified sporting activity</td></tr><tr><td>1</td><td>Leisure activity (excluding sporting activity)</td></tr><tr><td>2</td><td>Working for income</td></tr><tr><td>3</td><td>Other types of work</td></tr><tr><td>4</td><td>Resting, sleeping, eating or engaging in other vital activities</td></tr><tr><td>5</td><td>Other specified activities</td></tr><tr><td>6</td><td>Unspecified activities</td></tr></tbody></table>	Value	Meaning	0	Sports activity	00	Football, rugby	01	Football, Australian	02	Football, soccer	03	Hockey	04	Squash	05	Basketball	06	Netball	07	Cricket	08	Roller blading	09	Other and unspecified sporting activity	1	Leisure activity (excluding sporting activity)	2	Working for income	3	Other types of work	4	Resting, sleeping, eating or engaging in other vital activities	5	Other specified activities	6	Unspecified activities
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Collection and usage attributes

Guide for use:

To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of activity being undertaken by the person when injured, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

Data element attributes

Collection and usage attributes

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 item 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 [Activity when injured, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.7 KB)

Implementation in Data Set Specifications:

[Injury surveillance DSS](#) Health, Superseded 05/02/2008

[Injury surveillance DSS](#) Health, Superseded 14/12/2009

[Injury surveillance DSS](#) Health, Standard 14/12/2009

[Injury surveillance NMDS](#) Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Injury surveillance NMDS](#) Health, Superseded 07/12/2005

Actual place of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – setting of birth (actual), code N
<i>METeOR identifier:</i>	269937
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The actual place where the birth occurred, as represented by a code.
<i>Context:</i>	Perinatal statistics
<i>Data Element Concept:</i>	Birth event – setting of birth

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Hospital, excluding birth centre</td></tr><tr><td>2</td><td>Birth centre, attached to hospital</td></tr><tr><td>3</td><td>Birth centre, free standing</td></tr><tr><td>4</td><td>Home</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	1	Hospital, excluding birth centre	2	Birth centre, attached to hospital	3	Birth centre, free standing	4	Home	8	Other	9	Not stated
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3	Birth centre, free standing														
4	Home														
8	Other														
9	Not stated														
<i>Supplementary values:</i>															

Collection and usage attributes

<i>Comments:</i>	The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the states and territories.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This is to be recorded for each baby the mother delivers from this pregnancy. CODE 4 Home Should be reserved for those births that occur at the home intended. CODE 8 Other Used when birth occurs at a home other than that intended. May also include a community health centre or be used for babies 'born before arrival'.
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Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Actual place of birth, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.0 KB)

Implementation in Data Set Specifications: [Perinatal NMDS Health](#), Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS Health](#), Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008 Health](#), Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010 Health](#), Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011 Health](#), Standard 02/12/2009

Implementation start date: 01/07/2010

Acute coronary syndrome procedure type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – acute coronary syndrome procedure type, code NN
<i>METeOR identifier:</i>	356659
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of procedure performed, that is pertinent to the treatment of acute coronary syndrome, as represented by a code.
Data Element Concept:	Person – acute coronary syndrome procedure type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																							
<i>Data type:</i>	String																																							
<i>Format:</i>	NN																																							
<i>Maximum character length:</i>	2																																							
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Coronary artery bypass graft (CABG)</td></tr><tr><td>05</td><td>Reperfusion: fibrinolytic therapy</td></tr><tr><td>06</td><td>Reperfusion: primary percutaneous coronary intervention (PCI)</td></tr><tr><td>07</td><td>Reperfusion: rescue percutaneous coronary intervention (PCI)</td></tr><tr><td>08</td><td>Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities or for aortic aneurysm</td></tr><tr><td>09</td><td>Amputation for arterial vascular insufficiency</td></tr><tr><td>10</td><td>Diagnostic cardiac catheterisation/angiography</td></tr><tr><td>11</td><td>Blood transfusion</td></tr><tr><td>12</td><td>Insertion of pacemaker</td></tr><tr><td>13</td><td>Implantable cardiac defibrillator</td></tr><tr><td>14</td><td>Intra-aortic balloon pump (IABP)</td></tr><tr><td>15</td><td>Non-invasive ventilation (CPAP)</td></tr><tr><td>16</td><td>Invasive ventilation</td></tr><tr><td>17</td><td>Defibrillation</td></tr><tr><td>18</td><td>Revascularisation: percutaneous coronary intervention (PCI)</td></tr><tr><td>19</td><td>Pulmonary artery (Swan Ganz) catheter</td></tr><tr><td>88</td><td>Other</td></tr><tr><td><i>Supplementary values:</i></td><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	01	Coronary artery bypass graft (CABG)	05	Reperfusion: fibrinolytic therapy	06	Reperfusion: primary percutaneous coronary intervention (PCI)	07	Reperfusion: rescue percutaneous coronary intervention (PCI)	08	Vascular reconstruction, bypass surgery, or percutaneous intervention to the extremities or for aortic aneurysm	09	Amputation for arterial vascular insufficiency	10	Diagnostic cardiac catheterisation/angiography	11	Blood transfusion	12	Insertion of pacemaker	13	Implantable cardiac defibrillator	14	Intra-aortic balloon pump (IABP)	15	Non-invasive ventilation (CPAP)	16	Invasive ventilation	17	Defibrillation	18	Revascularisation: percutaneous coronary intervention (PCI)	19	Pulmonary artery (Swan Ganz) catheter	88	Other	<i>Supplementary values:</i>	99	Not stated/inadequately described
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Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use:

More than one procedure can be recorded. Record all codes that apply.

Codes '88' and '99' in combination cannot be used in multiple entries.

CODE 06 Reperfusion: primary percutaneous coronary intervention (PCI)

Primary PCI relates to balloon angioplasty and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI).

CODE 07 Reperfusion: rescue percutaneous coronary intervention (PCI)

Rescue PCI relates to a balloon angioplasty and/or stent implantation that is performed following failed fibrinolysis in people with continuing or recurrent myocardial ischaemia.

CODE 18 Revascularisation: percutaneous coronary intervention (PCI)

Revascularisation PCI relates to the restoration of blood flow through balloon angioplasty and/or stent implantation outside the setting of myocardial salvage for STEMI. Revascularisation PCI may be performed on a person following STEMI where there is objective evidence of spontaneous or inducible ischaemia or haemodynamic instability. Revascularisation PCI may also be performed on a person with high-risk non-ST-segment-elevation acute coronary syndrome.

When read in conjunction with Person – clinical procedure timing, code N, this metadata item provides information on the procedure(s) provided to a patient prior to or during this presentation.

When read in conjunction with Person – acute coronary syndrome risk stratum, code N, codes 01, 05, 06, 07, 08, 09, 10 and 18 of this metadata item provide information for risk stratification.

Where codes 06, 07 and 18 have been recorded please also record Person - percutaneous coronary intervention procedure, code N.

Collection methods:

For each Person-acute coronary syndrome procedure type, code NN, the following timing data elements must also be recorded, where applicable:

- Person - clinical procedure timing, code N
- Person - intravenous fibrinolytic therapy date, DDMMYYYY
- Person - intravenous fibrinolytic therapy time, hhmm

- Person - primary percutaneous coronary intervention date, DDMMYYYY
- Person - primary percutaneous coronary intervention time, hhmm
- Person - rescue percutaneous coronary intervention date, DDMMYYYY
- Person - rescue percutaneous coronary intervention time, hhmm
- Person - revascularisation percutaneous coronary intervention date, DDMMYYYY
- Person - revascularisation percutaneous coronary intervention time, hhmm
- Person - pacemaker insertion date, DDMMYYYY
- Person - pacemaker insertion time, hhmm
- Person - implantable cardiac defibrillator procedure date, DDMMYYYY
- Person - implantable cardiac defibrillator procedure time, hhmm
- Person - intra-aortic balloon pump procedure date, DDMMYYYY
- Person - intra-aortic balloon pump procedure time, hhmm
- Person - non-invasive ventilation administration date, DDMMYYYY
- Person - non-invasive ventilation administration time, hhmm

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Steward:

The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes [Person – acute coronary syndrome procedure type, code NN](#) Health, Superseded 01/10/2008

See also [Person – clinical procedure timing, code N](#) Health, Standard 01/10/2008

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Acute coronary syndrome related clinical event type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with acute coronary syndrome – type of acute coronary syndrome related clinical event experienced, code N[N]
<i>METeOR identifier:</i>	338314
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of acute coronary syndrome related clinical event, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome – type of acute coronary syndrome related clinical event

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																		
<i>Data type:</i>	Number																																		
<i>Format:</i>	N[N]																																		
<i>Maximum character length:</i>	2																																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Cardiogenic shock</td></tr><tr><td>2</td><td>Cardiac rupture</td></tr><tr><td>3</td><td>Cardiac arrest</td></tr><tr><td>4</td><td>New or recurrent myocardial infarction</td></tr><tr><td>5</td><td>Stroke</td></tr><tr><td>6</td><td>Acute pulmonary oedema</td></tr><tr><td>7</td><td>Recurrent rest angina with electrocardiogram changes</td></tr><tr><td>8</td><td>Recurrent rest angina without electrocardiogram changes</td></tr><tr><td>9</td><td>New onset arrhythmia: atrial</td></tr><tr><td>10</td><td>New onset arrhythmia: ventricular</td></tr><tr><td>11</td><td>New onset arrhythmia: heart block (1,2,3)</td></tr><tr><td>12</td><td>Unplanned revascularisation</td></tr><tr><td>13</td><td>Acute renal failure</td></tr><tr><td>14</td><td>Thrombocytopaenia</td></tr><tr><td><i>Supplementary values:</i></td><td>99</td></tr><tr><td></td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Cardiogenic shock	2	Cardiac rupture	3	Cardiac arrest	4	New or recurrent myocardial infarction	5	Stroke	6	Acute pulmonary oedema	7	Recurrent rest angina with electrocardiogram changes	8	Recurrent rest angina without electrocardiogram changes	9	New onset arrhythmia: atrial	10	New onset arrhythmia: ventricular	11	New onset arrhythmia: heart block (1,2,3)	12	Unplanned revascularisation	13	Acute renal failure	14	Thrombocytopaenia	<i>Supplementary values:</i>	99		Not stated/inadequately described
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<i>Supplementary values:</i>	99																																		
	Not stated/inadequately described																																		

Collection and usage attributes

Guide for use:

CODE 1 Cardiogenic shock

Use this code when the person has experienced cardiogenic shock, including if the person was in shock at the time of presentation to the hospital.

Cardiogenic shock is defined as:

- hypotension (systolic BP <90mmHg for at least 30 minutes or the need for supportive measures to maintain blood pressure of greater than or equal to 90mmHg)
- end-organ hypoperfusion (cool extremities or a urine output of <30ml/hour, and a heart rate \geq 60 beats/minute)
- a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

CODE 2 Cardiac rupture

Use this code when the person has a rupture of the ventricular myocardium, the ventricular septum, or a frank papillary muscle rupture. This includes if the person experienced the rupture before presentation to the hospital.

CODE 3 Cardiac arrest

Use this code when the person has experienced cardiac arrest (i.e. the lack of effective cardiac output), including if the person was under arrest at the time of presentation to the hospital.

CODE 4 New or recurrent myocardial infarction

Use this code when the person experiences a myocardial infarction during hospitalisation distinct from the index event at the time of presentation.

Recurrent myocardial infarction is defined by clinical events and cardiac marker elevations after the first 24 hours following presentation to the hospital.

For people presenting without initial evidence of myonecrosis, recurrent MI is defined by:

- A rise in troponin T or I to greater than the diagnostic threshold level (with precision of 10% coefficient of variation) as defined by the local laboratory; OR
- A CK-MB elevation of greater than twice the upper limit of normal for the laboratory (if CK-MB is not available, CK may be used).

For people presenting with evidence of myonecrosis:

- A further rise in troponin of greater than 25% or a re-elevation in CK-MB of greater than 50% (if no CK-MB is drawn, CK may be used) will define recurrent MI
- If the event occurs within 24 hours of PCI, then a level of greater than 3 times the upper limit of normal for CK-MB will be used. If the event occurs within 24 hours of CABG, then a level of greater than 5 times the upper limit of normal for CK-MB will be used.

CODE 5 Stroke

Use this code if the person experiences a loss of neurological function with residual symptoms remaining for at least 24 hours after onset and which occurred before presentation to the hospital. The occurrence of stroke should be evidenced by a record of cerebral imaging (CT or MRI).

CODE 6 Acute pulmonary oedema/congestive heart failure

Use this code when the person has experienced acute pulmonary oedema or congestive heart failure with evidence of supportive clinical signs of ventricular dysfunction. These include:

- Third heart sound (S3)
- Cardiomegaly
- Elevated jugular venous pressure (JVP)
- Chest X-ray evidence of pulmonary congestion
- Requirement for ventilatory assistance (CPAP or intubation).

This includes if acute pulmonary oedema or congestive heart failure was present at the time of presentation to the hospital.

CODE 7 Recurrent rest angina with electrocardiogram (ECG) changes

Use this code when the person has experienced recurrent ischaemic pain occurring at rest believed to be cardiac in origin with associated ECG changes.

CODE 8 Recurrent rest angina without electrocardiogram (ECG) changes

Use this code when the person has experienced recurrent ischaemic pain occurring at rest believed to be cardiac in origin without associated ECG changes.

CODE 9 New onset arrhythmia: atrial

Use this code when the person has experienced an atrial arrhythmia, that was not present before this acute coronary syndrome event, documented by one of the following:

- Atrial fibrillation/flutter
- Supraventricular tachycardia requiring treatment (i.e. requiring cardioversion, drug therapy, or is sustained for greater than one minute).

CODE 10 New onset arrhythmia: ventricular

Use this code when the person has experienced ventricular tachycardia or ventricular fibrillation requiring cardioversion and/or intravenous antiarrhythmics, that was not present before this acute coronary syndrome event.

CODE 11 New onset arrhythmia: heart block (1,2,3)

Use this code when the person has experienced first, second or third degree atrioventricular block with bradycardia with or without the requirement for pacing.

CODE 12 Unplanned revascularisation

Use this code when the person has undergone revascularisation precipitated by 20 minutes or more of recurrent chest pain with/or without objective evidence of ischaemia on the ECG.

Code 13 Acute renal failure

Use this code when the person has acute renal failure as determined by a rise in serum creatinine of x 1.5 or a decrease in GFR by 25% or urine output <0.5mL/kg/h for 6 hours.

Code 14 Thrombocytopenia

Use this code when the person has thrombocytopenia as determined by the platelet count: platelet count dropped to less than $100 \times 10^9/L$.

Data element attributes

Collection and usage attributes

Guide for use:

Record all clinical events that the person experiences from the time of presentation to hospital until discharge from hospital.

More than one event may be recorded.

The time and date must be recorded for each clinical event that occurs.

Comments:

An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS.

Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.

Source and reference attributes

Reference documents:

Chew DPB et al. National data elements for the clinical management of acute coronary syndromes. Medical Journal of Australia. Volume 182 Number 9. 2 May 2005.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome clinical event cluster](#) Health, Standard 01/10/2008

Conditional obligation:

If a clinical event has occurred, record the clinical event type.

Acute coronary syndrome related medical history

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – acute coronary syndrome related medical history, code NN
<i>METeOR identifier:</i>	356598
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's history of acute coronary syndrome related medical conditions as represented by a code.
Data Element Concept:	Person – acute coronary syndrome related medical history

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																					
<i>Data type:</i>	Number																																					
<i>Format:</i>	NN																																					
<i>Maximum character length:</i>	2																																					
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>11</td><td>Angina (excluding unstable angina): prior existing</td></tr><tr><td>12</td><td>Angina (excluding unstable angina): new onset</td></tr><tr><td>13</td><td>Unstable angina</td></tr><tr><td>21</td><td>Chronic lung disease</td></tr><tr><td>31</td><td>Heart failure</td></tr><tr><td>41</td><td>Hypertension</td></tr><tr><td>51</td><td>Ischaemic: non-haemorrhagic cerebral infarction</td></tr><tr><td>52</td><td>Haemorrhagic: intracerebral haemorrhage</td></tr><tr><td>61</td><td>Peripheral artery disease</td></tr><tr><td>62</td><td>Aortic aneurysm</td></tr><tr><td>63</td><td>Renal artery stenosis</td></tr><tr><td>71</td><td>Sleep apnoea</td></tr><tr><td>81</td><td>Previous myocardial infarction</td></tr><tr><td>91</td><td>Atrial fibrillation</td></tr><tr><td>92</td><td>Other dysrhythmia or conductive disorder</td></tr><tr><td>93</td><td>Left ventricular hypertrophy</td></tr><tr><td><i>Supplementary values:</i></td><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	11	Angina (excluding unstable angina): prior existing	12	Angina (excluding unstable angina): new onset	13	Unstable angina	21	Chronic lung disease	31	Heart failure	41	Hypertension	51	Ischaemic: non-haemorrhagic cerebral infarction	52	Haemorrhagic: intracerebral haemorrhage	61	Peripheral artery disease	62	Aortic aneurysm	63	Renal artery stenosis	71	Sleep apnoea	81	Previous myocardial infarction	91	Atrial fibrillation	92	Other dysrhythmia or conductive disorder	93	Left ventricular hypertrophy	<i>Supplementary values:</i>	99	Not stated/inadequately described
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<i>Supplementary values:</i>	99	Not stated/inadequately described																																				

Collection and usage attributes

Guide for use:

Angina:

CODE 11 Angina (excluding unstable angina): prior existing

This code is used where there are symptoms, which can be described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing) suggestive of cardiac ischaemia, the onset of which occurred more than two weeks ago.

CODE 12 Angina (excluding unstable angina): new onset

This code is used where there are symptoms which can be described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing) suggestive of cardiac ischaemia; the onset of which occurred two or less weeks ago.

CODE 13 Unstable angina

This code is used where a person has experienced new onset or prior existing angina (described as chest pain or pain in either or both shoulders, the back, neck or jaw, or other equivalent discomfort (such as tightness, gripping or squeezing)), which is increasing in severity, duration or frequency.

Chronic lung disease:

CODE 21 Chronic lung disease

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

Heart failure:

CODE 31 Heart failure

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

Hypertension:

CODE 41 Hypertension

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

CODE 51 Ischaemic: non-haemorrhagic cerebral infarction

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

CODE 52 Haemorrhagic: intracerebral haemorrhage

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

Peripheral arterial disease:

CODE 61 Peripheral artery disease

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

CODE 62 Aortic aneurysm

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

CODE 63 Renal artery stenosis

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

Sleep apnoea syndrome:

CODE 71 Sleep apnoea

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

Myocardial infarction:

CODE 81 Previous myocardial infarction

This code is used where a person has previously experienced a myocardial infarction, excluding the current event that prompted this presentation to hospital. This may be supported by clinical documentation and evidenced by ECG changes or serum cardiac biomarker changes.

Other vascular conditions:

CODE 91 Atrial fibrillation

This code is used where there is a history or symptoms suggestive of atrial fibrillation.

CODE 92 Other cardiac arrhythmias or conductive disorders

This code is used where there is a history of other cardiac arrhythmias or conductive disorders.

CODE 93 Left ventricular hypertrophy

This code is used where there is a history or symptoms suggestive of left ventricular hypertrophy.

Data element attributes

Collection and usage attributes

Guide for use:

More than one medical condition may be recorded.

Record only those codes that apply.

Record all codes that apply.

Collection methods:

Where codes 21, 31, 51, 52, 61, 62, 63, 71, 91, 92 and 93 are recorded Person - clinical evidence status (acute coronary syndrome related medical conditions), yes/no code N must also be recorded.

Comments:

A history of the listed medical conditions is pertinent to the risk stratification and treatment of acute coronary syndrome.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Reference documents: National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Related metadata references: Supersedes [Person – acute coronary syndrome concurrent clinical condition, code NN](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Acute coronary syndrome stratum

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – acute coronary syndrome risk stratum, code N
<i>METeOR identifier:</i>	356665
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Risk stratum of a person presenting with clinical features consistent with an acute coronary syndrome defined by accompanying clinical, electrocardiogram (ECG) and biochemical features, as represented by a code.
Data Element Concept:	Person – acute coronary syndrome risk stratum

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>ST-segment-elevation (myocardial infarction)</td></tr><tr><td>2</td><td>Non-ST-segment-elevation ACS with high-risk features</td></tr><tr><td>3</td><td>Non-ST-segment-elevation ACS with intermediate-risk features</td></tr><tr><td>4</td><td>Non-ST-segment-elevation ACS with low-risk features</td></tr></tbody></table>	Value	Meaning	1	ST-segment-elevation (myocardial infarction)	2	Non-ST-segment-elevation ACS with high-risk features	3	Non-ST-segment-elevation ACS with intermediate-risk features	4	Non-ST-segment-elevation ACS with low-risk features
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3	Non-ST-segment-elevation ACS with intermediate-risk features										
4	Non-ST-segment-elevation ACS with low-risk features										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 ST-segment-elevation (myocardial infarction)</p> <p>This code is used where persistent ST elevation of ≥ 1mm in two contiguous limb leads, or ST elevation of ≥ 2mm in two contiguous chest leads, or with new left bundle -branch block (BBB) pattern on the ECG.</p> <p>This classification is intended for identification of patients potentially eligible for reperfusion therapy, either pharmacologic or intervention-based. Other considerations such as the time to presentation and the clinical appropriateness of instituting reperfusion are not reflected in this metadata item.</p> <p>CODE 2 Non-ST-segment-elevation ACS with high-risk features</p> <p>This code is used when presentation with clinical features consistent with an acute coronary syndrome with high-risk features which include any of the following:</p>
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- repetitive or prolonged (> 10 minutes) ongoing chest pain or discomfort;
- elevated level of at least one cardiac biomarker (troponin or creatine kinase-MB isoenzyme);
- persistent or dynamic ECG changes of ST segment depression $\geq 0.5\text{mm}$ or new T wave $\geq 2\text{mm}$;
- transient ST-segment elevation ($\geq 0.5\text{ mm}$) in more than 2 contiguous leads;
- haemodynamic compromise: Blood pressure $< 90\text{ mmHg}$ systolic, cool peripheries, diaphoresis, Killip Class > 1 , and/or new onset mitral regurgitation;
- sustained ventricular tachycardia;
- syncope;
- left ventricular systolic dysfunction (left ventricular ejection fraction < 0.40);
- prior percutaneous coronary intervention within 6 months or prior coronary artery bypass surgery;
- presence of known diabetes (with typical symptoms of ACS);or
- chronic kidney disease (estimated glomerular filtration rate $< 60\text{mL/minute}$) (with typical symptoms of ACS).

This classification is intended for identification of patients potentially eligible for aggressive medical management and coronary angiography and revascularisation.

CODE 3 Non-ST-segment-elevation ACS with intermediate-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome and any of the following intermediate-risk features AND NOT meeting the criteria for high-risk ACS:

- chest pain or discomfort within the past 48 hours that occurred at rest, or was repetitive or prolonged (but currently resolved);
- age greater than 65yrs;
- known coronary heart disease: prior myocardial infarction with left ventricular ejection fraction ≥ 0.40 known coronary lesion more than 50% stenosed;
- no high-risk changes on electrocardiography (see high-risk features);
- two or more of the following risk factors: known hypertension, family history, active smoking or hyperlipidaemia;
- presence of known diabetes (with atypical symptoms of ACS);
- chronic kidney disease (estimated glomerular filtration rate $< 60\text{mL/minute}$) (with atypical symptoms of ACS); or
- prior aspirin use.

This classification is intended for identification of patients potentially eligible for accelerated diagnostic evaluation and further risk stratification.

CODE 4 Non-ST-segment-elevation ACS with low-risk features

This code is used when presentation with clinical features consistent with an acute coronary syndrome without intermediate or high-risk features of non-ST-segment-elevation ACS. This includes onset of anginal symptoms within the last month, or worsening in severity or frequency of angina, or lowering of anginal threshold.

This classification is intended for identification of patients potentially eligible for outpatient investigation discharge on upgraded medical therapy and outpatient investigation.

Data element attributes

Collection and usage attributes

Guide for use:

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

Acute coronary syndrome symptoms may include:

- tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrists and hands
- dyspnoea, nausea/vomiting, cold sweat or syncope.

Collection methods:

Recorded at time of presentation.

Only one code should be recorded.

Must be recorded in conjunction with Person – acute coronary syndrome procedure type, code NN and Person – clinical procedure timing, code N.

Comments:

The clinical, electrocardiogram and biochemical characteristics are important to enable early risk stratification.

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Origin:

National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

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

Relational attributes

Related metadata references:

Supersedes [Person – acute coronary syndrome risk stratum, code N](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Additional diagnosis

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	391322
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	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

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>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.</p> <p>The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.</p> <p>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).</p>
<i>Collection methods:</i>	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:

Supersedes [Episode of care – additional diagnosis, code \(ICD-10-AM 6th edn\) ANN{.N\[N\]} Health](#), Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v 6\) NN Health](#), Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v 6\) ANNA Health](#), Standard 22/12/2009

Implementation in Data Set Specifications:

[Admitted patient care NMDS 2010-2011 Health](#), Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS 2010-2011 Health](#), Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS 2010-11 Health](#), Standard 05/01/2010

Implementation start date: 01/07/2010

[Residential mental health care NMDS 2010-2011 Health](#), Standard 05/01/2010

Implementation start date: 01/07/2010

Address line (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address)— address line, text [X(180)]
<i>Synonymous names:</i>	Australian address line
<i>METeOR identifier:</i>	286620
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A composite of one or more standard address components that describes a low level of geographical/physical description of a location, as represented by text. Used in conjunction with the other high-level address components i.e. Suburb/town/locality, Postcode— Australian, Australian state/territory, and Country, forms a complete geographical/physical address of a person.
Data Element Concept:	Person (address)— address line

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(180)]
<i>Maximum character length:</i>	180

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A high-level address component is defined as a broad geographical area that is capable of containing more than one specific physical location. Some examples of a broad geographical area are:</p> <ul style="list-style-type: none">- Suburb, town or locality- Postcode— Australian or international- State, Territory, local government area, electorate, statistical local area- Postal delivery point identifier- Countries, provinces, etc other than in Australia <p>These components of a complete address do not form part of the Address line.</p> <p>When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:</p> <ul style="list-style-type: none">- Building/complex sub-unit type- Building/complex sub-unit number
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- Building/property name
- Floor/level number
- Floor/level type
- House/property number
- Lot/section number
- Street name
- Street type code
- Street suffix code

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

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

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

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

Multiple Address lines may be recorded as required.

Collection methods:

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

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.
- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.
- Street name is to be used in conjunction with Street type code and Street suffix code.
- Street type code is to be used in conjunction with Street name and Street suffix code.
- Street suffix code is to be used in conjunction with Street name and Street type code.
- House/property number is to be used in conjunction with Street name.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

Health Data Standards Committee

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia.

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:

Is formed using [Person \(address\) – street suffix, code A\[A\]](#)
Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using [Person \(address\) – street type, code A\[AAA\]](#)
Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using [Person \(address\) – street name, text \[A\(30\)\]](#)
Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using [Person \(address\) – lot/section identifier, N\[X\(14\)\]](#) Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using [Person \(address\) – house/property identifier, text \[X\(12\)\]](#) Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using [Person \(address\) – floor/level type, code A\[A\]](#)
Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using [Person \(address\) – floor/level identifier, \[NNNA\]](#) Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using [Person \(address\) – building/complex sub-unit type, code A\[AAA\]](#) Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using [Person \(address\) – building/complex sub-unit identifier, \[X\(7\)\]](#) Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Is formed using [Person \(address\) – building/property name, text \[X\(30\)\]](#) Health, Standard 01/03/2005, Community services, Standard 30/09/2005

Supersedes [Person \(address\) – health address line, text \[X\(180\)\]](#)
Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Address line (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – address line, text [X(180)]
<i>METeOR identifier:</i>	290315
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A composite of one or more standard address components, as represented by text.
Data Element Concept:	Service provider organisation (address) – address line

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(180)]
<i>Maximum character length:</i>	180

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A high-level address component is defined as a broad geographical area that is capable of containing more than one specific physical location. Some examples of a broad geographical area are:</p> <ul style="list-style-type: none">• Suburb, town or locality• Postcode• Australian or international• State, Territory, local government area, electorate, statistical local area• Postal delivery point identifier• Countries, provinces, etc. other than in Australia <p>These components of a complete address do not form part of the Address line.</p> <p>When addressing an Australian location, following are the standard address data elements that may be concatenated in the Address line:</p> <ul style="list-style-type: none">• Building/complex sub-unit type• Building/complex sub-unit number• Building/property name• Floor/level number
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- Floor/level type
- House/property number
- Lot/section number
- Street name
- Street type code
- Street suffix code

One complete identification/description of a location/site of an address can comprise one or more than one instance of address line. Instances of address lines are commonly identified in electronic information systems as Address-line 1, Address-line 2, etc. The format of data collection is less important than consistent use of conventions in the recording of address data. Hence, address may be collected in an unstructured manner but should ideally be stored in a structured format. Where Address line is collected as a stand-alone item, software may be used to parse the Address line details to separate the sub-components. Multiple Address lines may be recorded as required.

Collection methods:

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

- Building/complex sub-unit type is to be collected in conjunction with Building/complex sub-unit number and vice versa.
- Floor/level type is to be collected in conjunction with Floor/level number and vice versa.
- Street name is to be used in conjunction with Street type code and Street suffix code.
- Street type code is to be used in conjunction with Street name and Street suffix code.
- Street suffix code is to be used in conjunction with Street name and Street type code.
- House/property number is to be used in conjunction with Street name.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

Health Data Standards Committee

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia.

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Is formed using [Service provider organisation \(address\) – street suffix, code A\[A\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using [Service provider organisation \(address\) – street type, code A\[AAA\]](#) Health, Standard 04/05/2005, Community

services, Standard 30/09/2005

Is formed using [Service provider organisation \(address\) – street name, text \[A\(30\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using [Service provider organisation \(address\) – lot/section identifier, N\[X\(14\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using [Service provider organisation \(address\) – house/property identifier, text \[X\(12\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using [Service provider organisation \(address\) – floor/level type, code A\[A\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using [Service provider organisation \(address\) – floor/level identifier, \[NNNA\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using [Service provider organisation \(address\) – building/complex sub-unit type, code A\[AAA\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using [Service provider organisation \(address\) – building/complex sub-unit identifier, \[X\(7\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is formed using [Service provider organisation \(address\) – building/property name, text \[X\(30\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications:

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Address type (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – address type, code N
<i>METeOR identifier:</i>	286728
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A code set representing a type of address, as represented by a code.
Data Element Concept:	Person (address) – address type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Business</td></tr><tr><td>2</td><td>Mailing or postal</td></tr><tr><td>3</td><td>Residential</td></tr><tr><td>4</td><td>Temporary residential</td></tr></tbody></table>	Value	Meaning	1	Business	2	Mailing or postal	3	Residential	4	Temporary residential
Value	Meaning										
1	Business										
2	Mailing or postal										
3	Residential										
4	Temporary residential										
<i>Supplementary values:</i>	9 Unknown/Not stated/inadequately described										

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Business</p> <p>This code is used to indicate an address that is the physical location of a business, an office or from where a service is delivered.</p> <p>CODE 2 Mailing or postal</p> <p>This code is used to indicate an address that is only for correspondence purposes.</p> <p>CODE 3 Residential</p> <p>This code is used to indicate where a person is living. Note that this code is not valid for organisations.</p> <p>CODE 4 Temporary residential</p> <p>Temporary accommodation address (such as for a person from rural Australia who is visiting an oncology centre for a course of treatment, or a person who usually resides overseas). Note that this is not valid for organisations.</p>
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CODE 9 Unknown/Not stated/inadequately described

This code may also be used where the person has no fixed address or does not wish to have their residential or a correspondence address recorded.

Data element attributes

Collection and usage attributes

Guide for use:

A single address may have multiple address types associated with it. Record as many as required.

Collection methods:

At least one address must be recorded (this may be an unknown Address type).

Health care establishments should always attempt to collect the residential address of a person who is a health care client when a service is provided. When recording the address for a health care provider or organisation, the business address should always be collected. In addition, other addresses may also need to be recorded for individuals and organisations.

Overseas address:

For individuals record the overseas address as the residential address and record a temporary accommodation address as their contact address in Australia.

Comments:

'No fixed address' is coded as unknown because it (the concept) is not a type of address for a person but is an attribute of the person only i.e. it is not a location for which an address may be derived. It is not recommended that an implementation collects this attribute as an address type. A person not having a fixed address constrains the number of address types that can be collected i.e. temporary accommodation and residential address types cannot be collected. However, if it is imperative that this occurs, it is suggested that code 9 be used.

Source and reference attributes

Submitting organisation:

Standards Australia

Australian Institute of Health and Welfare

Origin:

AS5017 Health Care Client Identification, 2002, Sydney:
Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia
In AS4846 and AS5017 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:

Supersedes [Person \(address\) – address type, code A](#) Health,
Superseded 04/05/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Address type (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – address type, code N
<i>METeOR identifier:</i>	286792
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The type of geographical/physical location where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address) – address type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Business</td></tr><tr><td>2</td><td>Mailing or postal</td></tr><tr><td>9</td><td>Unknown/Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Business	2	Mailing or postal	9	Unknown/Not stated/inadequately described
Value	Meaning								
1	Business								
2	Mailing or postal								
9	Unknown/Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Business This code is used to indicate an address that is the physical location of a business, an office or from where a service is delivered.</p> <p>CODE 2 Mailing or postal This code is used to indicate an address that is only for correspondence purposes.</p> <p>CODE 9 Unknown/Not stated/inadequately described This code may also be used where the person has no fixed address or does not wish to have their residential or a correspondence address recorded</p>
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	A single address may have multiple address types associated with it. Record as many as required.
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Collection methods:

At least one address must be recorded (this may be an unknown Address type). When recording the address for a health care provider or organisation, the business address should always be collected. In addition, other addresses may also need to be recorded for individuals and organisations.

Source and reference attributes

Origin:

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

In AS4846 and AS5017 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Address—country identifier (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address)—country identifier, code (SACC 2008) NNNN
<i>METeOR identifier:</i>	370937
<i>Registration status:</i>	Health, Standard 01/10/2008 Community services, Standard 02/06/2008
<i>Definition:</i>	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

<i>Classification scheme:</i>	Standard Australian Classification of Countries 2008
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

Collection and usage attributes

<i>Guide for use:</i>	<p>The Standard Australian Classification of Countries 2008 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country.</p> <p>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.</p>
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Collect the data at the 4-digit level.
<i>Comments:</i>	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

<i>Reference documents:</i>	Standard Australian Classification of Countries Edition 2, Catalogue number 1269.0 , 2008, Canberra: Australian Bureau of Statistics
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Relational attributes

Related metadata references:

Supersedes [Person \(address\) – country identifier, code \(SACC 1998\) NNNN](#) Health, Superseded 01/10/2008, Community services, Superseded 02/06/2008

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Administrative health region name

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Administrative health region – region name, text [A(80)]
<i>METeOR identifier:</i>	297639
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Textual description of the full name of an administrative health region.
Data Element Concept:	Administrative health region – region name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(80)]
<i>Maximum character length:</i>	80

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Administrative health regions are determined by the relevant state or territory.
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Source and reference attributes

<i>Submitting organisation:</i>	Palliative Care Intergovernmental Forum
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Palliative care performance indicators DSS Health, Standard 05/12/2007
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Administrative health region palliative care strategic plan indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Administrative health region – palliative care strategic plan indicator, yes/no code N
<i>METeOR identifier:</i>	288331
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Whether an administrative health region has a written strategic plan which incorporates palliative care elements, as represented by a code.
Data Element Concept:	Administrative health region – palliative care strategic plan indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A palliative care strategic plan may be an entire health region's plan, or an aggregation of the region's sub-units' plans. The plan may be specifically for palliative care or a general health service plan that includes palliative care elements.</p> <p>The palliative care elements in the plan must include all of the following aspects:</p> <ul style="list-style-type: none">• timeframe (the beginning and end-date in years), with a minimum time period of two years to demonstrate a strategic focus• measurable objectives relating to: service access, quality, utilisation, responsiveness and evaluation• demonstrated stakeholder involvement in plan development, such as the inclusion of a description of the consultation process in the strategic plan document• demonstrated links with the National Palliative Care Strategy
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- implementation strategies (can include resources identified for service delivery)
- evidence of ongoing development in subsequent plans.

A strategic plan typically has a mission statement, outlines a vision, values and strategies, and includes goals and objectives. A strategic plan may: serve as a framework for decisions; provide a basis for more detailed planning; explain the business to others in order to inform, motivate and involve; assist benchmarking and performance monitoring; stimulate change and become a building block for next plan.

The plan will ideally address both palliative care at the specialist level and palliative care at the primary care (i.e. non-specialist) level.

CODE 1 Yes

The administrative health region has a written strategic plan which incorporates palliative care elements, and which includes all specified strategic plan aspects.

CODE 2 No

The administrative health region does not have a written strategic plan which incorporates palliative care elements, or has a plan with only partial coverage of the specified strategic plan aspects.

Source and reference attributes

Submitting organisation:

Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

[Palliative care performance indicators DSS](#) Health, Standard 05/12/2007

Admission date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – admission date, DDMMYYYY
<i>METeOR identifier:</i>	269967
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date on which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care – admission date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Admission date, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
	Is used in the formation of Episode of admitted patient care – major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009
	Is used in the formation of Episode of admitted patient care – diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009
	Is used in the formation of Episode of admitted patient care – diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009
	Is used in the formation of Episode of admitted patient care – major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009
	Is used in the formation of Episode of admitted patient care – length of stay (including leave days), total N[NN] Health, Standard 04/07/2007
	Is used in the formation of Episode of admitted patient care – length of stay (including leave days) (antenatal), total N[NN] Health, Standard 04/07/2007

Implementation in Data Set Specifications:

Is used in the formation of [Episode of admitted patient care – length of stay \(excluding leave days\), total N\[NN\]](#) Health, Standard 01/03/2005

Is used in the formation of [Episode of care – number of psychiatric care days, total N\[NNNN\]](#) Health, Standard 01/03/2005

Is used in the formation of [Episode of admitted patient care – length of stay \(including leave days\), total N\[NN\]](#) Health, Superseded 04/07/2007

Is used in the formation of [Episode of admitted patient care \(antenatal\) – length of stay \(including leave days\), total N\[NN\]](#) Health, Superseded 04/07/2007

Is used in the formation of [Non-admitted patient emergency department service episode – waiting time \(to hospital admission\), total hours and minutes NNNN](#) Health, Standard 01/03/2005

Is used in the formation of [Elective surgery waiting list episode – waiting time \(at removal\), total days N\[NNN\]](#) Health, Standard 01/03/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Admission time

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – admission time, hhmm
<i>METeOR identifier:</i>	269972
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Time at which an admitted patient commences an episode of care.
Data Element Concept:	Episode of admitted patient care – admission time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Comments:</i>	Required to identify the time of commencement of the episode or hospital stay, for calculation of waiting times and length of stay.
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Admission time, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB) Is used in the formation of Non-admitted patient emergency department service episode – waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Admitted patient election status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – patient election status, code N
<i>METeOR identifier:</i>	326619
<i>Registration status:</i>	Health, Standard 23/10/2006
<i>Definition:</i>	Accommodation chargeable status elected by a patient on admission , as represented by a code.
Data Element Concept:	Episode of admitted patient care – patient election status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Public</td></tr><tr><td>2</td><td>Private</td></tr></tbody></table>	Value	Meaning	1	Public	2	Private
Value	Meaning						
1	Public						
2	Private						

Collection and usage attributes

<i>Guide for use:</i>	<p>Public patient:</p> <p>A person, eligible for Medicare, who receives or elects to receive a public hospital service free of charge.</p> <p>Includes: patients in public psychiatric hospitals who do not have the choice to be treated as a private patient. Also includes overseas visitors who are covered by a reciprocal health care agreement, and who elect to be treated as public patients.</p> <p>Private patient:</p> <p>A person who elects to be treated as a private patient and elects to be responsible for paying fees for the type referred to in clause 49 of the Australian Health Care Agreements (2003–2008).</p> <p>Clause 49 states that:</p> <p>Private patients, compensable patients and ineligible persons may be charged an amount for public hospital services as determined by (the state or territory).</p> <p>All patients in private hospitals (other than those receiving public hospital services and electing to be treated as a public patient) are private patients.</p> <p>Includes: all patients who are charged (regardless of the level of the charge) or for whom a charge is raised for a third party payer (for example, Department of Veterans' Affairs and Compensable patients). Also includes patients who are Medicare ineligible and</p>
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receive public hospital services free of charge at the discretion of the hospital, and prisoners, who are Medicare ineligible while incarcerated.

Data element attributes

Collection and usage attributes

Guide for use:

Australian Health Care Agreements 2003–08 state that eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services.

At the time of, or as soon as practicable after, admission for a public hospital service, the patient must elect in writing to be treated as either

- a public patient or
- a private patient

This item is independent of the patient's hospital insurance status and room type.

Notes:

Inability to sign: In cases where the patient is unable to complete the patient election form, the patient should be assumed to be a public patient.

Compensation funding decisions: A patient may be recorded as a public patient as an interim patient election status while the patient's compensable status is being decided.

Inter-hospital contracted care: If the patient receives inter-hospital contracted care the following guidelines can be used if no further information is available:

- If the patient received contracted care that was purchased by a public hospital then it will be assumed that they elected to be treated as a public patient.
- If the patient received contracted care that was purchased by a private hospital then it will be assumed that they elected to be treated as a private patient.

Source and reference attributes

Submitting organisation:

Admitted patient care NMDS Technical Reference Group

Relational attributes

Related metadata references:

Supersedes [Episode of admitted patient care – elected accommodation status, code N](#) Health, Superseded 23/10/2006

Implementation in Data Set Specifications:

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded
22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

Age

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – age, total years N[NN]
<i>METeOR identifier:</i>	303794
<i>Registration status:</i>	Health, Standard 08/02/2006 Community services, Standard 29/04/2006 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	The age of the person in (completed) years at a specific point in time.
<i>Context:</i>	Age is a core data element in a wide range of social, labour and demographic statistics. It is used in the analyses of service utilisation by age group and can be used as an assistance eligibility criterion.
Data Element Concept:	Person – age

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning 999 Unknown/not stated
<i>Unit of measure:</i>	Year

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Age in single years (if aged under one year, record as zero). If age (or date of birth) is unknown or not stated, and cannot be estimated, use Code 999. National community services and housing assistance data dictionary specific: If year of birth is known (but date of birth is not) use the date, 0101YYYY of the birth year to estimate age (where YYYY is the year of birth). National housing assistance data dictionary specific: In the housing assistance data collections age is calculated at 30 June for the corresponding year.
<i>Collection methods:</i>	Although collection of date of birth allows more precise calculation of age, this may not be feasible in some data collections, and alternative questions are: Age last birthday? What was age last birthday?

What is age in complete years?

Comments:

National community services data dictionary specific:

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

Those who need to conduct data collections for children where age is collected in months, weeks, or days should do so in a manner that allows for aggregation of those results to this standard.

Source and reference attributes

Submitting organisation:

National Public Health Information Working Group

Origin:

Australian Bureau of Statistics, *Standards for Social, Labour and Demographic Variables*. Reference through:

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DirClassManualsbyCatalogue/76CD93AA32E74B29CA25713E0005A2EA?OpenDocument>

Relational attributes

Related metadata references:

See also [Person – date of birth, MMYYYY](#) Health, Standard 10/12/2009

Supersedes [Person – age, total years N\[NN\]](#) Health, Superseded 08/02/2006

Implementation in Data Set Specifications:

[Computer Assisted Telephone Interview demographic module DSS](#) Health, Superseded 03/12/2008

[Computer Assisted Telephone Interview demographic module DSS](#) Health, Standard 03/12/2008

Age range

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – age range, code NN
<i>METeOR identifier:</i>	290540
<i>Registration status:</i>	Health, Standard 04/05/2005
<i>Definition:</i>	The age range that best accommodates a person's completed age in years, at the time of data collection, as represented by a code.
Data Element Concept:	Person – age range

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	NN																				
<i>Maximum character length:</i>	2																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>0-4</td></tr><tr><td>02</td><td>5-14</td></tr><tr><td>03</td><td>15-24</td></tr><tr><td>04</td><td>25-34</td></tr><tr><td>05</td><td>35-44</td></tr><tr><td>06</td><td>45-54</td></tr><tr><td>07</td><td>55-64</td></tr><tr><td>08</td><td>65-74</td></tr><tr><td>09</td><td>75 years or older</td></tr></tbody></table>	Value	Meaning	01	0-4	02	5-14	03	15-24	04	25-34	05	35-44	06	45-54	07	55-64	08	65-74	09	75 years or older
Value	Meaning																				
01	0-4																				
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03	15-24																				
04	25-34																				
05	35-44																				
06	45-54																				
07	55-64																				
08	65-74																				
09	75 years or older																				
<i>Supplementary values:</i>	99 Not stated																				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Used in computer assisted telephone interview (CATI) surveys in cases where the specific age is not available. Depending on the collection a different starting age may be used, but should map back to the standard output. Information at a finer level can be collected as long as it maps back to the proposed data domain, e.g. 75+ age group can be split into 75-84 and 85 years or older.
<i>Collection methods:</i>	Although collection of date of birth allows more precise calculation of age, as does the collection of a single age, this may not always be feasible. Age range should be derived from a

question on date of birth or age at last birthday.

Comments:

In cases where an exact age is not known or not stated, age may be reported as an age range. The age ranges are consistent with the standard 10 year ranges recommended by the ABS.

Source and reference attributes

Submitting organisation:

National Public Health Information Working Group

Origin:

ABS, Statistical Concepts Library, Standards for Social, Labour and Demographic Variables. Age.

Reference documents:

Reference through:

<http://www.abs.gov.au/Ausstats/abs@.nsf/StatsLibrary> and choose, Other ABS Statistical Standards, Standards for Social, Labour and Demographic Variables, Demographic Variables, Age.

Relational attributes

Implementation in Data Set Specifications:

[Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008](#)

[Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008](#)

Alcohol consumption frequency (self reported)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – alcohol consumption frequency (self-reported), code NN
<i>METeOR identifier:</i>	270247
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person’s self-reported frequency of alcohol consumption, as represented by a code.
Data Element Concept:	Person – alcohol consumption frequency

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																										
<i>Data type:</i>	String																										
<i>Format:</i>	NN																										
<i>Maximum character length:</i>	2																										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Every day/7 days per week</td></tr><tr><td>02</td><td>5 to 6 days per week</td></tr><tr><td>03</td><td>3 to 4 days per week</td></tr><tr><td>04</td><td>1 to 2 days per week</td></tr><tr><td>05</td><td>2 to 3 days per month</td></tr><tr><td>06</td><td>Once per month</td></tr><tr><td>07</td><td>7 to 11 days in the past year</td></tr><tr><td>08</td><td>4 to 6 days in the past year</td></tr><tr><td>09</td><td>2 to 3 days in the past year</td></tr><tr><td>10</td><td>Once in the past year</td></tr><tr><td>11</td><td>Never drank any alcoholic beverage in the past year</td></tr><tr><td>12</td><td>Never in my life</td></tr></tbody></table>	Value	Meaning	01	Every day/7 days per week	02	5 to 6 days per week	03	3 to 4 days per week	04	1 to 2 days per week	05	2 to 3 days per month	06	Once per month	07	7 to 11 days in the past year	08	4 to 6 days in the past year	09	2 to 3 days in the past year	10	Once in the past year	11	Never drank any alcoholic beverage in the past year	12	Never in my life
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10	Once in the past year																										
11	Never drank any alcoholic beverage in the past year																										
12	Never in my life																										
<i>Supplementary values:</i>	99 Not reported																										

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	The World Health Organisation, in its 2000 International Guide for Monitoring Alcohol Consumption and Related Harm document, suggests that in assessing alcohol consumption patterns a ‘Graduated Quantity Frequency’ method is preferred. This method requires that questions about the quantity and frequency of alcohol consumption should be asked to help determine short-term and long-term health consequences. This
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information can be collected (but not confined to) the following ways:

- in a clinical setting with questions asked by a primary healthcare professional
- as a self-completed questionnaire in a clinical setting
- as part of a health survey
- as part of a computer aided telephone interview.

It should be noted that, particularly in telephone interviews, the question(s) asked may not be a direct repetition of the Value domain; yet they may still yield a response that could be coded to the full Value domain or a collapsed version of the Value domain.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

Australian Alcohol Guidelines: Health Risks and Benefits, National Health & Medical Research Council, October 2001

Relational attributes

Related metadata references:

Supersedes [Alcohol consumption frequency- self report, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (24.3 KB)

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Alcohol consumption in standard drinks per day (self reported)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – alcohol consumption amount (self-reported), total standard drinks NN
<i>METeOR identifier:</i>	270249
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's self-reported usual number of alcohol-containing standard drinks on a day when they consume alcohol.
Data Element Concept:	Person – alcohol consumption amount

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NN
<i>Maximum character length:</i>	2
<i>Supplementary values:</i>	Value Meaning
	99 Consumption not reported
<i>Unit of measure:</i>	Standard drink

Collection and usage attributes

<i>Guide for use:</i>	Alcohol consumption is usually measured in standard drinks. An Australian standard drink contains 10 grams of alcohol, which is equivalent to 12.5 millilitres of alcohol.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This estimation is based on the person's description of the type (spirits, beer, wine, other) and number of standard drinks, as defined by the National Health and Medical Research Council (NH&MRC), consumed per day. One standard drink contains 10 grams of alcohol.</p> <p>The following gives the NH&MRC examples of a standard drink:</p> <ul style="list-style-type: none">• Light beer (2.7%): - 1 can or stubbie = 0.8 a standard drink• Medium light beer (3.5%): - 1 can or stubbie = 1 standard drink• Regular Beer - (4.9% alcohol):
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- 1 can = 1.5 standard drinks
- 1 jug = 4 standard drinks
- 1 slab (cans or stubbies) = about 36 standard drinks
- Wine (9.5% - 13% alcohol):
 - 750-ml bottle = about 7 to 8 standard drinks
 - 4-litre cask = about 30 to 40 standard drinks
- Spirits:
 - 1 nip = 1 standard drink
 - Pre-mixed spirits (around 5% alcohol) = 1.5 standard drinks

When calculating consumption in standard drinks per day, the total should be reported with part drinks recorded to the next whole standard drink (e.g. 2.4 = 3).

Collection methods:

The *World Health Organisation's 2000 International Guide for Monitoring Alcohol Consumption and Related Harm* document suggests that in assessing alcohol consumption patterns a 'Graduated Quantity Frequency' method is preferred. This method requires that questions about the quantity and frequency of alcohol consumption should be asked to help determine short-term and long-term health consequences.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

The World Health Organisation's 2000 International Guide for Monitoring Alcohol Consumption and Related Harm document - National Health and Medical Research Council's Australian Alcohol Guidelines, October 2001.

Relational attributes

Related metadata references:

Supersedes [Alcohol consumption in standard drinks per day - self report, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (18.6 KB)

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Anaesthesia administered for operative delivery of the baby

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – anaesthesia administered, code N
<i>METeOR identifier:</i>	292044
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	Anaesthesia administered to the woman for the operative delivery of the baby, as represented by a code.
Data Element Concept:	Birth event – anaesthesia administered

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>None</td></tr><tr><td>2</td><td>Local anaesthetic to perineum</td></tr><tr><td>3</td><td>Pudendal</td></tr><tr><td>4</td><td>Epidural or caudal</td></tr><tr><td>5</td><td>Spinal</td></tr><tr><td>6</td><td>General anaesthetic</td></tr><tr><td>7</td><td>Combined spinal-epidural</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	None	2	Local anaesthetic to perineum	3	Pudendal	4	Epidural or caudal	5	Spinal	6	General anaesthetic	7	Combined spinal-epidural	8	Other	9	Not stated/inadequately described
Value	Meaning																				
1	None																				
2	Local anaesthetic to perineum																				
3	Pudendal																				
4	Epidural or caudal																				
5	Spinal																				
6	General anaesthetic																				
7	Combined spinal-epidural																				
8	Other																				
9	Not stated/inadequately described																				
<i>Supplementary values:</i>																					

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Operative delivery includes caesarean section, forceps and vacuum extraction.</p> <p>Code 7: this code is used when this technique has been selected for the administration of anaesthesia for the operative delivery of the baby.</p>
<i>Collection methods:</i>	<p>More than one agent or technique can be recorded, except where 1=none applies.</p> <p>This item should only be recorded for the operative delivery of the baby and not third stage labour e.g. removal of placenta.</p>

Comments: Anaesthetic use may influence the duration of labour, may affect the health status of the baby at birth and is an indicator of obstetric intervention.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Birth event – anaesthesia administered, code N](#) Health, Superseded 07/12/2005

Analgesia administered for labour

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – analgesia administered, code N
<i>METeOR identifier:</i>	292546
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	Analgesia administered to the woman to relieve pain for labour, as represented by a code.
Data Element Concept:	Birth event – analgesia administered

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	N																		
<i>Maximum character length:</i>	1																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>None</td></tr><tr><td>2</td><td>Nitrous oxide</td></tr><tr><td>4</td><td>Epidural or caudal</td></tr><tr><td>5</td><td>Spinal</td></tr><tr><td>6</td><td>Systemic opioids</td></tr><tr><td>7</td><td>Combined spinal-epidural</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	None	2	Nitrous oxide	4	Epidural or caudal	5	Spinal	6	Systemic opioids	7	Combined spinal-epidural	8	Other	9	Not stated/inadequately described
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6	Systemic opioids																		
7	Combined spinal-epidural																		
8	Other																		
9	Not stated/inadequately described																		
<i>Supplementary values:</i>																			

Collection and usage attributes

<i>Guide for use:</i>	
<i>Comments:</i>	Note: Code 3, 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

<i>Guide for use:</i>	Systemic opioids include both intra-muscular and intravenous opioids. Code 7: this code is used when this technique has been selected for the administration of analgesia for labour.
<i>Collection methods:</i>	More than one agent or technique can be recorded, except where 1=none applies.

This item is to be recorded for first and second stage labour, but not 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.

Source and reference attributes

Submitting organisation:

National Perinatal Data Development Committee

Relational attributes

Related metadata references:

Supersedes [Birth event – analgesia administered, code N](#) Health, Superseded 07/12/2005

Angina status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – angina status, Canadian Cardiovascular Society code N
<i>METeOR identifier:</i>	338335
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The limitation of physical activity experienced by a person with the onset of angina, as represented by the Canadian Cardiovascular Society code.
Data Element Concept:	Person – angina status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>No angina with ordinary physical activity</td></tr><tr><td>2</td><td>Slight limitation of ordinary physical activity</td></tr><tr><td>3</td><td>Marked limitation of ordinary physical activity</td></tr><tr><td>4</td><td>Inability for any physical activity without anginal symptoms</td></tr></tbody></table>	Value	Meaning	1	No angina with ordinary physical activity	2	Slight limitation of ordinary physical activity	3	Marked limitation of ordinary physical activity	4	Inability for any physical activity without anginal symptoms
Value	Meaning										
1	No angina with ordinary physical activity										
2	Slight limitation of ordinary physical activity										
3	Marked limitation of ordinary physical activity										
4	Inability for any physical activity without anginal symptoms										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Collection and usage attributes

<i>Guide for use:</i>	<p>Code 1 No angina with ordinary physical activity Use this code for patients who have no angina on ordinary physical activity such as walking or stair climbing. Angina occurs with strenuous, rapid or prolonged exertion at work or recreation.</p> <p>Code 2 Slight limitation of ordinary physical activity Use this code for patients for whom angina occurs on walking or climbing stairs rapidly, walking uphill, walking or climbing stairs after a meal, or under emotional stress, or in the cold, or only during the first few hours after waking.</p> <p>Code 3 Marked limitation or ordinary physical activity Use this code for patients where angina occurs walking one or two blocks on the level and climbing one or more flights of stairs in normal conditions and at a normal pace.</p>
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Code 4 Inability for any physical activity without anginal symptoms

Use this code for patients who are unable to carry on any physical activity without discomfort - anginal symptoms may be present at rest.

Collection methods:

Angina status is self-reported by the person but is interpreted, coded and recorded by the health professional.

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard
01/10/2008

Angiotensin converting enzyme (ACE) inhibitors therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – angiotensin converting enzyme inhibitors therapy status, code NN
<i>METeOR identifier:</i>	284751
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The person's ACE inhibitor therapy status, as represented by a code.
Data Element Concept:	Person – angiotensin converting enzyme inhibitors therapy status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																						
<i>Data type:</i>	Number																						
<i>Format:</i>	NN																						
<i>Maximum character length:</i>	2																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>10</td><td>Given</td></tr><tr><td>21</td><td>Not given - patient refusal</td></tr><tr><td>22</td><td>Not given - allergy or intolerance (e.g. cough) to ACE inhibitors</td></tr><tr><td>23</td><td>Not given - moderate to severe aortic stenosis</td></tr><tr><td>24</td><td>Not given - bilateral renal artery stenosis</td></tr><tr><td>25</td><td>Not given - history of angio-oedema, hives, or rash in response to ACE inhibitors</td></tr><tr><td>26</td><td>Not given - hyperkalaemia</td></tr><tr><td>27</td><td>Not given - symptomatic hypotension</td></tr><tr><td>28</td><td>Not given - severe renal dysfunction</td></tr><tr><td>29</td><td>Not given - other</td></tr></tbody></table>	Value	Meaning	10	Given	21	Not given - patient refusal	22	Not given - allergy or intolerance (e.g. cough) to ACE inhibitors	23	Not given - moderate to severe aortic stenosis	24	Not given - bilateral renal artery stenosis	25	Not given - history of angio-oedema, hives, or rash in response to ACE inhibitors	26	Not given - hyperkalaemia	27	Not given - symptomatic hypotension	28	Not given - severe renal dysfunction	29	Not given - other
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27	Not given - symptomatic hypotension																						
28	Not given - severe renal dysfunction																						
29	Not given - other																						
<i>Supplementary values:</i>	90 Not stated/inadequately described																						

Collection and usage attributes

<i>Guide for use:</i>	CODES 21 - 29 Not given If recording 'Not given', record the principal reason if more than one code applies.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group
Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes [Angiotensin converting enzyme \(ACE\) inhibitors therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008
[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

Anticipated patient election status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – anticipated accommodation status, code N
<i>METeOR identifier:</i>	270074
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Accommodation chargeable status nominated by the patient when placed on an elective surgery waiting list, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode – anticipated accommodation status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Public
	2	Private

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Public patient: An eligible person who receives or elects to receive a public hospital service free of charge. CODE 2 Private patient: An eligible person who elects to be treated as a private patient; and elects to be responsible for paying fees of the type referred to in clause 57 (clause 58 of the Northern Territory Agreement) of the Australian Health Care Agreements. Clause 57 states that 'Private patients and ineligible persons may be charged an amount for public hospital services as determined by the State'.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The election status nominated by the patient at the time of being placed on an elective surgery waiting list, to be treated as either: <ul style="list-style-type: none">• a public patient; or• a private patient
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This item is independent of patient's hospital insurance status. The definitions of a public and private patient are those in the 1998-2003 Australian Health Care Agreements

Patients whose charges are to be met by the Department of Veterans' Affairs are regarded as private patients.

Comments:

Anticipated election status may be used for the management of elective surgery waiting lists, but the term is not defined under the 1998-2003 Australian Health Care Agreements. Under the Australian Health Care Agreements, patients are required to elect to be treated as a public or private patient, at the time of, or as soon as practicable after admission. Therefore, the anticipated patient election status is not binding on the patient and may vary from the election the patient makes on admission.

Relational attributes

Related metadata references:

Supersedes [Anticipated patient election status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf](#) (15.2 KB)

Apgar score at 1 minute

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth – Apgar score (at 1 minute), code NN
<i>METeOR identifier:</i>	289345
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	Numerical score used to indicate the baby’s condition at 1 minute after birth.
Data Element Concept:	Birth – Apgar score

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	NN	
<i>Maximum character length:</i>	2	
<i>Permissible values:</i>	Value	Meaning
	00-10	Apgar score
<i>Supplementary values:</i>	99	Not stated/inadequately described

Collection and usage attributes

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

Collection and usage attributes

<i>Comments:</i>	Required to analyse pregnancy outcome, particularly after complications of pregnancy, labour and birth. The Apgar score is an indicator of the health of a baby.
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Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Birth – Apgar score (at 1 minute), code NN Health, Superseded 07/12/2005
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Apgar score at 5 minutes

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth – Apgar score (at 5 minutes), code NN
<i>METeOR identifier:</i>	289360
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	Numerical score used to indicate the baby's condition at 5 minutes after birth.
Data Element Concept:	Birth – Apgar score

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	NN	
<i>Maximum character length:</i>	2	
<i>Permissible values:</i>	Value	Meaning
	00-10	Apgar score
<i>Supplementary values:</i>	99	Not stated/inadequately described

Collection and usage attributes

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

Collection and usage attributes

<i>Comments:</i>	Required to analyse pregnancy outcome, particularly after complications of pregnancy, labour and birth. The Apgar score is an indicator of the health of a baby.
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Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Birth – Apgar score (at 5 minutes), code NN Health, Superseded 07/12/2005
<i>Implementation in Data Set Specifications:</i>	Perinatal NMDS Health, Superseded 06/09/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Area of practice—dental

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—principal area of practice, dental code NN
<i>METeOR identifier:</i>	377981
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The area of dental practice in which a dentist spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																														
<i>Data type:</i>	Number																														
<i>Format:</i>	NN																														
<i>Maximum character length:</i>	2																														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>General dental practice</td></tr><tr><td>02</td><td>Dento-maxillofacial radiology</td></tr><tr><td>03</td><td>Endodontics</td></tr><tr><td>04</td><td>Oral and maxillofacial surgery</td></tr><tr><td>05</td><td>Oral surgery</td></tr><tr><td>06</td><td>Oral medicine</td></tr><tr><td>07</td><td>Oral pathology</td></tr><tr><td>08</td><td>Orthodontics</td></tr><tr><td>09</td><td>Paedodontics</td></tr><tr><td>10</td><td>Periodontics</td></tr><tr><td>11</td><td>Prosthodontics</td></tr><tr><td>12</td><td>Public health dentistry</td></tr><tr><td>13</td><td>Special needs dentistry</td></tr><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	01	General dental practice	02	Dento-maxillofacial radiology	03	Endodontics	04	Oral and maxillofacial surgery	05	Oral surgery	06	Oral medicine	07	Oral pathology	08	Orthodontics	09	Paedodontics	10	Periodontics	11	Prosthodontics	12	Public health dentistry	13	Special needs dentistry	99	Not stated/inadequately described
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<i>Supplementary values:</i>																															

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 01 GENERAL DENTAL PRACTICE</p> <p>That part of dental practice that deals with a range of general dental care.</p> <p>CODE 02 DENTO-MAXILLOFACIAL RADIOLOGY</p> <p>That part of dental practice that deals with diagnostic imaging procedures applicable to the hard and soft tissues of the oral and</p>
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maxillofacial region and to other structures which are relevant for the proper assessment of oral conditions.

CODE 03 ENDODONTICS

That part of dental practice that deals with the morphology, physiology, and pathology of the human tooth and, in particular, the dental pulp, root and peri-radicular tissues. It includes the biology of the normal pulp, crown, root and peri-radicular tissues and the aetiology, prevention, diagnosis and treatment of diseases and injuries that affect these tissues.

CODE 04 ORAL AND MAXILLOFACIAL SURGERY

That part of dental practice that deals with the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects of the human jaws and associated structures.

CODE 05 ORAL SURGERY

That part of dental practice that deals with the diagnosis, surgical and adjunctive treatment of diseases and injuries limited to the dento-alveolar complex.

CODE 06 ORAL MEDICINE

That part of dental practice that deals with the clinical diagnosis, assessment and principally non-surgical, pharmacological management of anatomical variants, pathological conditions, diseases and pain of the dental, oral and adjacent anatomical structures and the dental/oral manifestations and complications of systemic diseases, pathology and conditions and their treatment.

CODE 07 ORAL PATHOLOGY

That part of dental practice that deals with diseases of the teeth, jaws, oral soft tissues and associated structures, studies their causes, pathogenesis and effects, and by use of clinical, radiographic, microscopic and other laboratory procedures establishes differential diagnoses and provides forensic evaluations.

CODE 08 ORTHODONTICS

That part of dental practice that deals with the study and supervision of the growth and development of the dentition and its related anatomical structures, including preventive and corrective procedures of dentofacial irregularities requiring the re-positioning of teeth, jaws, and/or soft tissues by functional or mechanical means.

CODE 09 PAEDIATRIC DENTISTRY (PAEDODONTICS)

That part of dental practice that deals with the prevention and the treatment of dental diseases and abnormalities in children and their associated developmental and behavioural problems.

CODE 10 PERIODONTICS

That part of dental practice that deals with the prevention, recognition, diagnosis and treatment of the diseases and disorders of the investing and supporting tissues of natural teeth or their substitutes.

CODE 11 PROSTHODONTICS

That part of dental practice that deals with the restoration and maintenance of oral health, function and appearance by coronal alteration or reconstruction of natural teeth, or the replacement of missing teeth and contiguous oral and maxillofacial tissues with substitutes.

CODE 12 PUBLIC HEALTH DENTISTRY

That part of dental practice that deals with the community as the patient rather than the individual, being concerned with oral health education of the public, applied dental research and administration of dental care programmes including prevention and control of oral diseases on a community basis.

CODE 13 SPECIAL NEEDS DENTISTRY

That part of dental practice that deals with patients where intellectual disability, medical, physical or psychiatric conditions require special methods or techniques to prevent or treat oral health problems, or where such conditions necessitate special dental treatment plans.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Australian Dental Association
<i>Reference documents:</i>	Australian Dental Association Policy Statement 2.4, November 2008 <i>Specialisation in Dentistry</i>

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Health professional – area of clinical practice (principal), code ANN Health, Superseded 10/12/2009
<i>Implementation in Data Set Specifications:</i>	Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009
	Second job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009

Area of practice—midwifery

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—principal area of practice, midwifery code NN
<i>METeOR identifier:</i>	382168
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The area of midwifery practice in which a midwife spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																						
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<i>Supplementary values:</i>	99 Not stated/inadequately described																						

Collection and usage attributes

<i>Guide for use:</i>	The midwifery care during the woman's pregnancy, labour and birth and the postnatal period as well as the care of the well, normal baby is undertaken in partnership with the woman, consulting and referring to other health professionals as required. This care also includes preventative measures, the promotion of normal birth, the detection of complication in mother and child, accessing medical care or other appropriate assistance and the carrying out of emergency measures.
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CODE 01 ANTENATAL CARE

Care, including counselling and education of the woman, and care of her unborn baby from the time the woman's pregnancy is diagnosed until the onset of labour.

CODE 02 CARE DURING LABOUR AND BIRTH

Care, including advocacy and support of the woman and her baby during all stages of labour and during the baby's birth.

CODE 03 CONTINUUM OF MIDWIFERY CARE

Care across the continuum of the woman's pregnancy, labour, the baby's birth and the post natal period.

CODE 04 MATERNAL AND CHILD HEALTH

Care of the mother and child following the postnatal period of 6 weeks focussing on parenting and the child's growth and development, up until at least the age of 5 years and in some cases beyond that age.

CODE 05 MIDWIFERY EDUCATION

The design, planning, implementation, delivery and evaluation of midwifery education and/or staff development programs and management of educational resources.

CODE 06 MIDWIFERY MANAGEMENT

The management of a health unit or sub-unit of a service, hospital or community health care facility providing midwifery services and care, supervising midwives and the financial resources to enable the provision safe, cost effective midwifery care within the service and monitors quality, clinical standards and the professional development of midwives.

CODE 07 MIDWIFERY RESEARCH

The design, planning, implementation and evaluation of midwifery research programs and projects and management of research resources.

CODE 08 NEONATAL CARE

Care and close observation of the normal well newborn baby ensuring the baby's continued well being, growth and development in the first 6 weeks of life.

CODE 09 POSTNATAL CARE

Care, including counselling and education of the woman and care of her baby from the baby's birth until the baby is 6 weeks old.

CODE 10 OTHER

All other areas of midwifery not covered above.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes [Health professional – area of clinical practice \(principal\), code ANN](#) Health, Superseded 10/12/2009

Implementation in Data Set Specifications: [Main job of registered midwife cluster](#) Health, Standard 10/12/2009

[Second job of registered midwife cluster](#) Health, Standard 10/12/2009

Area of practice—nursing

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—principal area of practice, nursing code NN
<i>METeOR identifier:</i>	377983
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The area of nursing practice in which a nurse spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																				
<i>Data type:</i>	Number																																				
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16	Other																																				
<i>Supplementary values:</i>	99 Not stated/inadequately described																																				

Collection and usage attributes

<i>Guide for use:</i>	CODE 01 AGED CARE Nursing care to the elderly in community settings, residential aged care facilities, retirement villages and health care facilities.
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CODE 02 CHILD AND FAMILY HEALTH

Nursing care to children from birth to school age and their families with an emphasis on the prevention, early detection of, and early intervention in, physical, emotional and social problems affecting children and their families such as assistance with parentcraft, immunisation and developmental milestones.

CODE 03 COMMUNITY HEALTH

Nursing care, health counselling, screening and education to individuals, families and groups in the wider community with a focus on patient independence and health promotion.

CODE 04 CRITICAL CARE AND EMERGENCY

Provides nursing care to critically ill patients and patients with unstable health following injury, surgery or during the acute phase of diseases, integrating new technological equipment into care in settings such as high dependency units, intensive care units, emergency departments or retrieval services.

CODE 05 EDUCATION

Design, planning, implementation, evaluation and delivery of nursing education and staff development programs, and management of educational resources.

CODE 06 MANAGEMENT

Management of a health service unit or sub-unit of a hospital, aged care or community health care facility, supervision of nursing staff and financial resources to enable the provision of safe, cost effective nursing care within a specified field or for a particular unit, and monitoring of quality, clinical standards and professional development of nurses.

CODE 07 MEDICAL

Nursing care to patients with conditions, such as infections, metabolic disorders and degenerative conditions, which require medical intervention in a range of health, aged care and community settings.

CODE 08 GENERAL PRACTICE/MEDICAL PRACTICE

Clinical care to patients, clinical organisation and practice administration, and the facilitation of communication within a general practice environment and between the practice and outside organisations and individuals.

CODE 09 MENTAL HEALTH

Nursing care to patients with mental health illness, disorder and dysfunction, and those experiencing emotional difficulties, distress and crisis in health, welfare and aged care facilities, correctional services and the community.

CODE 10 MIDWIFERY

Nursing care and advice to women during pregnancy, labour and childbirth, and postnatal care for women and babies in a range of settings such as the home, community, hospitals, clinics and health units.

CODE 11 PAEDIATRICS

Providing nursing care and advice regarding internal diseases and disorders in children from birth up to, and including, adolescence.

CODE 12 PERI-OPERATIVE

Nursing care to patients before, during and immediately after surgery, assessment of patients' condition, planning of nursing care for surgical intervention, maintenance of a safe and comfortable environment, assistance to Surgeons and Anaesthetists during surgery, and monitoring of patients' recovery from anaesthetic, prior to return to, or discharge from, ward.

CODE 13 REHABILITATION AND DISABILITY

Nursing care to patients recovering from injury and illness, and assistance and facilitation for patients with disabilities to live more independently.

CODE 14 RESEARCH

The design, conduct and evaluation of nursing and interdisciplinary research projects, and promotion of the implementation of research findings into clinical nursing practice.

CODE 15 SURGICAL

Nursing care to patients with injuries and illness that require surgical intervention.

CODE 16 OTHER

All other areas of nursing practice not covered above.

Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

These definitions are based on occupational definitions as described in the Australian and New Zealand Standard Classification of Occupations, First Edition (ABS cat. no. 1220.0)

Data element attributes

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes [Health professional – area of clinical practice \(principal\), code ANN](#) Health, Superseded 10/12/2009

Implementation in Data Set Specifications:

[Main job of registered nursing professional cluster](#) Health, Standard 10/12/2009

[Second job of registered nursing professional cluster](#) Health, Standard 10/12/2009

Area of practice—psychology

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—principal area of practice, psychology code NN
<i>METeOR identifier:</i>	377985
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The area of psychology practice in which a psychologist spent the most hours in their main job in the week prior to registration, as represented by a code.
Data Element Concept:	Registered health professional—principal area of practice

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	NN																		
<i>Maximum character length:</i>	2																		
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<i>Supplementary values:</i>																			

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 01 ASSESSMENT</p> <p>Includes behavioural, neuropsychological, cognitive, medico-legal, and educational.</p> <p>CODE 02 PSYCHOLOGICAL INTERVENTION</p> <p>Includes counselling, mental health intervention, personal development/coaching, physical health and lifestyle intervention, intervention for drug and/or alcohol misuse and/or other addiction.</p> <p>CODE 03 COMMUNITY PSYCHOLOGY</p> <p>Includes mental health promotion, community engagement/education, health promotion.</p>
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CODE 04 MANAGEMENT/ADMINISTRATION

Includes planning and coordination of psychology programs and services, maintaining standards of care, provision of leadership to ensure an appropriately skilled workforce, and contribution to health service planning.

CODE 05 ORGANISATIONAL PSYCHOLOGY

Includes organisational practices, consulting/advising for work purposes, recruitment and vocational assessment.

CODE 06 RESEARCH

Includes research design and implementation, statistical analysis, project/program development and evaluation.

CODE 07 TEACHING/SUPERVISION

Includes teaching, supervision and assessment of the psychological work of a student, provisional/probationary psychologist or a colleague.

CODE 08 OTHER

Includes all other areas of psychology practice not defined above. Registered health professionals on leave at the time of registration are asked to report their usual principle area of practice worked.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Categories and definitions are based on advice from the Australian Psychological Society Ltd - www.psychology.org.au
<i>Reference documents:</i>	

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Health professional – area of clinical practice (principal), code ANN Health, Superseded 10/12/2009
<i>Implementation in Data Set Specifications:</i>	Main job of registered psychologist cluster Health, Standard 10/12/2009
	Second job of registered psychologist cluster Health, Standard 10/12/2009

Area of usual residence

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – area of usual residence, geographical location code (ASGC 2009) NNNNN
<i>METeOR identifier:</i>	386783
<i>Registration status:</i>	Health, Standard 02/10/2009
<i>Definition:</i>	Geographical location of usual residence of the person, as represented by a code.
Data Element Concept:	Person – area of usual residence

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Australian Standard Geographical Classification 2009
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNNN
<i>Maximum character length:</i>	5

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The geographical location is reported using a five digit numerical code. The first digit is the single-digit code to indicate State or Territory. The remaining four digits are the numerical code for the Statistical Local Area (SLA) within the State or Territory.</p> <p>The single digit codes for the states and territories and the four digit codes for the SLAs are as defined in the Australian Standard Geographical Classification (ASGC).</p> <p>The ASGC is updated on an annual basis with a date of effect of 1 July each year. The codes for SLA are unique within each State and Territory, but not within the whole country. Thus, to define a unique location, the code of the State or Territory is required in addition to the code for the SLA.</p> <p>The Australian Bureau of Statistics' (ABS) National Localities Index (NLI) (ABS Catalogue number 1252.0) can be used to assign each locality or address in Australia to a SLA. The NLI is a comprehensive list of localities in Australia with their full code (including State or Territory and SLA) from the main structure of the ASGC.</p> <p>For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign a SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used</p>
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with the locality name to assign the SLA. In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the person's residence is used with the Streets Sub-index of the NLI to assign the SLA.

If the information available on the person's address indicates that it is in a split locality but is insufficient to assign an SLA, the code for the SLA which includes most of the split locality should be reported. This is in accordance with the NLI assignment of SLA when a split locality is identified and further detail about the address is not available.

The NLI does not assign a SLA code if the information about the address is insufficient to identify a locality, or is not an Australian locality. In these cases, the appropriate codes for undefined SLA within Australia (State or Territory unstated), undefined SLA within a stated State or Territory, no fixed place of abode (within Australia or within a stated State or Territory) or overseas should be used.

Collection methods:

When collecting the geographical location of a person's usual place of residence, the Australian Bureau of Statistics (ABS) recommends that 'usual' be defined as: 'the place where the person has or intends to live for 6 months or more, or the place that the person regards as their main residence, or where the person has no other residence, the place they currently reside.' Apart from collecting a person's usual place of residence there is also a need in some collections to collect area of residence immediately prior to or after assistance is provided, or at some other point in time.

Comments:

Geographical location is reported using Statistical Local Area (SLA) to enable accurate aggregation of information to larger areas within the Australian Standard Geographical Classification (ASGC) (such as Statistical Subdivisions and Statistical Divisions) as well as detailed analysis at the SLA level. The use of SLA also allows analysis relating the data to information compiled by the Australian Bureau of Statistics on the demographic and other characteristics of the population of each SLA. Analyses facilitated by the inclusion of SLA information include:

- comparison of the use of services by persons residing in different geographical areas,
- characterisation of catchment areas and populations for establishments for planning purposes, and
- documentation of the provision of services to residents of States or Territories other than the State or Territory of the provider.

Relational attributes

Related metadata references:

Supersedes [Person – area of usual residence, geographical location code \(ASGC 2008\) NNNNN](#) Health, Superseded 02/10/2009

Implementation in Data Set Specifications:

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Non-admitted patient emergency department care NMDS 2010-
2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Aspirin therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – aspirin therapy status, code NN
<i>METeOR identifier:</i>	284785
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The person's aspirin therapy status, as represented by a code.
Data Element Concept:	Person – aspirin therapy status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	NN														
<i>Maximum character length:</i>	2														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>10</td><td>Given</td></tr><tr><td>21</td><td>Not given - patient refusal</td></tr><tr><td>22</td><td>Not given - true allergy to aspirin</td></tr><tr><td>23</td><td>Not given - active bleeding</td></tr><tr><td>24</td><td>Not given - bleeding risk</td></tr><tr><td>29</td><td>Not given - other</td></tr></tbody></table>	Value	Meaning	10	Given	21	Not given - patient refusal	22	Not given - true allergy to aspirin	23	Not given - active bleeding	24	Not given - bleeding risk	29	Not given - other
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10	Given														
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23	Not given - active bleeding														
24	Not given - bleeding risk														
29	Not given - other														
<i>Supplementary values:</i>	90 Not stated/inadequately described														

Collection and usage attributes

<i>Guide for use:</i>	CODES 21 - 29 Not given If recording 'Not given', record the principal reason if more than one code applies.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Aspirin therapy status, version 1, DE, NHDD .
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*Implementation in Data Set
Specifications:*

[NHIMG, Superseded 01/03/2005.pdf](#) (14.2 KB)

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
07/12/2005

Assistance with activities

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – need for assistance with activities in a life area, code N
<i>METeOR identifier:</i>	320213
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The level of help and/or supervision a person requires (or would require if the person currently helping/supervising was not available) to perform tasks and actions in a specified life area, as represented by a code.
<i>Context:</i>	Human functioning and disability
<i>Data Element Concept:</i>	Person – need for assistance with activities in a life area

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001	
<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	0	Does not need help/supervision
	1	Sometimes needs help/supervision
	2	Always needs help/supervision
	3	Unable to do this task or action, even with assistance
<i>Supplementary values:</i>	8	Not specified
	9	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.</p> <p>In the context of health, an activity is the execution of a task or action by an individual. Activity limitations are difficulties an individual may have in executing an activity.</p> <p>Activity limitation varies with the environment and is assessed in relation to a particular environment; the absence or presence of assistance, including aids and equipment, is an aspect of the environment.</p>
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This value domain records the level of a person's need for help or supervision, in a specified domain, in their overall life. This means that the need for assistance may not be directly relevant to the health or community care service being provided.

Where a life area includes a range of examples, (e.g. domestic life includes cooking, cleaning and shopping), if a person requires assistance in any of the areas then the highest level of assistance should be recorded.

Where need for assistance varies markedly over time (e.g. episodic psychiatric conditions) please record the average level of assistance needed.

The presence of an activity limitation with a given domain is indicated by a non-zero response in this value domain. Activity is limited when an individual, in the context of a health condition, either has need for assistance in performing an activity in an expected manner, or cannot perform the activity at all.

CODE 0 is used when the person has no need for supervision or help and can undertake the activity independently.

CODE 1 is used when the person sometimes needs assistance to perform an activity.

CODE 2 is used when the person always needs assistance to undertake the activity and cannot do the activity without assistance.

CODE 3 is used when the person cannot do the activity even with assistance

CODE 8 is used when a person's need for assistance to undertake the activity is unknown or there is insufficient information to use codes 0-3.

CODE 9 is used where the need for help or supervision is due to the person's age. For example, Education for persons less than 5 years and work for persons less than 15 years.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.html>

Data element attributes

Collection and usage attributes

Guide for use: This data element, in conjunction with Person – activities and participation life area, code (ICF 2001) AN[NNN], indicates a person’s need for assistance in a given domain of activity.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also [Person – activity and participation life area, code \(ICF 2001\) AN\[NNN\]](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: [Activities and Participation cluster](#) Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Australian State/Territory identifier (establishment)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – Australian state/territory identifier, code N
<i>METeOR identifier:</i>	269941
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An identifier of the Australian state or territory in which an establishment is located, as represented by a code.
Data Element Concept:	Establishment – Australian state/territory identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
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Collection and usage attributes

<i>Guide for use:</i>	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).
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Source and reference attributes

<i>Reference documents:</i>	Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.
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Data element attributes

Collection and usage attributes

Guide for use: This metadata item applies to the location of the establishment and not to the patient's area of usual residence.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare
Origin: National Health Data Committee
National Community Services Data Committee

Relational attributes

Related metadata references: Supersedes [Australian State/Territory identifier, version 4, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf](#) (18.8 KB)

Is used in the formation of [Service delivery outlet – geographic location, code \(ASGC 2009\) NNNNN](#) Health, Standard 02/10/2009

Is used in the formation of [Establishment – geographical location, code \(ASGC 2009\) NNNNN](#) Health, Standard 02/10/2009

Is used in the formation of [Service delivery outlet – geographic location, code \(ASGC 2008\) NNNNN](#) Health, Superseded 02/10/2009

Is used in the formation of [Establishment – geographical location, code \(ASGC 2008\) NNNNN](#) Health, Superseded 02/10/2009

Is used in the formation of [Establishment – geographical location, code \(ASGC 2007\) NNNNN](#) Health, Superseded 04/02/2009

Is used in the formation of [Service delivery outlet – geographic location, code \(ASGC 2007\) NNNNN](#) Health, Superseded 04/02/2009

Is used in the formation of [Service delivery outlet – geographic location, code \(ASGC 2006\) NNNNN](#) Health, Superseded 05/02/2008

Is used in the formation of [Establishment – geographical location, code \(ASGC 2006\) NNNNN](#) Health, Superseded 05/02/2008

Is used in the formation of [Establishment – geographical location, code \(ASGC 2005\) NNNNN](#) Health, Superseded 14/09/2006

Is used in the formation of [Service delivery outlet – geographic location, code \(ASGC 2005\) NNNNN](#) Health, Superseded 14/09/2006

Is used in the formation of [Establishment – organisation identifier \(Australian\), NNX\[X\]NNNNN](#) Health, Standard 01/03/2005

Is used in the formation of [Service delivery outlet – geographic location, code \(ASGC 2004\) NNNNN](#) Health, Superseded 21/03/2006

Implementation in Data Set Specifications:

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

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[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Community mental health care NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Residential mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Australian State/Territory identifier (jurisdiction)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Jurisdiction – Australian state/territory identifier, code N
<i>METeOR identifier:</i>	352480
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	An identifier of the Australian state or territory of a jurisdiction, as represented by a code.
Data Element Concept:	Jurisdiction – Australian state/territory identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
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Collection and usage attributes

<i>Guide for use:</i>	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).
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Source and reference attributes

<i>Reference documents:</i>	Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.
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Data element attributes

Source and reference attributes

Submitting organisation: Health expenditure advisory committee

Relational attributes

Implementation in Data Set Specifications: [Government health expenditure NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Government health expenditure NMDS 2009-2010](#) Health, Standard 01/04/2009

Implementation start date: 01/07/2009

Australian state of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – Australian state/territory of birth, code N
<i>METeOR identifier:</i>	375455
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The Australian state/territory in which a person was born, as represented by a code.
Data Element Concept:	Person – state/territory of birth

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
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Collection and usage attributes

<i>Guide for use:</i>	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).
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Source and reference attributes

<i>Reference documents:</i>	Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.
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Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

[Registered midwifery labour force DSS](#) Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

[Registered optometry labour force DSS](#) Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

[Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

[Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

[Registered podiatry labour force DSS](#) Health, Standard 10/12/2009

Conditional obligation:
Applicable to persons born in Australia

[Registered psychology labour force DSS](#) Health, Standard
10/12/2009

Conditional obligation:

Applicable to persons born in Australia

Australian state/territory identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – Australian state/territory identifier, code N
<i>METeOR identifier:</i>	286919
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	The Australian state or territory where a person can be located, as represented by a code.
Data Element Concept:	Person – Australian state/territory identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
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Collection and usage attributes

<i>Guide for use:</i>	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).
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Source and reference attributes

<i>Reference documents:</i>	Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.
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Data element attributes

Collection and usage attributes

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

Source and reference attributes

Origin: Australian Bureau of Statistics 2004. [Australian Standard Geographical Classification](#) (ASGC) (Cat No. 1216.0). Viewed 13 October 2005.

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
AS5017 Health Care Client Identification, 2004, Sydney: Standards Australia
In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references: See also [Person \(address\) – Australian postcode, code \(Postcode datafile\) {NNNN}](#) Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Implementation in Data Set Specifications: [Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Australian state/territory identifier (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – Australian state/territory identifier, code N
<i>METeOR identifier:</i>	289083
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 07/12/2005
<i>Definition:</i>	An identifier of the Australian state or territory where an organisation or agency can be located, as represented by a code.
Data Element Concept:	Service provider organisation – Australian state/territory identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
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Collection and usage attributes

<i>Guide for use:</i>	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).
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Source and reference attributes

<i>Reference documents:</i>	Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.
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Data element attributes

Collection and usage attributes

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

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Origin: Health Data Standard Committee

National Community Services Data Committee

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

AS5017 Health Care Client Identification, 2002, Sydney:
Standards Australia

In AS4846 and AS5017 alternative codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications: [Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Average available beds for hospital-in-the-home patients

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Occupied bed – hospital in the home care, average number of beds N[NNN.N]
<i>METeOR identifier:</i>	373955
<i>Registration status:</i>	Health, Standard 24/03/2009
<i>Definition:</i>	The number of beds used to care for hospital admitted patients in their place of residence as a substitute for hospital accommodation, calculated by dividing the number of days of hospital-in-the-home care reported for the period by the number of days in the period. Place of residence may be permanent or temporary.
Data Element Concept:	Occupied bed – hospital in the home care

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN.N]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Bed

Collection and usage attributes

<i>Guide for use:</i>	Average available beds, rounded to the nearest decimal or whole number.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Calculated by dividing the total hospital-in-the-home patient days by the number of days in the period, e.g. in a normal year, a hospital records 4000 hospital-in-the-home patient days - the average hospital-in-the-home beds would be $4000/365 = 11.0$.
<i>Collection methods:</i>	Beds exclusively or predominantly for overnight-stay admitted care, beds exclusively or predominantly for same-day admitted care, and non-special-care neonatal cots are collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted and that no available bed is counted more than once. A bed should first be assessed as available and then categorised according to its predominant use. For large hospitals a reconciliation of the sum of the counts for the four available bed types and an unduplicated establishment bed count is advisable.

Comments: This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Submitting organisation: Victorian Department of Human Services

Average available beds for overnight-stay patients

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Available bed – overnight-stay admitted care, average number of beds N[NNN.N]
<i>METeOR identifier:</i>	374151
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The number of beds available to provide overnight accommodation for patients (other than neonatal cots (non-special-care) and beds occupied by hospital-in-the-home patients), averaged over the counting period .
<i>Context:</i>	Public hospital establishments
<i>Data Element Concept:</i>	Available bed – overnight-stay admitted care

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN.N]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Bed

Collection and usage attributes

<i>Guide for use:</i>	Average available beds, rounded to the nearest decimal or whole number.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The number of available beds should be collected at least monthly at the same time on the same day. To improve accuracy data could be collected more frequently (e.g. daily). If so it should be collected at the same time on each day. More frequent data collection is preferable if a single monthly count is likely to be significantly different from the monthly average.</p> <p>Inclusions: Both occupied and unoccupied beds are included in the count as they are deemed as available beds.</p> <p>The number of beds available to provide overnight accommodation is recorded, e.g. maternity ward beds are counted but beds in the delivery suite are not. However, if in a delivery suite patients are admitted, deliver and are discharged from the same bed, such beds should be included because these beds are available for use for overnight-stay patients.</p>
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Collection methods:

Exclusions: surgical tables, recovery trolleys, delivery beds, discharge lounges for patients who have been formally discharged, medi-hotel beds, beds exclusively or predominantly for same-day admitted care, neonatal cots (non-special-care), hospital-in-the home beds, and beds exclusively or predominantly for non-admitted patients (e.g. emergency trolleys) or residential care. No adjustment should be made for contracted services, either provided by, or to this hospital.

Beds exclusively or predominantly for overnight-stay admitted care, beds exclusively or predominantly for same-day admitted care and, if required, non-special care neonatal cots are to be collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted once and only once. A bed should first be assessed as available and then categorised to its predominant use. For large hospitals, a reconciliation of the sum of the bed types and an unduplicated establishment bed count is advisable.

The assessment of availability must reflect the ability of the hospital to provide the necessary resources. This can be significantly impacted by seasonal demand or events such as a strike, clinical staff shortage, fire or renovation. This is illustrated by the following examples.

Example 1: A large hospital, which conducts a daily bed count, has a ward containing 20 beds suitably equipped for overnight admitted patient care. The funding for this ward would allow an average of 15 beds to be staffed over the year. Provided demand is constant and there are no circumstances which prevent these beds from being available for patients, such as a strike, clinical staff shortage, fire or renovation, the hospital would report 15 available beds for this ward.

Example 2: A small hospital, which conducts a monthly bed count, is located in a summer holiday area and has 30 beds suitably equipped for overnight admitted patient care. It manages its resources in such a way that 30 beds are fully staffed during the four months from December to March, but only 15 beds are staffed during the remaining eight months from April to November. The annual average number of available beds is the average of the twelve counts – i.e. $((30 \text{ beds} \times 4 \text{ months}) + (15 \text{ beds} \times 8 \text{ months}) \text{ divided by } 12 \text{ counting periods}) = 20 \text{ beds}$.

Example 3: A hospital conducts a monthly bed count. Ward A containing 20 beds is closed for six months for a planned renovation. During this period a temporary 10 bed ward (B) is established and the necessary resources are provided. The annual average number of available beds for Ward A is the average of the twelve counts i.e. $(20 \text{ beds} \times 6 \text{ months}) + (0 \text{ beds} \times 6 \text{ months}) \text{ divided by } 12 \text{ counting periods} = 10 \text{ beds}$. The annual average number of available beds for Ward B is $(0 \text{ beds} \times 6 \text{ months}) + (10 \text{ beds} \times 6 \text{ months}) \text{ divided by } 12 \text{ counting periods} = 5 \text{ beds}$.

Example 4: A hospital conducts a daily bed count. A 20 bed ward is closed during the first week of June because of a strike, but for the remainder of June it is fully staffed so that all 20 beds are available. So the average number of beds available for this ward in June is $((0 \text{ beds} \times 7 \text{ days}) + (20 \text{ beds} \times 23 \text{ days}) / 30 = 15.3$.

Comments:

This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Submitting organisation:

Victorian Department of Human Services

Relational attributes

Related metadata references:

Supersedes [Establishment – number of available beds for admitted patients/residents, average N\[NNN\]](#) Health, Superseded 03/12/2008

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Average available beds for residential mental health patients

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Available bed – residential mental health care, average number of beds N[NNN.N]
<i>METeOR identifier:</i>	373650
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The number of beds available in the specialised residential mental health services for overnight accommodation, averaged over the counting period.
Data Element Concept:	Available bed – residential mental health care

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN.N]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Bed

Collection and usage attributes

<i>Guide for use:</i>	Average available beds, rounded to the nearest decimal or whole number.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Residential mental health beds are available only if they are suitably located and equipped to provide residential mental health care and the necessary financial and human resources can be provided. Average available residential mental health beds are the average bed counts conducted during the year as required.</p> <p>Inclusions: Both occupied and unoccupied residential mental health beds are included.</p>
<i>Collection methods:</i>	<p>Specialised residential mental health care services should establish clear recording and reporting practices and criteria that ensure that each available residential mental health bed is counted and that no available residential mental health bed is counted more than once.</p> <p>The assessment of availability must reflect the ability of the specialised residential mental health care service to provide the necessary resources, and this can be significantly impacted by events such as a strike, clinical staff shortage, fire or renovation.</p>

This is illustrated by the following examples.

Example 1: A specialised residential mental health care service containing 20 residential mental health beds (A) is closed for several months, either for a planned renovation or in response to an unplanned event such as a fire. During this period a temporary 10 specialised residential mental health bed facility (B) is established and the necessary resources are provided. The specialised residential mental health care service would not report the residential mental health beds in facility A, but it would report the 10 residential mental health beds in facility B.

Example 2: A 20 bed specialised residential mental health service is closed during the first week of February because of a strike, but for the remaining three weeks of February it is fully staffed so that all 20 residential mental health beds can be occupied during those three weeks. So the average number of residential mental health beds available for this service in February is 15.

Comments:

This data element is necessary to provide an indicator of the capacity of the residential service.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Average available beds for same-day patients

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Available bed – same-day admitted care, average number of beds N[NNN.N]
<i>METeOR identifier:</i>	373966
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The number of beds, chairs or trolleys available to provide accommodation for same-day patients, averaged over the counting period.
Data Element Concept:	Available bed – same-day admitted care

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN.N]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Bed

Collection and usage attributes

<i>Guide for use:</i>	Average available beds, rounded to the nearest decimal or whole number.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The number of beds, chairs or trolleys available to provide accommodation for same-day patients is recorded. Same-day patients are accommodated in the following ways:</p> <ol style="list-style-type: none">1. Patients occupy a single bed or chair in a single location throughout their stay, e.g. dialysis or chemotherapy chair. In this situation the bed or chair is counted as a bed available for same-day patients.2. Patients occupy a trolley which is moved to different locations throughout their stay – e.g. endoscopy suite, where patients move from the same-day ward to a procedure room, onto a recovery room and back to the same-day ward. In this situation the trolley is counted as a bed available for same-day patients.3. Same-day patients are accommodated in a general ward after being transferred from another area of the hospital (e.g. Emergency, another ward, etc). In this situation the beds may be counted as either overnight-stay or same-day according to their predominant use.
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The number of available same day beds should be collected at least monthly at the same time on the same day. To improve accuracy data could be collected more frequently (e.g. daily) at the same time on each day. More frequent data collection is preferable if a single monthly count is likely to be significantly different from the monthly average.

Inclusions: Both occupied and unoccupied beds are included. Beds, chairs or trolleys available, exclusively or predominantly intended to accommodate same-day admitted care or treatment. This includes day surgery beds, dialysis, chemotherapy, electroconvulsive therapy (ECT) and dental chairs for admitted patients.

Exclusions: Exclude beds, chairs or trolleys designated exclusively for same-day non-admitted patient care or predominantly used by non-admitted patients (e.g. emergency trolleys), medical ambulatory care, discharge lounges for patients who have been formally discharged, medi-hotel beds, hospital-in-the-home, neonatal cots (non-special-care), and beds for overnight-stay patients (even where overnight beds are used for unplanned same-day episodes e.g. patients who die or abscond on the day of admission). No adjustment should be made for contracted services, either provided by, or to this hospital.

Collection methods:

Beds exclusively or predominantly for overnight-stay admitted care, beds exclusively or predominantly for same-day admitted care and, if required, non-special-care neonatal cots are to be collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted once and only once. A bed should first be assessed as available and then categorised to the most appropriate accommodation category. For large hospitals, a reconciliation of the sum of the bed types and an unduplicated establishment bed count is advisable.

The assessment of availability must reflect the ability of the hospital to provide the necessary resources, and this can be significantly impacted by seasonal demand or events such as a strike, clinical staff shortage, fire or renovation. This is illustrated by the following examples:

Example 1: A large hospital, which conducts a daily bed count, has a ward containing 20 beds suitably equipped for same-day admitted patient care. The funding for this ward would allow an average of 15 beds to be staffed over the year. Provided demand is constant and there are no circumstances which prevent these beds from being available for patients, such as a strike, clinical staff shortage, fire or renovation, the hospital would report 15 available beds for this ward.

Example 2: A hospital located in a summer holiday area, which conducts monthly bed counts, has 12 beds suitably equipped for same-day admitted patient care. It manages its resources in such a way that 12 beds are fully staffed during the four months from December to March, but only 9 beds are staffed during the remaining eight months from April to November. The annual average number of available beds is the average of the twelve monthly averages, i.e. $((12 \text{ beds} \times 4 \text{ months}) + (9 \text{ beds} \times 8 \text{ months})) \div 12 \text{ counting periods} = 120/12 = 10 \text{ beds}$.

Example 3: A hospital conducts a monthly bed count. Ward A containing 20 beds is closed for six months, for a planned renovation. During this period a temporary 10 bed ward (B) is established and the necessary resources are provided. The annual average number of available beds for Ward A is the average of the twelve counts, i.e. (20 beds X 6 months) + (0 beds X 6 months) divided by 12 counting periods = 120/12 = 10 beds. The annual average number of available beds for Ward B is (0 beds X 6 months) + (10 beds X 6 months) divided by 12 counting periods = 60/12 = 5 beds.

Example 4: A 20 bed ward is closed during the first week of June because of a strike, but for the remainder of June it is fully staffed so that all 20 beds are available. So the average number of beds available for this ward in June is ((0 beds X 7 days) + (20 beds X 23 days) divided by 30 counting periods) = 460/30 = 15.3.

Comments:

This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Origin:

Victorian Department of Human Services

Relational attributes

Implementation in Data Set Specifications:

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Average available neonatal cots (non-special-care)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Available bed – neonatal admitted care (Non-special-care), average number of beds N[NNN.N]
<i>METeOR identifier:</i>	373640
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The number of cots available to provide neonatal accommodation, other than special care accommodation, averaged over the counting period.
Data Element Concept:	Available bed – neonatal admitted care (Non-special-care)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN.N]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Bed

Collection and usage attributes

<i>Guide for use:</i>	Average available beds, rounded to the nearest decimal or whole number.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Average available cots are the average of 12 monthly (or more frequent) counts of these available cots.</p> <p>The number of available cots should be collected at least monthly at the same time on the same day. To improve accuracy data could be collected more frequently (e.g. daily). If so, it should be collected at the same time on each day. More frequent data collection is preferable if a single monthly count is likely to be significantly different from the monthly average.</p> <p>Inclusions: neonatal cots which are not in an intensive care facility approved by the Commonwealth Health Minister for the purpose of the provision of special care. They accommodate unqualified newborns and may also accommodate qualified newborns who do not need to be treated in such a facility (e.g. healthy second twin).</p> <p>Exclusions: cots in intensive care facilities approved by the Commonwealth Health Minister for the purpose of the provision of special care. Also exclude cots intended to accommodate older (not newborn) babies when they are admitted to hospital. (These cots are reported as available overnight beds.)</p>
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Collection methods:

Beds exclusively or predominantly for overnight stay admitted care, beds exclusively or predominantly for same-day admitted care and, if required, non-special care neonatal cots are to be collected and reported in separate categories. Hospitals should establish clear recording and reporting practices. Criteria should exist to ensure that each available bed is counted once and only once. A bed should first be assessed as available and then categorised to its predominant use. For large hospitals, a reconciliation of the sum of the bed types and an unduplicated establishment bed count is advisable.

The assessment of availability must reflect the ability of the hospital to provide the necessary resources. This can be significantly impacted by seasonal demand or events such as a strike, clinical staff shortage, fire or renovation. This is illustrated by the following examples.

Example 1: A large maternity hospital, which conducts a daily bed count, has a ward (not an approved intensive care facility) containing 20 cots used to accommodate newborns. The funding for this ward would allow an average of 15 cots to be staffed over the year.

Provided demand is constant and there are no circumstances which prevent these cots from being available for patients, such as a strike, clinical staff shortage, fire or renovation, the hospital would report 15 available cots for this ward.

Example 2: A maternity hospital, which conducts a monthly bed count, has a ward (not an approved intensive care facility) containing 30 cots used to accommodate newborns. It manages its resources in such a way that it is staffed for 30 cots for four months of the year and staffed for 24 cots during the remaining eight months. The annual average number of available cots is the average of the twelve counts - i.e. (30 cots x 4 months) + (24 cots x 8 months) divided by 12 counting periods = (120 + 192)/12 = 26 cots.

Example 3: A hospital conducts a monthly bed count. Ward A containing 20 cots is closed for six months, for a planned renovation. During this period a temporary ward (B) containing 10 cots is established and the necessary resources are provided. The annual average number of available cots in Ward A is the average of the twelve counts, i.e. (20 cots X 6 months) + (0 cots X 6 months) divided by 12 counting periods = 10 cots. The annual average number of available cots for Ward B is (0 cots X 6 months) + (10 cots X 6 months) divided by 12 counting periods = 5 cots.

Example 4: A hospital conducts a daily bed count. A ward containing 20 cots is closed during the first week of June because of a strike, but for the remainder of June it is fully staffed so that all 20 cots are available. So the average number of cots available for this ward in June is ((0 cots X 7 days) + (20 cots X 23 days) = 460/30 = 15.3.

Comments:

This data element is necessary to provide an indicator of the availability and type of service for an establishment.

Source and reference attributes

Origin:

Victorian Department of Human Services

Behaviour-related risk factor intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – behaviour-related risk factor intervention, code NN
<i>METeOR identifier:</i>	270165
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The intervention taken to modify or manage the patient's behaviour-related risk factor(s), as represented by a code.
Data Element Concept:	Episode of care – behaviour-related risk factor intervention

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	String																				
<i>Format:</i>	NN																				
<i>Maximum character length:</i>	2																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>No intervention</td></tr><tr><td>02</td><td>Information and education (not including written regimen)</td></tr><tr><td>03</td><td>Counselling</td></tr><tr><td>04</td><td>Pharmacotherapy</td></tr><tr><td>05</td><td>Referral provided to a health professional</td></tr><tr><td>06</td><td>Referral to a community program, support group or service</td></tr><tr><td>07</td><td>Written regimen provided</td></tr><tr><td>08</td><td>Surgery</td></tr><tr><td>98</td><td>Other</td></tr></tbody></table>	Value	Meaning	01	No intervention	02	Information and education (not including written regimen)	03	Counselling	04	Pharmacotherapy	05	Referral provided to a health professional	06	Referral to a community program, support group or service	07	Written regimen provided	08	Surgery	98	Other
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08	Surgery																				
98	Other																				
<i>Supplementary values:</i>	99 Not stated/inadequately defined																				

Collection and usage attributes

<i>Guide for use:</i>	CODE 01 No intervention Refers to no intervention taken with regard to the behaviour-related risk factor intervention-purpose.
	CODE 02 Information and education (not including written regimen) Refers to where there is no treatment provided to the patient for a behaviour-related risk factor intervention-purpose other than information and education.

CODE 03 Counselling

Refers to any method of individual or group counselling directed towards the behaviour-related risk factor intervention-purpose. This code excludes counselling activities that are part of referral options as defined in code 05 and 06.

CODE 04 Pharmacotherapy

Refers to pharmacotherapies that are prescribed or recommended for the management of the behaviour-related risk factor intervention-purpose.

CODE 05 Referral provided to a health professional

Refers to a referral to a health professional who has the expertise to assist the patient manage the behaviour-related risk factor intervention-purpose.

CODE 06 Referral to a community program, support group or service

Refers to a referral to community program, support group or service that has the expertise and resources to assist the patient manage the behaviour-related risk factor intervention-purpose.

CODE 07 Written regimen provided

Refers to the provision of a written regimen (nutrition plan, exercise prescription, smoking contract) given to the patient to assist them with the management of the behaviour-related risk factor intervention-purpose.

CODE 08 Surgery

Refers to a surgical procedure undertaken to assist the patient with the management of the behaviour-related risk factor intervention-purpose.

Data element attributes

Collection and usage attributes

Guide for use: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Relational attributes

Related metadata references: Supersedes [Behaviour-related risk factor intervention, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (18.6 KB)

Implementation in Data Set Specifications: [Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Behaviour-related risk factor intervention—purpose

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – behaviour-related risk factor intervention purpose, code N
<i>METeOR identifier:</i>	270338
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The behaviour-related risk factor(s) associated with an intervention(s), as represented by a code.
Data Element Concept:	Episode of care – behaviour-related risk factor intervention purpose

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Smoking</td></tr><tr><td>2</td><td>Nutrition</td></tr><tr><td>3</td><td>Alcohol misuse</td></tr><tr><td>4</td><td>Physical inactivity</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Smoking	2	Nutrition	3	Alcohol misuse	4	Physical inactivity	8	Other	9	Not stated/inadequately described
Value	Meaning														
1	Smoking														
2	Nutrition														
3	Alcohol misuse														
4	Physical inactivity														
8	Other														
9	Not stated/inadequately described														
<i>Supplementary values:</i>															

Data element attributes

Collection and usage attributes

Guide for use: More than one code can be recorded.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: Smoking, Nutrition, Alcohol, Physical Activity (SNAP) Framework - Commonwealth Department of Health and Ageing - June 2001.

Australian Institute of Health and Welfare 2002. Chronic Diseases and associated risk factors in Australians, 2001; Canberra.

Relational attributes

Related metadata references:

Supersedes [Behaviour-related risk factor intervention - purpose, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#)
(19.5 KB)

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard
22/12/2009

Beta-blocker therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – beta-blocker therapy status, code NN
<i>METeOR identifier:</i>	284802
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The person's beta-blocker therapy status, as represented by a code.
Data Element Concept:	Person – beta-blocker therapy status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																						
<i>Data type:</i>	Number																						
<i>Format:</i>	NN																						
<i>Maximum character length:</i>	2																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>10</td><td>Given</td></tr><tr><td>21</td><td>Not given - patient refusal</td></tr><tr><td>22</td><td>Not given - allergy or history of intolerance</td></tr><tr><td>23</td><td>Not given - bradycardia (heart rate less than 50 beats per minute)</td></tr><tr><td>24</td><td>Not given - symptomatic acute heart failure</td></tr><tr><td>25</td><td>Not given - systolic blood pressure of less than 90 mmHg</td></tr><tr><td>26</td><td>Not given - PR interval greater than 0.24 seconds</td></tr><tr><td>27</td><td>Not given - second and third degree heart block or bifascicular heart block</td></tr><tr><td>28</td><td>Not given - asthma/airways hyper-reactivity</td></tr><tr><td>29</td><td>Not given - other</td></tr></tbody></table>	Value	Meaning	10	Given	21	Not given - patient refusal	22	Not given - allergy or history of intolerance	23	Not given - bradycardia (heart rate less than 50 beats per minute)	24	Not given - symptomatic acute heart failure	25	Not given - systolic blood pressure of less than 90 mmHg	26	Not given - PR interval greater than 0.24 seconds	27	Not given - second and third degree heart block or bifascicular heart block	28	Not given - asthma/airways hyper-reactivity	29	Not given - other
Value	Meaning																						
10	Given																						
21	Not given - patient refusal																						
22	Not given - allergy or history of intolerance																						
23	Not given - bradycardia (heart rate less than 50 beats per minute)																						
24	Not given - symptomatic acute heart failure																						
25	Not given - systolic blood pressure of less than 90 mmHg																						
26	Not given - PR interval greater than 0.24 seconds																						
27	Not given - second and third degree heart block or bifascicular heart block																						
28	Not given - asthma/airways hyper-reactivity																						
29	Not given - other																						
<i>Supplementary values:</i>	90 Not stated/inadequately described																						

Collection and usage attributes

<i>Guide for use:</i>	CODES 15 - 29 Not given If recording 'Not given', record the principal reason if more than one code applies.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group
Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes [Beta-blocker therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)
Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008
[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

Birth order

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth—birth order, code N
<i>METeOR identifier:</i>	269992
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The sequential order of each baby of a multiple birth, as represented by a code.
Data Element Concept:	Birth—birth order

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	N																		
<i>Maximum character length:</i>	1																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Singleton or first of a multiple birth</td></tr><tr><td>2</td><td>Second of a multiple birth</td></tr><tr><td>3</td><td>Third of a multiple birth</td></tr><tr><td>4</td><td>Fourth of a multiple birth</td></tr><tr><td>5</td><td>Fifth of a multiple birth</td></tr><tr><td>6</td><td>Sixth of a multiple birth</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	1	Singleton or first of a multiple birth	2	Second of a multiple birth	3	Third of a multiple birth	4	Fourth of a multiple birth	5	Fifth of a multiple birth	6	Sixth of a multiple birth	8	Other	9	Not stated
Value	Meaning																		
1	Singleton or first of a multiple birth																		
2	Second of a multiple birth																		
3	Third of a multiple birth																		
4	Fourth of a multiple birth																		
5	Fifth of a multiple birth																		
6	Sixth of a multiple birth																		
8	Other																		
9	Not stated																		
<i>Supplementary values:</i>																			

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 2 Second of a multiple birth Stillborns are counted such that, if twins were born, the first stillborn and the second live-born, the second twin would be recorded as code 2 Second of a multiple birth (and not code 1 Singleton or first of a multiple birth).
<i>Collection methods:</i>	This data should be collected routinely for persons aged 28 days or less.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee Standards Australia
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Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Birth order, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.9 KB)

[Health care client identification](#) Health, Superseded 04/05/2005

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Perinatal NMDS](#) Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Birth plurality

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – birth plurality, code N
<i>Synonymous names:</i>	Multiple birth
<i>METeOR identifier:</i>	269994
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The number of babies resulting from a single pregnancy, as represented by a code.
Data Element Concept:	Birth event – birth plurality

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Singleton</td></tr><tr><td>2</td><td>Twins</td></tr><tr><td>3</td><td>Triplets</td></tr><tr><td>4</td><td>Quadruplets</td></tr><tr><td>5</td><td>Quintuplets</td></tr><tr><td>6</td><td>Sextuplets</td></tr><tr><td>8</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Singleton	2	Twins	3	Triplets	4	Quadruplets	5	Quintuplets	6	Sextuplets	8	Other
Value	Meaning																
1	Singleton																
2	Twins																
3	Triplets																
4	Quadruplets																
5	Quintuplets																
6	Sextuplets																
8	Other																
<i>Supplementary values:</i>	9 Not stated																

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Plurality of a pregnancy is determined by the number of live births or by the number of fetuses that remain in utero at 20 weeks gestation and that are subsequently born separately. In multiple pregnancies, or if gestational age is unknown, only live births of any birthweight or gestational age, or fetuses weighing 400 g or more, are taken into account in determining plurality. Fetuses aborted before 20 completed weeks or fetuses compressed in the placenta at 20 or more weeks are excluded.
<i>Collection methods:</i>	This data should be collected routinely for persons aged 28 days or less.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Birth plurality, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.6 KB)

Implementation in Data Set Specifications: [Health care client identification](#) Health, Superseded 04/05/2005

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Perinatal NMDS](#) Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Bleeding episode using TIMI criteria (status)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – bleeding episode status, Thrombolysis in Myocardial Infarction (TIMI) code N
<i>METeOR identifier:</i>	356725
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's episode of bleeding as described by the Thrombolysis In Myocardial Infarction (TIMI) criteria, as represented by a code.
Data Element Concept:	Person – bleeding episode status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Major</td></tr><tr><td>2</td><td>Minor</td></tr><tr><td>3</td><td>Non TIMI bleeding</td></tr></tbody></table>	Value	Meaning	1	Major	2	Minor	3	Non TIMI bleeding
Value	Meaning								
1	Major								
2	Minor								
3	Non TIMI bleeding								
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	9	Not stated/inadequately described						
9	Not stated/inadequately described								

Collection and usage attributes

<i>Guide for use:</i>	<p>Note in calculating the fall in haemoglobin or haematocrit, transfusion of whole blood or packed red blood cells is counted as 1g/dl (0.1g/l) haemoglobin or 3% absolute haematocrit.</p> <p>CODE 1 Major</p> <p>Overt clinical bleeding (or documented intracranial or retroperitoneal haemorrhage) associated with a drop in haemoglobin of greater than 5g/dl (0.5g/l) or a haematocrit of greater than 15% (absolute).</p> <p>CODE 2 Minor</p> <p>Overt clinical bleeding associated with a fall in haemoglobin of 3 or less than or equal to 5g/dl (0.5g/l) or a haematocrit of 9% to less than or equal to 15% (absolute).</p> <p>CODE 3 Non TIMI Bleeding</p> <p>Bleeding event that does not meet the major or minor definition.</p>
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Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Origin: Rao AK, Pratt C, Berke A, et al. Thrombolysis in Myocardial Infarction (TIMI) Trial, phase I: hemorrhagic manifestations and changes in plasma fibrinogen and the fibrinolytic system in patients with recombinant tissue plasminogen activator and streptokinase. J Am Coll Cardiol 1988; 11:1-11.

Relational attributes

Related metadata references: See also [Person with acute coronary syndrome – bleeding location, instrumented code N\(N\)](#) Health, Standard 01/10/2008

Supersedes [Person – bleeding episode status, code N](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Blindness (diabetes complication)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – blindness, code N
<i>METeOR identifier:</i>	270065
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether the individual has become legally blind in either or both eyes, as represented by a code.
Data Element Concept:	Person – blindness

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Blindness - (</td></tr><tr><td>2</td><td>Blindness - (</td></tr><tr><td>3</td><td>Blindness - (</td></tr><tr><td>4</td><td>No blindness</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Blindness - (2	Blindness - (3	Blindness - (4	No blindness	9	Not stated/inadequately described
Value	Meaning												
1	Blindness - (
2	Blindness - (
3	Blindness - (
4	No blindness												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Collection and usage attributes

<i>Guide for use:</i>	CODE 3 Blindness - (< 6/60) occurred in one eye within 12 months and in the other eye prior to the last 12 months Blindness can be diagnosed in one eye within 12 months even though it has been previously diagnosed on the other eye.
<i>Collection methods:</i>	Ask the individual if he/she has been diagnosed as legally blind (< 6/60) in both or either eye. If so record whether it has occurred within or prior to the last 12 months. Alternatively determine blindness from appropriate documentation obtained from an ophthalmologist or optometrist.

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes [Blindness - diabetes complication, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf](#) (19.7 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS Health](#), Superseded 21/09/2005

[Diabetes \(clinical\) DSS Health](#), Standard 21/09/2005

Blood pressure—diastolic (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – blood pressure (diastolic) (measured), millimetres of mercury NN[N]
<i>METeOR identifier:</i>	270072
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The person’s diastolic blood pressure , measured in millimetres of mercury (mmHg).
Data Element Concept:	Person – blood pressure (diastolic)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	NN[N]				
<i>Maximum character length:</i>	3				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	999	Not stated/inadequately described
Value	Meaning				
999	Not stated/inadequately described				
<i>Unit of measure:</i>	Millimetre of mercury (mmHg)				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The diastolic pressure is recorded as phase V Korotkoff (disappearance of sound) however phase IV Korotkoff (muffling of sound) is used if the sound continues towards zero but does not cease.</p> <p>If Blood pressure - diastolic is not collected or not able to be collected, code 999.</p>
<i>Collection methods:</i>	<p>Measurement protocol for resting blood pressure:</p> <p>The diastolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the minimum pressure to which the arteries are exposed.</p> <ul style="list-style-type: none">• The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured.• Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User’s Guide).• Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracy.

- Bladder length should be at least 80%, and width at least 40% of the circumference of the mid-upper arm. If the velcro on the cuff is not totally attached, the cuff is probably too small.
- Wrap cuff snugly around upper arm, with the centre of the bladder of the cuff positioned over the brachial artery and the lower border of the cuff about 2 cm above the bend of the elbow.
- Ensure cuff is at heart level, whatever the position of the patient.
- Palpate the radial pulse of the arm in which the blood pressure is being measured.
- Inflate cuff to the pressure at which the radial pulse disappears and note this value. Deflate cuff, wait 30 seconds, and then inflate cuff to 30 mm Hg above the pressure at which the radial pulse disappeared.
- Deflate the cuff at a rate of 2-3 mm Hg/beat (2-3 mm Hg/sec) or less.
- Recording the diastolic pressure use phase V Korotkoff (disappearance of sound). Use phase IV Korotkoff (muffling of sound) only if sound continues towards zero but does not cease. Wait 30 seconds before repeating the procedure in the same arm. Average the readings.
- If the first two readings differ by more than 4 mmHg diastolic or if initial readings are high, take several readings after five minutes of quiet rest.

Comments:

The pressure head is the height difference a pressure can raise a fluid's equilibrium level above the surface subjected to pressure. (Blood pressure is usually measured as a head of Mercury, and this is the unit of measure nominated for this metadata item.)

The current (2002) definition of hypertension is based on the level of blood pressure above which treatment is recommended, and this depends on the presence of other risk factors, e.g. age, diabetes etc. (NHF 1999 Guide to Management of Hypertension).

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin:

The National Heart Foundation Blood Pressure Advisory Committee's 'Guidelines for the Management of Hypertension - 1999' which are largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO-ISH: 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17:151-83).

Australian Bureau of Statistics 1998. National Nutrition Survey User's Guide 1995. Cat. No. 4801.0. Canberra: ABS. (p. 20).

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents:

'Guidelines for the Management of Hypertension - 1999' largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO) J Hypertension 1999; 17: 151-83.).

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

UKPDS 38 Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UK Prospective Diabetes Study Group. British Medical Journal (1998); 317: 703-713.

Relational attributes

Related metadata references:

Supersedes [Blood pressure - diastolic measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf](#) (26.3 KB)

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Blood pressure—systolic (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – blood pressure (systolic) (measured), millimetres of mercury NN[N]
<i>METeOR identifier:</i>	270073
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The person's systolic blood pressure , measured in millimetres of mercury (mmHg).
Data Element Concept:	Person – blood pressure (systolic)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	NN[N]				
<i>Maximum character length:</i>	3				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	999	Not stated/inadequately described
Value	Meaning				
999	Not stated/inadequately described				
<i>Unit of measure:</i>	Millimetre of mercury (mmHg)				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	For recording the systolic reading, use phase I Korotkoff (the first appearance of sound). If Blood pressure - systolic is not collected or not able to be collected, code 999.
<i>Collection methods:</i>	<p>Measurement protocol for resting blood pressure:</p> <p>The systolic blood pressure is one component of a routine blood pressure measurement (i.e. systolic/diastolic) and reflects the maximum pressure to which the arteries are exposed.</p> <ul style="list-style-type: none">• The patient should be relaxed and seated, preferably for several minutes, (at least 5 minutes). Ideally, patients should not take caffeine-containing beverages or smoke for two hours before blood pressure is measured.• Ideally, patients should not exercise within half an hour of the measurement being taken (National Nutrition Survey User's Guide).• Use a mercury sphygmomanometer. All other sphygmomanometers should be calibrated regularly against mercury sphygmomanometers to ensure accuracy.• Bladder length should be at least 80%, and width at least 40% of the circumference of the mid-upper arm. If the Velcro on the cuff is not totally attached, the cuff is probably too small.

- Wrap cuff snugly around upper arm, with the centre of the bladder of the cuff positioned over the brachial artery and the lower border of the cuff about 2 cm above the bend of the elbow.
- Ensure cuff is at heart level, whatever the position of the patient.
- Palpate the radial pulse of the arm in which the blood pressure is being measured.
- Inflate cuff to the pressure at which the radial pulse disappears and note this value. Deflate cuff, wait 30 seconds, and then inflate cuff to 30 mm Hg above the pressure at which the radial pulse disappeared.
- Deflate the cuff at a rate of 2-3 mm Hg/beat (2-3 mm Hg/sec) or less.
- For recording the systolic reading, use phase I Korotkoff (the first appearance of sound). Wait 30 seconds before repeating the procedure in the same arm. Average the readings. If the first two readings differ by more than 6 mm Hg systolic or if initial readings are high, take several readings after five minutes of quiet rest.

Comments:

The pressure head is the height difference a pressure can raise a fluid's equilibrium level above the surface subjected to pressure. (Blood pressure is usually measured as a head of Mercury, and this is the unit of measure nominated for this metadata item.)

The current (2002) definition of hypertension is based on the level of blood pressure above which treatment is recommended, and this depends on the presence of other risk factors, e.g. age, diabetes etc. (NHF 1999 Guide to Management of Hypertension).

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin:

The National Heart Foundation Blood Pressure Advisory Committee's 'Guidelines for the Management of Hypertension - 1999' which are largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO-SH: 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17:151-83).

Australian Bureau of Statistics 1998. National Nutrition Survey User's Guide 1995. Cat. No. 4801.0. Canberra: ABS. (p. 20).

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents:

'Guidelines for the Management of Hypertension - 1999' largely based on World Health Organization Recommendations. (Guidelines Subcommittee of the WHO) J Hypertension 1999; 17: 151-83.).

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993.

UKPDS 38 Tight blood pressure control and risk of

macrovascular and microvascular complications in type 2 diabetes: UK Prospective Diabetes Study Group. British Medical Journal (1998); 317: 703-713.

Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Blood pressure - systolic measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf](#) (25.9 KB)

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Bodily location of main injury

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – bodily location of main injury, code NN
<i>METeOR identifier:</i>	268943
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The bodily location of the injury chiefly responsible for the attendance of the person at the health care facility, as represented by a code.
Data Element Concept:	Person – bodily location of main injury

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																										
<i>Data type:</i>	String																																										
<i>Format:</i>	NN																																										
<i>Maximum character length:</i>	2																																										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Head (excludes face)</td></tr><tr><td>02</td><td>Face (excludes eye)</td></tr><tr><td>03</td><td>Neck</td></tr><tr><td>04</td><td>Thorax</td></tr><tr><td>05</td><td>Abdomen</td></tr><tr><td>06</td><td>Lower back (includes loin)</td></tr><tr><td>07</td><td>Pelvis (includes perineum, anogenital area and buttocks)</td></tr><tr><td>08</td><td>Shoulder</td></tr><tr><td>09</td><td>Upper arm</td></tr><tr><td>10</td><td>Elbow</td></tr><tr><td>11</td><td>Forearm</td></tr><tr><td>12</td><td>Wrist</td></tr><tr><td>13</td><td>Hand (include fingers)</td></tr><tr><td>14</td><td>Hip</td></tr><tr><td>15</td><td>Thigh</td></tr><tr><td>16</td><td>Knee</td></tr><tr><td>17</td><td>Lower leg</td></tr><tr><td>18</td><td>Ankle</td></tr><tr><td>19</td><td>Foot (include toes)</td></tr><tr><td>20</td><td>Unspecified bodily location</td></tr></tbody></table>	Value	Meaning	01	Head (excludes face)	02	Face (excludes eye)	03	Neck	04	Thorax	05	Abdomen	06	Lower back (includes loin)	07	Pelvis (includes perineum, anogenital area and buttocks)	08	Shoulder	09	Upper arm	10	Elbow	11	Forearm	12	Wrist	13	Hand (include fingers)	14	Hip	15	Thigh	16	Knee	17	Lower leg	18	Ankle	19	Foot (include toes)	20	Unspecified bodily location
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18	Ankle																																										
19	Foot (include toes)																																										
20	Unspecified bodily location																																										

21	Multiple injuries (involving more than one bodily location)
22	Bodily location not required

Data element attributes

Collection and usage attributes

Guide for use:

If the full International Classification of Diseases - Tenth Revision - Australian Modification code is used to code the injury, this metadata item is not required (see metadata items Principal diagnosis and Additional diagnosis).

If any code from 01 to 12 or 26 to 29 in the metadata item Nature of main injury has been selected, the body region affected by that injury must be specified.

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

Comments:

The injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. The nature of main injury together with the bodily location of the main injury indicates the diagnosis.

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

Source and reference attributes

Submitting organisation:

National Injury Surveillance Unit, Flinders University, Adelaide
National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references:

See also [Injury event – nature of main injury, non-admitted patient code NN{.N}](#) Health, Standard 01/03/2005

*Implementation in Data Set
Specifications:*

Supersedes [Bodily location of main injury, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.5 KB)

[Injury surveillance DSS](#) Health, Superseded 05/02/2008

[Injury surveillance DSS](#) Health, Superseded 14/12/2009

[Injury surveillance DSS](#) Health, Standard 14/12/2009

[Injury surveillance NMDS](#) Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Injury surveillance NMDS](#) Health, Superseded 07/12/2005

Body function

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – body function, code (ICF 2001) AN[NNNN]
<i>Synonymous names:</i>	Body function code
<i>METeOR identifier:</i>	320141
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The physiological or psychological function of a person's body system, as represented by a code.
Data Element Concept:	Person – body function

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	AN[NNNN]
<i>Maximum character length:</i>	6

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.</p> <p>Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both Exercise tolerance functions (3 digit level) and 'fatigability' (4-digit level) as the former includes the latter.</p> <p>The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with <i>Impairment extent code N</i> will use the codes as indicated.</p> <p>CODE b1 Mental functions CODE b2 Sensory functions and pain CODE b3 Voice and speech functions CODE b4 Functions of the cardiovascular, haematological, immunological and respiratory systems CODE b5 Functions of the digestive, metabolic and the endocrine system CODE b6 Genitourinary and reproductive functions CODE b7 Neuromusculoskeletal and movement-related functions CODE b8 Functions of the skin and related structures</p>
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Data collected at this level will provide a general description of the structures and can only be compared with data collected at the same level.

Each chapter contains categories at different levels ordered from general to detailed. For more detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter. The full range of permissible values together, with definitions is listed in the *Body Functions* component of the ICF.

An example of a value domain at the 3 digit level from the Sensory functions and pain chapter may include:

CODE b210 Seeing functions
CODE b230 Hearing functions
CODE b235 Vestibular functions
CODE b250 Taste functions
CODE b255 Smell functions
CODE b260 Proprioceptive functions
CODE b265 Touch functions
CODE b270 Sensory functions related to temperature and other stimuli
CODE b279 Additional sensory functions, other specified and unspecified

An example of a value domain at the 4 digit level from the body function component may include:

CODE b1300 Energy level
CODE b1400 Sustaining attention
CODE b1442 Retrieval of memory
CODE b1521 Regulation of emotion
CODE b1641 Organization and planning

The prefix *b* denotes the domains within the component of *Body Functions*.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.cfm>

Data element attributes

Collection and usage attributes

Guide for use:

This data element can be used to record positive or neutral body function, as well as impairment of body function when used in conjunction with the metadata item Person—extent of impairment of body function, code (ICF 2001)N.

Where multiple body functions or impairments of body functions are recorded, the following prioritising system should be useful.

- The first recorded body function or impairment of body function is the one having the greatest impact on the individual.
- Second and subsequent body function or impairment of body function is also of relevance to the individual.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also [Person—extent of impairment of body function, code \(ICF 2001\) N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

[Body functions cluster](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Body mass index—adult (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Adult – body mass index (measured), ratio NN[N].N[N]
<i>METeOR identifier:</i>	270084
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A measure of an adult's weight (body mass) relative to height used to assess the extent of weight deficit or excess where height and weight have been measured.
Data Element Concept:	Adult – body mass index

Value domain attributes

Representational attributes

<i>Representation class:</i>	Ratio	
<i>Data type:</i>	Number	
<i>Format:</i>	NN[N].N[N]	
<i>Maximum character length:</i>	5	
<i>Supplementary values:</i>	Value	Meaning
	888.8	Unknown
	999.9	Not reported

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Formula: BMI = weight (kg) divided by height (m) squared. Body mass index is a continuous variable. Code body mass index to one or two decimal places (i.e. 99.99 or 99.9). If any component necessary for its calculation (i.e. weight or height for adults) is unknown or has not been collected, code to 888.8, 999.9.
<i>Collection methods:</i>	NN.NN for BMI calculated from measured height and weight. BMI should be derived after data entry of weight and height. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
<i>Comments:</i>	This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the United States Centers for Disease Control 2000 BMI-for-age chart be used for in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th percentile would be classified as overweight, while a BMI greater

than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

BMI is a low cost technique, with low respondent and investigator burden. In addition, it offers low inter-observer and intra-observer error, therefore offering good reliability.

Overweight and obesity, as defined by the World Health Organisation (WHO) for the interpretation of BMI (WHO 2000), are exceedingly common in Australia and their prevalence is increasing.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

Body mass index can be calculated from measured height and weight, or self-reported height and weight, however for children and adolescents, self-reported or parentally reported data should be used cautiously if at all.

For adults, body mass index tends to be underestimated when based on self-reported, rather than measured, height and weight. This is due to the fact that, on average, height tends to be overestimated and weight tends to be underestimated when self-reported by respondents.

There are many individuals for whom BMI is an inappropriate measure of body fatness. These are individuals whose high body mass is due to excess muscle rather than fat (e.g. body builders or others in whom the level of physical activity promotes an increase in muscle mass); or in those with osteoporosis who will have a lower than usual BMI; or those who have a different body build (e.g. individuals with unusually long or short legs or a different body fat distribution) (WHO Expert Committee 1995).

This is particularly important when assessing individuals but

should also be taken into account in interpreting data from populations in which there are sub-groups with genetic or environmental differences in body build, composition, skeletal proportions or body fat distribution. As such, both BMI and a measure of fat distribution (waist circumference or waist: hip ratio) are important in calculating the risk of obesity comorbidities.

Epidemiological research shows that there is a strong association between BMI and health risk. Excess adipose tissue in adults is associated with excess morbidity and mortality from conditions such as hypertension, unfavourable blood lipid concentrations, diabetes mellitus, coronary heart disease, some cancers, gall bladder disease, and osteoarthritis. It may also lead to social and economic disadvantage as well as psychosocial problems. It is a major public health issue in most industrialised societies.

Thinness (low BMI) is also an indicator of health risk, often being associated with general illness, anorexia, cigarette smoking, drug addiction and alcoholism. Low BMI is consistently associated with increased risk of osteoporosis and fractures in the elderly.

Source and reference attributes

Submitting organisation:

The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

Origin:

Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. 2000. World Health Organization.

Relational attributes

Related metadata references:

See also [Person – body mass index \(classification\), code N\[.N\]](#) Health, Standard 01/03/2005

Supersedes [Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (25.7 KB)

Is formed using [Person – height \(measured\), total centimetres NN\[N\].N](#) Health, Standard 01/03/2005

Is formed using [Person – weight \(measured\), total kilograms N\[NN\].N](#) Health, Standard 01/03/2005

Body mass index—adult (self-reported)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Adult – body mass index (self-reported), ratio NN[N].N[N]
<i>METeOR identifier:</i>	270086
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A measure of an adult's weight (body mass) relative to height used to assess the extent of weight deficit or excess where at least one of the measures is self reported.
Data Element Concept:	Adult – body mass index

Value domain attributes

Representational attributes

<i>Representation class:</i>	Ratio	
<i>Data type:</i>	Number	
<i>Format:</i>	NN[N].N[N]	
<i>Maximum character length:</i>	5	
<i>Supplementary values:</i>	Value	Meaning
	888.8	Unknown
	999.9	Not reported

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	NN.N for BMI calculated from either self-reported height and/or self-reported weight. BMI calculated from measured height and weight should be distinguished from BMI calculated from self-reported height and/or weight. When either self-reported height or self-reported weight is used in the calculation, BMI should be recorded as self-reported BMI. Self-reported or parentally reported height and weight for children and adolescents should be used cautiously if at all. BMI should be derived after the data entry of weight and height. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
<i>Comments:</i>	This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the United States Centers for Disease Control 2000 BMI-for-age chart be used for in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th

percentile would be classified as overweight, while a BMI greater than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

BMI is a low cost technique, with low respondent and investigator burden. In addition, it offers low inter-observer and intra-observer error, therefore offering good reliability.

Overweight and obesity, as defined by the World Health Organisation (WHO) for the interpretation of BMI (WHO 2000), are exceedingly common in Australia and their prevalence is increasing.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

Body mass index can be calculated from measured height and weight, or self-reported height and weight, however for children and adolescents, self-reported or parentally reported data should be used cautiously if at all.

For adults, body mass index tends to be underestimated when based on self-reported, rather than measured, height and weight. This is due to the fact that, on average, height tends to be overestimated and weight tends to be underestimated when self-reported by respondents.

There are many individuals for whom BMI is an inappropriate measure of body fatness. These are individuals whose high body mass is due to excess muscle rather than fat (e.g. body builders or others in whom the level of physical activity promotes an increase in muscle mass); or in those with osteoporosis who will have a lower than usual BMI; or those who have a different body build (e.g. individuals with unusually long or short legs or a different body fat distribution) (WHO Expert Committee 1995).

This is particularly important when assessing individuals but should also be taken into account in interpreting data from populations in which there are sub-groups with genetic or environmental differences in body build, composition, skeletal proportions or body fat distribution. As such, both BMI and a measure of fat distribution (waist circumference or waist: hip ratio) are important in calculating the risk of obesity comorbidities.

Epidemiological research shows that there is a strong association between BMI and health risk. Excess adipose tissue in adults is associated with excess morbidity and mortality from conditions such as hypertension, unfavourable blood lipid concentrations, diabetes mellitus, coronary heart disease, some cancers, gall bladder disease, and osteoarthritis. It may also lead to social and economic disadvantage as well as psychosocial problems. It is a major public health issue in most industrialised societies.

Thinness (low BMI) is also an indicator of health risk, often being associated with general illness, anorexia, cigarette smoking, drug addiction and alcoholism. Low BMI is consistently associated with increased risk of osteoporosis and fractures in the elderly.

Source and reference attributes

Submitting organisation:

The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

Origin:

Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. 2000. World Health Organization.

Relational attributes

Related metadata references:

See also [Person – body mass index \(classification\), code N\[N\].N](#) Health, Standard 01/03/2005

Is formed using [Person – weight \(measured\), total kilograms N\[NN\].N](#) Health, Standard 01/03/2005

Is formed using [Person – height \(self-reported\), total centimetres NN\[N\].N](#) Health, Standard 01/03/2005

Is formed using [Person – height \(measured\), total centimetres NN\[N\].N](#) Health, Standard 01/03/2005

Supersedes [Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (25.7 KB)

Is formed using [Person – weight \(self-reported\), total kilograms NN\[N\].N](#) Health, Standard 14/07/2005

Body mass index—child (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Child – body mass index (measured), ratio NN[N].N[N]
<i>METeOR identifier:</i>	270085
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A measure of a child’s weight (body mass) relative to height used to assess the extent of weight excess where height and weight have been measured.
Data Element Concept:	Child – body mass index

Value domain attributes

Representational attributes

<i>Representation class:</i>	Ratio	
<i>Data type:</i>	Number	
<i>Format:</i>	NN[N].N[N]	
<i>Maximum character length:</i>	5	
<i>Supplementary values:</i>	Value	Meaning
	888.8	Unknown
	999.9	Not reported

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	NN.NN for BMI calculated from measured height and weight. BMI should be derived after the data entry of weight and height. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
<i>Comments:</i>	This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the United States Centers for Disease Control 2000 BMI-for-age chart be used for in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th percentile would be classified as overweight, while a BMI greater than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults. BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

BMI is a low cost technique, with low respondent and investigator burden. In addition, it offers low inter-observer and intra-observer error, therefore offering good reliability.

Overweight and obesity, as defined by the World Health Organisation (WHO) for the interpretation of BMI (WHO 2000), are exceedingly common in Australia and their prevalence is increasing.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

Body mass index can be calculated from measured height and weight, or self-reported height and weight, however for children and adolescents, self-reported or parentally reported data should be used cautiously if at all.

For adults, body mass index tends to be underestimated when based on self-reported, rather than measured, height and weight. This is due to the fact that, on average, height tends to be overestimated and weight tends to be underestimated when self-reported by respondents.

There are many individuals for whom BMI is an inappropriate measure of body fatness. These are individuals whose high body mass is due to excess muscle rather than fat (e.g. body builders or others in whom the level of physical activity promotes an increase in muscle mass); or in those with osteoporosis who will have a lower than usual BMI; or those who have a different body build (e.g. individuals with unusually long or short legs or a different body fat distribution) (WHO Expert Committee 1995).

This is particularly important when assessing individuals but should also be taken into account in interpreting data from populations in which there are sub-groups with genetic or environmental differences in body build, composition, skeletal proportions or body fat distribution. As such, both BMI and a measure of fat distribution (waist circumference or waist: hip ratio) are important in calculating the risk of obesity comorbidities.

Epidemiological research shows that there is a strong association between BMI and health risk. Excess adipose tissue in adults is associated with excess morbidity and mortality from conditions such as hypertension, unfavourable blood lipid concentrations, diabetes mellitus, coronary heart disease, some cancers, gall bladder disease, and osteoarthritis. It may also lead to social and economic disadvantage as well as psychosocial problems. It is a major public health issue in most industrialised societies.

Thinness (low BMI) is also an indicator of health risk, often being associated with general illness, anorexia, cigarette smoking, drug addiction and alcoholism. Low BMI is consistently associated with increased risk of osteoporosis and fractures in the elderly.

Source and reference attributes

Submitting organisation:

The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

Origin:

Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. 2000. World Health Organization.

Cole TJ, Bellizzi MC, Flegal KM, Bietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. *British Medical Journal* 2000; 320: 1240-1243

Relational attributes

Related metadata references:

See also [Person – body mass index \(classification\), code N\[.N\]](#) Health, Standard 01/03/2005

Supersedes [Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (25.7 KB)

Is formed using [Person – height \(measured\), total centimetres NN\[N\].N](#) Health, Standard 01/03/2005

Is formed using [Person – weight \(measured\), total kilograms N\[NN\].N](#) Health, Standard 01/03/2005

Body mass index—child (self-reported)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Child – body mass index (self-reported), ratio NN[N].N[N]
<i>METeOR identifier:</i>	270087
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A measure of a child’s weight (body mass) relative to height used to assess the extent of weight excess where at least one of the measures is self reported.
Data Element Concept:	Child – body mass index

Value domain attributes

Representational attributes

<i>Representation class:</i>	Ratio	
<i>Data type:</i>	Number	
<i>Format:</i>	NN[N].N[N]	
<i>Maximum character length:</i>	5	
<i>Supplementary values:</i>	Value	Meaning
	888.8	Unknown
	999.9	Not reported

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	NN.N for BMI calculated from either self-reported height and/or self-reported weight. BMI calculated from measured height and weight should be distinguished from BMI calculated from self-reported height and/or weight. When either self-reported height or self-reported weight is used in the calculation, BMI should be recorded as self-reported BMI. Self-reported or parentally reported height and weight for children and adolescents should be used cautiously if at all. BMI should be derived after the data entry of weight and height. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
<i>Comments:</i>	This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference such as the United States Centers for Disease Control 2000 BMI-for-age chart be used for in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th

percentile would be classified as overweight, while a BMI greater than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.

BMI is relatively easy to determine, and has been validated against more direct measures of adiposity such as Magnetic Resonance Imaging and Dual X-ray Absorptiometry.

BMI is a low cost technique, with low respondent and investigator burden. In addition, it offers low inter-observer and intra-observer error, therefore offering good reliability.

Overweight and obesity, as defined by the World Health Organisation (WHO) for the interpretation of BMI (WHO 2000), are exceedingly common in Australia and their prevalence is increasing.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles a sample size of at least 200 is recommended for each group for which the centiles are being specified.

Body mass index can be calculated from measured height and weight, or self-reported height and weight, however for children and adolescents, self-reported or parentally reported data should be used cautiously if at all.

For adults, body mass index tends to be underestimated when based on self-reported, rather than measured, height and weight. This is due to the fact that, on average, height tends to be overestimated and weight tends to be underestimated when self-reported by respondents.

There are many individuals for whom BMI is an inappropriate measure of body fatness. These are individuals whose high body mass is due to excess muscle rather than fat (e.g. body builders or others in whom the level of physical activity promotes an increase in muscle mass); or in those with osteoporosis who will have a lower than usual BMI; or those who have a different body build (e.g. individuals with unusually long or short legs or a different body fat distribution) (WHO Expert Committee 1995).

This is particularly important when assessing individuals but should also be taken into account in interpreting data from populations in which there are sub-groups with genetic or environmental differences in body build, composition, skeletal proportions or body fat distribution. As such, both BMI and a measure of fat distribution (waist circumference or waist: hip ratio) are important in calculating the risk of obesity comorbidities.

Epidemiological research shows that there is a strong association between BMI and health risk. Excess adipose tissue in adults is associated with excess morbidity and mortality from conditions such as hypertension, unfavourable blood lipid concentrations, diabetes mellitus, coronary heart disease, some cancers, gall bladder disease, and osteoarthritis. It may also lead to social and economic disadvantage as well as psychosocial problems. It is a major public health issue in most industrialised societies.

Thinness (low BMI) is also an indicator of health risk, often being associated with general illness, anorexia, cigarette smoking, drug addiction and alcoholism. Low BMI is consistently associated with increased risk of osteoporosis and fractures in the elderly.

Source and reference attributes

Submitting organisation:

The Commonwealth Department of Health and Ageing based on the work of the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; based at the Children Hospital at Westmead.

Origin:

Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. 2000. World Health Organization.

Cole TJ, Bellizzi MC, Flegal KM, Bietz WH. Establishing a standard definition for child overweight and obesity worldwide: international survey. British Medical Journal 2000; 320: 1240-1243

Relational attributes

Related metadata references:

Supersedes [Body mass index, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (25.7 KB)

Is formed using [Person – height \(measured\), total centimetres NN\[N\].N](#) Health, Standard 01/03/2005

Is formed using [Person – height \(self-reported\), total centimetres NN\[N\]](#) Health, Standard 01/03/2005

Is formed using [Person – weight \(measured\), total kilograms N\[NN\].N](#) Health, Standard 01/03/2005

See also [Person – body mass index \(classification\), code N\[N\]](#) Health, Standard 01/03/2005

Is formed using [Person – weight \(self-reported\), total kilograms NN\[N\]](#) Health, Standard 14/07/2005

Body mass index—classification

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person—body mass index (classification), code N[.N]
<i>METeOR identifier:</i>	270474
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Data Element Concept:</i>	Person—body mass index (classification)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																						
<i>Data type:</i>	Number																						
<i>Format:</i>	N[.N]																						
<i>Maximum character length:</i>	2																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Not overweight or obese</td></tr><tr><td>1.1</td><td>Underweight</td></tr><tr><td>1.2</td><td>Normal range 18.50 - 24.99 Average</td></tr><tr><td>2</td><td>Overweight \geq 25.00 Average</td></tr><tr><td>2.1</td><td>Overweight \geq 25.0 Average</td></tr><tr><td>2.2</td><td>Pre Obese 25.00 - 29.99 Increased</td></tr><tr><td>3</td><td>Obese \geq 30 Increased</td></tr><tr><td>3.1</td><td>Obese class 1 30.00 - 34.99 Moderate</td></tr><tr><td>3.2</td><td>Obese class 2 35.00 - 39.99 Severe</td></tr><tr><td>3.3</td><td>Obese class 3 \geq 40.00 Very severe</td></tr></tbody></table>	Value	Meaning	1	Not overweight or obese	1.1	Underweight	1.2	Normal range 18.50 - 24.99 Average	2	Overweight \geq 25.00 Average	2.1	Overweight \geq 25.0 Average	2.2	Pre Obese 25.00 - 29.99 Increased	3	Obese \geq 30 Increased	3.1	Obese class 1 30.00 - 34.99 Moderate	3.2	Obese class 2 35.00 - 39.99 Severe	3.3	Obese class 3 \geq 40.00 Very severe
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<i>Supplementary values:</i>	9 Not stated/inadequately described																						

Collection and usage attributes

<i>Guide for use:</i>	<p>Adults:</p> <p>Body mass index for adults cannot be calculated if components necessary for its calculation (weight or height) is unknown or has not been collected (i.e. is coded to 888.8 or 999.9).</p> <p>BMI for adults is categorised according to the range it falls within as indicated by codes 1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 3.3 or 9.9. For consistency, when the sample includes children and adolescents, adults can be analysed under the broader categories of 1, 2, 3 or 9 as used for categorising children and adolescents.</p> <p>Children/adolescents:</p> <p>Body mass index for children and adolescents aged 2 to 17 years cannot be calculated if components necessary for its calculation (date of birth, sex, weight or height) is unknown or has not been collected (i.e. is coded to 888.8, 999.9 or 9).</p>
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Self-reported or parentally reported height and weight for children and adolescents should be used cautiously if at all.

To determine overweight and obesity in children and adolescents, compare the derived BMI against those recorded for the relevant age and sex of the subject to be classified, against Table 1: Classification of BMI for children and adolescents, based on BMI cut-points developed by Cole et al (see below). For example, an 11 year old boy with a BMI of 21 would be considered overweight (i.e. coded as 2), or a 7 year old girl with a BMI of 17.5 would be considered not overweight or obese (i.e. coded as 1).

Using this method, children and adolescents can only be coded as 1, 2, 3 or 9.

Collection methods:

Use N for BMI category determined (1, 2, 3 or 9) for persons (children and adolescents) aged 2 to 17 years.

Use N.N for BMI category determined (1.1, 1.2, 2.1, 2.2, 3.1, 3.2, 3.3 or 9.9) for persons aged 18 years or older.

Standard definitions of overweight and obesity in terms of BMI are used to derive age-specific and age-adjusted indicators of overweight and obesity for reporting progress towards National public health policy .

Data element attributes

Collection and usage attributes

Guide for use:

Table 1: Classification of overweight and obesity for children and adolescents				
Age(years)	BMI equivalent to 25 kg/m ²		BMI equivalent to 30 kg/m ²	
	Males	Females	Males	Females
2	18.41	18.02	20.09	19.81
2.5	18.13	17.76	19.80	19.55
3	17.89	17.56	19.57	19.36
3.5	17.69	17.40	19.39	19.23
4	17.55	17.28	19.29	19.15
4.5	17.47	17.19	19.26	19.12
5	17.42	17.15	19.30	19.17
5.5	17.45	17.20	19.47	19.34
6	17.55	17.34	19.78	19.65
6.5	17.71	17.53	20.23	20.08
7	17.92	17.75	20.63	20.51
7.5	18.16	18.03	21.09	21.01
8	18.44	18.35	21.60	21.57
8.5	18.76	18.69	22.17	22.18

9	19.10	19.07	22.77	22.81
9.5	19.46	19.45	23.39	23.46
10	19.84	19.86	24.00	24.11
10.5	20.20	20.29	24.57	24.77
11	20.55	20.74	25.10	25.42
11.5	20.89	21.20	25.58	26.05
12	21.22	21.68	26.02	26.67
12.5	21.56	22.14	26.43	27.24
13	21.91	22.58	26.84	27.76
13.5	22.27	22.98	27.25	28.20
14	22.62	23.34	27.63	28.57
14.5	22.96	23.66	27.98	28.87
15	23.29	23.94	28.30	29.11
15.5	23.60	24.17	28.60	29.29
16	23.90	24.37	28.88	29.43
16.5	24.19	24.54	29.14	29.56
17	24.46	24.70	29.41	26.69
17.5	24.73	24.85	29.70	29.84
18	25.00	25.00	30.00	30.00

Comments:

This metadata item applies to persons aged 2 years or older. It is recommended for use in population surveys and health care settings for adults and population surveys only for children and adolescents. It is recommended that calculated BMI for children and adolescents be compared with a suitable growth reference chart in health care settings such as hospitals, clinics and in general practice. A BMI greater than the 85th percentile would be classified as overweight, while a BMI greater than the 95th percentile would be classified as obese. These percentiles are arbitrary and do not relate to morbidity as the BMI cut-points do in adults.

BMI can be considered to provide the most useful, albeit crude, population-level measure of obesity. The robust nature of the measurements and the widespread routine inclusion of weights and heights in clinical and population health surveys mean that a more selective measure of adiposity, such as skinfold thickness measurements, provides additional rather than primary information. BMI can be used to estimate the prevalence of obesity within a population and the risks associated with it, but does not, however, account for the wide variation in the nature of obesity between different individuals and populations (WHO 2000).

BMI values for adults are age-independent and the same for both sexes.

However, BMI values for children and adolescents aged 2 to 17 years are age and sex specific and are classified by comparing

against the above table, Table 1: Classification of BMI for children and adolescents.

For adults and children and adolescents BMI may not correspond to the same degree of fatness in different populations due, in part, to differences in body proportions. The classification table shows a simplistic relationship between BMI and the risk of comorbidity, which can be affected by a range of factors, including the nature of the diet, ethnic group and activity level. The risks associated with increasing BMI are continuous and graded and begin at a BMI of 25 (or equivalent to 25 for children and adolescents). The interpretation of BMI grades in relation to risk may differ for different populations. Both BMI and a measure of fat distribution (waist circumference or waist: hip ratio in adults) are important in calculating the risk of obesity comorbidities.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous Status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Methods used to establish cut-off points for overweight have been arbitrary and, as a result, cut-off points vary between countries. The data are derived mainly from studies of mortality and morbidity risk performed in people living in western Europe or the United States of America, and cut-off points for BMI as an indicator of adiposity and risk in populations who differ in body build and genetic disposition are likely to vary.

Caution is required in relation to BMI cut-off points when used for different ethnic groups because of limited outcome data for some ethnic groups, e.g. Aboriginal and Torres Strait Islander peoples. As with overweight the cut-off points for a given level of risk are likely to vary with body build, genetic background and physical activity.

The classification above is different to ones that have been used in the past and it is important that in any trend analysis consistent definitions are used.

BMI should not be rounded before categorisation to the classification above.

Source and reference attributes

Submitting organisation:

World Health Organization (see also Comments) and the consortium to develop an Australian standard definition of child/adolescent overweight and obesity; at the Children's Hospital at Westmead on behalf of the Commonwealth Department of Health & Ageing

Origin:

Obesity: Preventing and Managing the Global Epidemic (Report of a WHO Consultation: World Health Organization 2000); Cole TJ, Bellizzi MC, Flegal KM, Dietz WH. Establishing a

standard definition for child overweight and obesity worldwide: international survey. British Medical Journal 2000; 320: 1240-1243

Relational attributes

Related metadata references:

See also [Child – body mass index \(measured\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

See also [Adult – body mass index \(self-reported\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Supersedes [Body mass index - classification, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (79.5 KB)

Body structure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – body structure, code (ICF 2001) AN[NNNN]
<i>Synonymous names:</i>	Body structure code
<i>METeOR identifier:</i>	320147
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	An anatomical part of a person's body such as organs, limbs or their components, as represented by a code.
Data Element Concept:	Person – body structure

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	AN[NNNN]
<i>Maximum character length:</i>	6

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept disability and gives an indication of the experience of disability for a person.</p> <p>Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both 'Skin and related structures' (chapter level) and 'Structure of nails' (3 digit level) as the former includes the latter.</p> <p>The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with respective qualifiers (<i>Impairment extent code N, Impairment nature code N, Impairment location code N</i>) will use the codes as indicated.</p> <p>CODE s1 Structures of the nervous system CODE s2 The eye, ear and related structures CODE s3 Structures involved in voice and speech CODE s4 Structures of the cardiovascular, immunological and respiratory systems CODE s5 Structures related to the digestive, metabolic and endocrine systems CODE s6 Structures related to the genitourinary and reproductive systems CODE s7 Structures related to movement</p>
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CODE s8 Skin and related structures

Data collected at this level will provide a general description of the structures and can only be compared with data collected at the same level.

Each chapter contains categories at different levels ordered from general to detailed. For more detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter. The full range of permissible values together with definitions is listed in the [Body Structures](#) component of the ICF.

An example of a value domain at the 3 digit level from the Structures of the nervous system chapter may include:

CODE s110 Structure of the brain
CODE s120 Spinal cord and related structures
CODE s130 Structure of the meninges
CODE s140 Structure of sympathetic nervous system
CODE s150 Structure of parasympathetic nervous system
CODE s198 Structure of the nervous system, other specified
CODE s199 Structure of the nervous system, unspecified

An example of a value domain at the 4 digit level from the Structures related to movement chapter may include:

CODE s7300 Structure of upper arm
CODE s7301 Structure of forearm
CODE s7302 Structure of hand
CODE s7500 Structure of thigh
CODE s7501 Structure of lower leg
CODE s7502 Structure of ankle and foot
CODE s7600 Structure of vertebral column

The prefix *s* denotes the domains within the component of *Body Structures*.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.cfm>

Data element attributes

Collection and usage attributes

Guide for use:

This data element consists of a single, neutral list of body structures that can be used to record positive or neutral body function. In conjunction with *Impairment extent code N*, it enables the provision of information about the presence and extent of impairment for any given body structures; with *Impairment nature code N*, the provision of information about the nature of the impairment for given body functions; and *Impairment location code N*, the location of the impairment for given body functions.

Where multiple body structures or **impairments of body structures** are recorded, the following prioritising system should be useful:

- The first recorded body structure or impairment of body function is the one having the greatest impact on the individual.
- Second and subsequent body structure or impairment of body function is also of relevance to the individual.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specifications:

[Body structures cluster](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Building/complex sub-unit number (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – building/complex sub-unit identifier, [X(7)]
<i>METeOR identifier:</i>	270018
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The unique number or identifier for a building/complex, marina, etc. where a person resides.
Data Element Concept:	Person (address) – building/complex sub-unit identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	[X(7)]
<i>Maximum character length:</i>	7

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The building/complex sub-unit number must be recorded with its corresponding building/complex unit type - abbreviation. Where applicable, the number may be followed by an alphanumeric suffix.
<i>Collection methods:</i>	To be collected in conjunction with building/complex sub-unit type - abbreviation.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Australia Post Address Presentation Standard
<i>Reference documents:</i>	Australian Standard; Interchange of client information, 4590-2006.

Relational attributes

<i>Related metadata references:</i>	Supersedes Building/complex sub-unit number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB) Is used in the formation of Person (address) – address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005 Is used in the formation of Person (address) – health address line, text [X(180)] Health, Superseded 04/05/2005
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Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Building/complex sub-unit number (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – building/complex sub-unit identifier, [X(7)]
<i>METeOR identifier:</i>	290291
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The unique number or identifier of a building/complex, marina, etc. where an organisation is located.
Data Element Concept:	Service provider organisation (address) – building/complex sub-unit identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	[X(7)]
<i>Maximum character length:</i>	7

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Australia Post Address Presentation Standard

Relational attributes

<i>Related metadata references:</i>	Is used in the formation of Service provider organisation (address) – address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
<i>Implementation in Data Set Specifications:</i>	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Building/complex sub-unit type—abbreviation (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address)— building/ complex sub-unit type, code A[AAA]
<i>Synonymous names:</i>	Australian unit type
<i>METeOR identifier:</i>	270023
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The type of building/complex where a person can be located, as represented by a code.
Data Element Concept:	Person (address)— building/ complex sub-unit type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																										
<i>Data type:</i>	String																																										
<i>Format:</i>	A[AAA]																																										
<i>Maximum character length:</i>	4																																										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>APT</td><td>Apartment</td></tr><tr><td>CTGE</td><td>Cottage</td></tr><tr><td>DUP</td><td>Duplex</td></tr><tr><td>FY</td><td>Factory</td></tr><tr><td>F</td><td>Flat</td></tr><tr><td>HSE</td><td>House</td></tr><tr><td>KSK</td><td>Kiosk</td></tr><tr><td>MSNT</td><td>Maisonette</td></tr><tr><td>MB</td><td>Marine Berth</td></tr><tr><td>OFF</td><td>Office</td></tr><tr><td>PTHS</td><td>Penthouse</td></tr><tr><td>RM</td><td>Room</td></tr><tr><td>SHED</td><td>Shed</td></tr><tr><td>SHOP</td><td>Shop</td></tr><tr><td>SITE</td><td>Site</td></tr><tr><td>SL</td><td>Stall</td></tr><tr><td>STU</td><td>Studio</td></tr><tr><td>SE</td><td>Suite</td></tr><tr><td>TNHS</td><td>Townhouse</td></tr><tr><td>U</td><td>Unit</td></tr></tbody></table>	Value	Meaning	APT	Apartment	CTGE	Cottage	DUP	Duplex	FY	Factory	F	Flat	HSE	House	KSK	Kiosk	MSNT	Maisonette	MB	Marine Berth	OFF	Office	PTHS	Penthouse	RM	Room	SHED	Shed	SHOP	Shop	SITE	Site	SL	Stall	STU	Studio	SE	Suite	TNHS	Townhouse	U	Unit
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SE	Suite																																										
TNHS	Townhouse																																										
U	Unit																																										

VLLA	Villa
WARD	Ward
WE	Warehouse

Collection and usage attributes

Guide for use:

Addresses may contain multiple instances of building/complex type. Record each instance of building/complex type with its corresponding building/complex number when appropriate.

Examples:

APT 6

SHOP 3A

U 6

PTHS

Data element attributes

Collection and usage attributes

Collection methods:

To be collected in conjunction with building/complex sub unit number.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Origin:

Health Data Standards Committee

Relational attributes

Related metadata references:

Supersedes [Building/complex sub-unit type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.8 KB)

Is used in the formation of [Person \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of [Person \(address\) – health address line, text \[X\(180\)\]](#) Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Building/complex sub-unit type—abbreviation (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – building/complex sub-unit type, code A[AAA]
<i>METeOR identifier:</i>	290278
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The type of building/complex where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address) – building/complex sub-unit type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																								
<i>Data type:</i>	String																																								
<i>Format:</i>	A[AAA]																																								
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U	Unit
VLLA	Villa
WARD	Ward
WE	Warehouse

Collection and usage attributes

Guide for use:

Addresses may contain multiple instances of building/complex type. Record each instance of building/complex type with its corresponding building/complex number when appropriate.

Examples:

APT 6

SHOP 3A

U 6

PTHS

Data element attributes

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Origin:

Health Data Standards Committee

Relational attributes

Related metadata references:

Is used in the formation of [Service provider organisation \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications:

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Building/property name (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – building/property name, text [X(30)]
<i>Synonymous names:</i>	Australian address site name
<i>METeOR identifier:</i>	270028
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The name of a building or property where a person resides, as represented by text.
Data Element Concept:	Person (address) – building/property name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(30)]
<i>Maximum character length:</i>	30

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Usually this information is not abbreviated. Should include any reference to a wing or other components of a building complex, if applicable. A comma is to be used to separate the wing reference from the rest of the building name. Record each Building/property name relevant to the address: <ul style="list-style-type: none">• Building/property name 1 (30 alphanumeric characters)• Building/property name 2 (30 alphanumeric characters) For example: Building - TREASURY BUILDING Property - BRINDABELLA STATION
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Source and reference attributes

<i>Origin:</i>	Health Data Standards Committee Australia Post Address Presentation Standard
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes [Building/property name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (13.8 KB)

Is used in the formation of [Person \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of [Person \(address\) – health address line, text \[X\(180\)\]](#) Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Building/property name (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – building/property name, text [X(30)]
<i>METeOR identifier:</i>	290295
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The name of a building or property where an organisation is located, as represented by text.
Data Element Concept:	Service provider organisation (address) – building/property name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(30)]
<i>Maximum character length:</i>	30

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Usually this information is not abbreviated. Should include any reference to a wing or other components of a building complex, if applicable. A comma is to be used to separate the wing reference from the rest of the building name. Record each Building/property name relevant to the address: <ul style="list-style-type: none">• Building/property name 1 (30 alphanumeric characters)• Building/property name 2 (30 alphanumeric characters) For example: Building - TREASURY BUILDING Property - BRINDABELLA STATION
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Source and reference attributes

<i>Origin:</i>	Health Data Standards Committee Australia Post Address Presentation Standard
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Relational attributes

Related metadata references:

Is used in the formation of [Service provider organisation \(address\) – address line, text \[X\(180\)\]](#) Health, Standard
04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications:

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Bundle-branch block status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Electrocardiogram – bundle-branch block status, code N
<i>METeOR identifier:</i>	343866
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The bundle-branch block status identified on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram – bundle-branch block status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>New</td></tr><tr><td>2</td><td>Pre-existing</td></tr><tr><td>3</td><td>Uncertain timing</td></tr></tbody></table>	Value	Meaning	1	New	2	Pre-existing	3	Uncertain timing
Value	Meaning								
1	New								
2	Pre-existing								
3	Uncertain timing								
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	9	Not stated/inadequately described						
9	Not stated/inadequately described								

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To determine the bundle-branch block status, compare the current ECG to the preceding or most recently available ECG.
<i>Collection methods:</i>	<p>Record for each ECG that indicates a bundle-branch block is present.</p> <p>Only one bundle-branch block status can be recorded for each ECG performed.</p> <p>Only one bundle-branch block can occur at any one time, but in any given person, a left bundle-branch block may occur at one time point and a right bundle-branch block at another time point. Therefore, there can only be one bundle-branch block per ECG, but they may differ temporally.</p>

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Electrocardiogram cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> Record if a bundle-branch block has been detected on an electrocardiogram.
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C-reactive protein level (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – C-reactive protein level (measured), total milligrams per litre N[NN].N
<i>Synonymous names:</i>	CRP measured
<i>METeOR identifier:</i>	338256
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's serum C-reactive protein (CRP) level, measured in milligrams per litre.
<i>Data Element Concept:</i>	Person – C-reactive protein level (measured)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[NN].N				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999.9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	999.9	Not stated/inadequately described
Value	Meaning				
999.9	Not stated/inadequately described				
<i>Unit of measure:</i>	Milligram per litre (mg/L)				
<i>Unit of measure precision:</i>	1				

Data element attributes

Collection and usage attributes

<i>Comments:</i>	The value should be recorded on a high sensitivity assay. CRP is used in the assessment of acute phase reaction in inflammatory, infective and neoplastic disorders.
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Source and reference attributes

<i>Reference documents:</i>	The Royal College of Pathologists of Australia Version 4.0 12th March 2004 (last accessed 12May 2006). http://www.rcpamanual.edu.au/sections/pathologytest.asp?s=33&i=468
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Relational attributes

<i>Related metadata references:</i>	See also Person – C-reactive protein level measured time, hhmm Health, Standard 01/10/2008 See also Person – C-reactive protein level measured date, DDMMYYYY Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

CVD drug therapy—condition

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person—cardiovascular disease condition targeted by drug therapy, code NN
<i>METeOR identifier:</i>	270193
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The condition(s) for which drug therapy is being used for the prevention or long-term treatment of cardiovascular disease, as represented by a code.
Data Element Concept:	Person—cardiovascular disease condition targeted by drug therapy

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																												
<i>Data type:</i>	String																												
<i>Format:</i>	NN																												
<i>Maximum character length:</i>	2																												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Heart failure</td></tr><tr><td>02</td><td>Ischaemic heart disease</td></tr><tr><td>03</td><td>Hypertension</td></tr><tr><td>04</td><td>Atrial fibrillation (AF)</td></tr><tr><td>05</td><td>Other dysrhythmia or conductive disorder</td></tr><tr><td>06</td><td>Dyslipidaemia</td></tr><tr><td>07</td><td>Peripheral vascular disease (PVD)</td></tr><tr><td>08</td><td>Renal vascular disease</td></tr><tr><td>09</td><td>Stroke</td></tr><tr><td>10</td><td>Transient ischaemic attack (TIA)</td></tr><tr><td>97</td><td>Other</td></tr><tr><td>98</td><td>No CVD drugs prescribed</td></tr><tr><td>99</td><td>Not recorded</td></tr></tbody></table>	Value	Meaning	01	Heart failure	02	Ischaemic heart disease	03	Hypertension	04	Atrial fibrillation (AF)	05	Other dysrhythmia or conductive disorder	06	Dyslipidaemia	07	Peripheral vascular disease (PVD)	08	Renal vascular disease	09	Stroke	10	Transient ischaemic attack (TIA)	97	Other	98	No CVD drugs prescribed	99	Not recorded
Value	Meaning																												
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09	Stroke																												
10	Transient ischaemic attack (TIA)																												
97	Other																												
98	No CVD drugs prescribed																												
99	Not recorded																												
<i>Supplementary values:</i>																													

Collection and usage attributes

<i>Guide for use:</i>	The categorisations may be made using the most recent version of the Australian Modification of the appropriate International Classification of Diseases codes.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	More than one code can be recorded.
<i>Comments:</i>	References such as the Australian Medicines Handbook can be used to identify specific drugs that are appropriate for use in the management of the conditions identified in the value domain.

Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular Data Working Group
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Relational attributes

<i>Related metadata references:</i>	Supersedes CVD drug therapy - condition, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.0 KB)
<i>Implementation in Data Set Specifications:</i>	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Caesarean section indicator, last previous birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female – caesarean section indicator (last previous birth) code N
<i>METeOR identifier:</i>	301993
<i>Registration status:</i>	Health, Standard 29/11/2006
<i>Definition:</i>	Whether a caesarean section was performed for the woman's last previous birth, as represented by a code.
Data Element Concept:	Female – caesarean section indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This item should be completed if there has been a previous birth. In the case of no previous births, the item should be left blank.
<i>Comments:</i>	<p>Previous caesarean sections are associated with a higher risk of obstetric complications, and when used with other indicators provides important information on the quality of obstetric care.</p> <p>This item can be used to determine vaginal births occurring after a caesarean section delivery (VBAC).</p>

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Cancer initial treatment completion date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – non-surgical cancer treatment completion date, DDMMYYYY
<i>METeOR identifier:</i>	288136
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The date on which the initial non-surgical treatment for cancer was completed.
Data Element Concept:	Cancer treatment – non-surgical cancer treatment completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Collected for radiation therapy and systemic therapy.
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Source and reference attributes

<i>Submitting organisation:</i>	National Cancer Control Initiative
<i>Origin:</i>	Commission on Cancer, American College of Surgeons
<i>Reference documents:</i>	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

<i>Related metadata references:</i>	Supersedes Cancer initial treatment - completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)
<i>Implementation in Data Set Specifications:</i>	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009

Cancer initial treatment starting date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – non-surgical cancer treatment start date, DDMMYYYY
<i>METeOR identifier:</i>	288103
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The start date of the initial course of non-surgical treatment for cancer.
Data Element Concept:	Cancer treatment – non-surgical cancer treatment start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The start date of the treatment is recorded regardless of whether treatment is completed as intended or not. Treatment subsequent to a recurrence will not be recorded. Collected for radiation therapy and systemic therapy. Date of surgical treatment is collected as a separate item.
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Source and reference attributes

<i>Submitting organisation:</i>	National Cancer Control Institute
<i>Origin:</i>	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).

Relational attributes

<i>Related metadata references:</i>	Supersedes Cancer initial treatment - starting date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
<i>Implementation in Data Set Specifications:</i>	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009 Cancer (clinical) DSS Health, Superseded 22/12/2009 Cancer (clinical) DSS Health, Standard 22/12/2009

Cancer staging—M stage code

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – distant metastasis status, M stage (UICC TNM Classification of Malignant Tumours, 6th edn) code XX
<i>METeOR identifier:</i>	341300
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	Absence or presence of distant metastasis at the time of diagnosis of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer – distant metastasis status

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition	
<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	XX	
<i>Maximum character length:</i>	2	
<i>Supplementary values:</i>	Value	Meaning
	88	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	Valid M codes from the current edition of the UICC TNM Classification of Malignant Tumours. Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	TNM staging applies to solid tumours excluding brain tumours. Choose the lower (less advanced) M category when there is any uncertainty.
<i>Collection methods:</i>	From information provided by the treating doctor and recorded on the patient's medical record.
<i>Comments:</i>	Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site. Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the

anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

Source and reference attributes

Origin: International Union Against Cancer (UICC)
Commission on Cancer, American College of Surgeons

Reference documents: Sobin LH, Wittekind C. TNM Classification of Malignant Tumours. 6th ed. Hoboken, New Jersey: John Wiley & Sons; 2002
Commission on Cancer Facility Oncology Registry Data Standards (FORDS): Revised for 2004

Relational attributes

Related metadata references: Supersedes [Person with cancer – distant metastasis status, M stage \(UICC TNM Classification of Malignant Tumours 5th ed\) code XX](#) Health, Superseded 06/03/2009

Is used in the formation of [Person with cancer – extent of primary cancer, TNM stage \(UICC TNM Classification of Malignant Tumours, 6th ed\) code XXXX{\[X\]XX}](#) Health, Standard 06/03/2009

Implementation in Data Set Specifications: [Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

Conditional obligation:
Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Conditional obligation:
Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer staging—N stage code

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – regional lymph node metastasis status, N stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX
<i>METeOR identifier:</i>	341302
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	Extent of regional lymph node metastasis at the time of diagnosis of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer – regional lymph node metastasis status

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition	
<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	XX	
<i>Maximum character length:</i>	2	
<i>Supplementary values:</i>	Value	Meaning
	88	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	Valid N codes from the current edition of the UICC TNM Classification of Malignant Tumours. Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	TNM staging applies to solid tumours excluding brain tumours. Choose the lower (less advanced) N category when there is any uncertainty.
<i>Collection methods:</i>	From information provided by the treating doctor and recorded on the patient's medical record.
<i>Comments:</i>	Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site. Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an

internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

Source and reference attributes

Reference documents:

Sobin LH, Wittekind C. TNM Classification of Malignant Tumours. 6 ed. Hoboken, New Jersey: John Wiley & Sons; 2002
Commission on Cancer Facility Oncology Registry Data Standards (FORDS): Revised for 2004

Relational attributes

Related metadata references:

Supersedes [Person with cancer – regional lymph node metastasis status, N stage \(UICC TNM Classification of Malignant Tumours 5th ed\) code XX](#) Health, Superseded 06/03/2009

Is used in the formation of [Person with cancer – extent of primary cancer, TNM stage \(UICC TNM Classification of Malignant Tumours, 6th ed\) code XXXX{\[X\]XX}](#) Health, Standard 06/03/2009

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

Conditional obligation:

Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Conditional obligation:

Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer staging—T stage code

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – primary tumour status, T stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX[X]
<i>METeOR identifier:</i>	341306
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	Extent of primary cancer including tumour size, at the time of diagnosis, as represented by a code.
Data Element Concept:	Person with cancer – primary tumour status

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition	
<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	XX[X]	
<i>Maximum character length:</i>	3	
<i>Supplementary values:</i>	Value	Meaning
	88	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	Valid T codes from the current edition of the UICC TNM Classification of Malignant Tumours. Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	TNM staging applies to solid tumours excluding brain tumours. Choose the lower (less advanced) T category when there is any uncertainty. T stage value is derived from value of "Solid tumour size (at diagnosis) total millimetres". Refer to usage attributes for this data element for additional detail.
<i>Collection methods:</i>	From information provided by the treating doctor and recorded on the patient's medical record.
<i>Comments:</i>	Cancer prognosis and survival can be related to the extent of the disease at diagnosis. Survival rates are generally higher if the disease is localised to the organ of origin compared with cases in which the tumour has spread beyond the primary site.

Staging systems seek to classify patients having a similar prognosis into groups or stages. TNM staging is an internationally agreed staging classification system based on the anatomical site of the primary tumour and its extent of spread. The T component refers to the size of the tumour and whether or not it has spread to surrounding tissues. The N component describes the presence or absence of tumour in regional lymph nodes. The M component refers to the presence or absence of tumour at sites distant from the primary site.

Source and reference attributes

Reference documents:

Sobin LH, Wittekind C. TNM Classification of Malignant Tumours. 6 ed. Hoboken, New Jersey: John Wiley & Sons; 2002
Commission on Cancer Facility Oncology Registry Data Standards (FORDS): Revised for 2004

Relational attributes

Related metadata references:

Is formed using [Person with cancer – solid tumour size \(at diagnosis\), total millimetres NNN](#) Health, Standard 06/03/2009
Supersedes [Person with cancer – primary tumour status, T stage \(UICC TNM Classification of Malignant Tumours 5th ed\) code XX\[X\]](#) Health, Superseded 06/03/2009

Is used in the formation of [Person with cancer – extent of primary cancer, TNM stage \(UICC TNM Classification of Malignant Tumours, 6th ed\) code XXXX{\[X\]XX}](#) Health, Standard 06/03/2009

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

Conditional obligation:

Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Conditional obligation:

Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer staging—TNM stage grouping code

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – extent of primary cancer, TNM stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XXXX{[X]XX}
<i>METeOR identifier:</i>	341304
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The anatomical extent of disease at diagnosis based on the previously coded T, N and M stage categories, as represented by a code.
Data Element Concept:	Person with cancer – extent of primary cancer

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition	
<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	XXXX{[X]XX}	
<i>Maximum character length:</i>	7	
<i>Supplementary values:</i>	Value	Meaning
	8888	Not applicable
	9999	Unknown, Stage X

Collection and usage attributes

<i>Guide for use:</i>	Valid stage grouping codes from the current edition of the UICC TNM Classification of Malignant Tumours.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	TNM staging applies to solid tumours excluding brain tumours. Refer to the TNM Supplement: A Commentary on Uniform Use, 3rd Edition for coding rules. Choose the lower (less advanced) T category when there is any uncertainty.
<i>Collection methods:</i>	From information provided by the treating doctor and recorded on the patient's medical record.

Relational attributes

Related metadata references:

Is formed using [Person with cancer – primary tumour status, T stage \(UICC TNM Classification of Malignant Tumours, 6th ed\) code XX\[X\]](#) Health, Standard 06/03/2009

Is formed using [Person with cancer – distant metastasis status, M stage \(UICC TNM Classification of Malignant Tumours, 6th ed\) code XX](#) Health, Standard 06/03/2009

Is formed using [Person with cancer – regional lymph node metastasis status, N stage \(UICC TNM Classification of Malignant Tumours, 6th ed\) code XX](#) Health, Standard 06/03/2009

Supersedes [Person with cancer – extent of primary cancer, TNM stage \(UICC TNM Classification of Malignant Tumours 5th ed\) code XXXX{\[X\]XX}](#) Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

Conditional obligation:

Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Conditional obligation:

Collection of this element is conditional on the disease site being listed in the UICC TNM Classification.

Cancer treatment type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – cancer treatment type, code N
<i>METeOR identifier:</i>	288185
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The type of treatment for cancer given as initial treatment for the particular patient, as represented by a code.
Data Element Concept:	Cancer treatment – cancer treatment type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	N																		
<i>Maximum character length:</i>	1																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>No treatment</td></tr><tr><td>1</td><td>Surgical treatment</td></tr><tr><td>2</td><td>Radiation therapy</td></tr><tr><td>3</td><td>Systemic agent therapy</td></tr><tr><td>4</td><td>Surgical and radiation treatment</td></tr><tr><td>5</td><td>Surgical treatment and systemic agent treatment</td></tr><tr><td>6</td><td>Radiation and systemic agent treatment</td></tr><tr><td>7</td><td>All three treatment types</td></tr></tbody></table>	Value	Meaning	0	No treatment	1	Surgical treatment	2	Radiation therapy	3	Systemic agent therapy	4	Surgical and radiation treatment	5	Surgical treatment and systemic agent treatment	6	Radiation and systemic agent treatment	7	All three treatment types
Value	Meaning																		
0	No treatment																		
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3	Systemic agent therapy																		
4	Surgical and radiation treatment																		
5	Surgical treatment and systemic agent treatment																		
6	Radiation and systemic agent treatment																		
7	All three treatment types																		

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Source and reference attributes

<i>Origin:</i>	Commission on Cancer, American College of Surgeons. New South Wales Health Department.
<i>Reference documents:</i>	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998) Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Cancer treatment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.4 KB)

[Cancer \(clinical\) DSS Health](#), Superseded 07/12/2005

[Cancer \(clinical\) DSS Health](#), Superseded 06/03/2009

[Cancer \(clinical\) DSS Health](#), Superseded 22/12/2009

[Cancer \(clinical\) DSS Health](#), Standard 22/12/2009

Cancer treatment—target site (ICD-10-AM)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – target site for cancer treatment, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	391324
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	The site or region which is the target of particular surgical or radiotherapy treatment, as represented by an ICD-10-AM code.
Data Element Concept:	Cancer treatment – target site for cancer treatment

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This information is collected for surgical and radiotherapy treatments. Current edition of International Classification of Diseases (ICD-10-AM), Australian Modification, National Centre for Classification in Health, Sydney is used.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Cancer treatment – target site for cancer treatment, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009
<i>Implementation in Data Set Specifications:</i>	Cancer (clinical) DSS Health, Standard 22/12/2009

Cancer treatment—target site (ICDO-3)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – target site for cancer treatment, code (ICDO-3) ANN
<i>METeOR identifier:</i>	293161
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The site or region of cancer which is the target of a particular surgical or radiotherapy treatment, as represented by an ICDO-3 code.
Data Element Concept:	Cancer treatment – target site for cancer treatment

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Diseases for Oncology 3rd edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN
<i>Maximum character length:</i>	3

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This information is collected for surgical and radiotherapy treatments. Current edition of International Classification of Diseases for Oncology (ICD-O), World Health Organisation is used. Major organ only - first 3 characters.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Cancer treatment - target site, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.2 KB)
<i>Implementation in Data Set Specifications:</i>	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009 Cancer (clinical) DSS Health, Superseded 22/12/2009 Cancer (clinical) DSS Health, Standard 22/12/2009

Capital consumption expenses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Organisation – capital consumption expenses, total Australian currency NNNNN.N
<i>METeOR identifier:</i>	376399
<i>Registration status:</i>	Health, Standard 01/04/2009
<i>Definition:</i>	Expenses of an organisation consisting of consumption of fixed capital (depreciation), in Australian currency.
Data Element Concept:	Organisation – capital consumption expenses

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Currency
<i>Format:</i>	NNNNN.N
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Australian currency (AU\$)

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.</p> <p>Depreciation expenses are to be reported in millions to the nearest 100,000 e.g. \$4,064,000 should be reported as \$4.1 million.</p> <p>When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).</p> <p>Depreciation represents the expensing of a long-term asset over its useful life and is related to the basic accounting principle of matching revenue and expenses for the financial period.</p> <p>Depreciation charges for the current financial year only should be shown as expenditure. Where intangible assets are amortised (such as with some private hospitals) this should also be included in recurrent expenditure.</p>
<i>Collection methods:</i>	<p>Depreciation expenses are to be reported for the <i>Health industry relevant organisation type</i> and <i>Type of health and health related functions</i> data elements.</p> <p><i>Health industry relevant organisation type</i></p>

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references:

Supersedes [Organisation – depreciation expenses, total Australian currency NNNNN.N](#) Health, Superseded 01/04/2009

Is used in the formation of [Organisation – expenses, total Australian currency NNNNN.N](#) Health, Standard 05/12/2007

Implementation in Data Set Specifications:

[Government health expenditure organisation expenditure capital consumption data element cluster](#) Health, Standard 01/04/2009

[Government health expenditure organisation expenditure data element cluster](#) Health, Standard 01/04/2009

Cardiovascular medication (current)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – cardiovascular medication taken (current), code N
<i>METeOR identifier:</i>	270237
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether the individual is currently taking cardiovascular medication, as represented by a code.
Data Element Concept:	Person – cardiovascular medication taken

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Angiotensin converting enzyme (ACE) inhibitors</td></tr><tr><td>2</td><td>Angiotensin II (A2) receptor blockers</td></tr><tr><td>3</td><td>Beta blockers</td></tr><tr><td>4</td><td>Calcium antagonists</td></tr><tr><td>8</td><td>None of the above</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Angiotensin converting enzyme (ACE) inhibitors	2	Angiotensin II (A2) receptor blockers	3	Beta blockers	4	Calcium antagonists	8	None of the above	9	Not stated/inadequately described
Value	Meaning														
1	Angiotensin converting enzyme (ACE) inhibitors														
2	Angiotensin II (A2) receptor blockers														
3	Beta blockers														
4	Calcium antagonists														
8	None of the above														
9	Not stated/inadequately described														
<i>Supplementary values:</i>															

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Angiotensin converting enzyme (ACE) inhibitors Use this code for ACE inhibitors (captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril andtrandolapril).</p> <p>CODE 2 Angiotensin II (A2) receptor blockers Use this code for Angiotensin II receptor blockers (candesartan, eprosartan, irbesartan and telmisartan).</p> <p>CODE 3 Beta blockers Use this code for Beta blockers (atenolol, carvedilol, labetalol, metoprolol, oxprenolol, pindolol, propranolol and sotalol).</p> <p>CODE 4 Calcium antagonists Use this code for Calcium antagonists (amlodipine, diltiazem, felodipine, lercanidipine, nifedipine and verapamil).</p> <p>CODE 8 None of the above This code is used when none of the listed medications is being taken by the person.</p>
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CODE 9 Not stated/inadequately described

This code should only be used in situations where it is not practicable to ask the questions.

Collection methods:

The person should be asked a series of questions about any current medication for a cardiovascular condition as follows:

Are you currently taking any medication for a cardiovascular condition?

Yes No

If the person answers 'NO', then code 8 should be applied.

If the person answers 'YES', then ask which one(s) (from the list of drugs in the Guide for use).

Ace Inhibitors Yes No

Angiotensin II receptor blockers Yes No

Beta blockers Yes No

Calcium antagonists Yes No

The appropriate code should be recorded for each type of medication currently in use.

Data element attributes

Collection and usage attributes

Collection methods:

A person may be taking one or more of the following medications for a cardiovascular condition. Therefore more than one code may be reported.

Source and reference attributes

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary. Australian Medicines Handbook: last modified by February 2001 Contents of Cardiovascular, Version 3, 1999 Therapeutic Guidelines Limited (05.04.2002)].

Relational attributes

Related metadata references:

Supersedes [Cardiovascular medication - Superseded 01/03/2005, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (18.1 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Care type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Hospital service – care type, code N[N].N
<i>METeOR identifier:</i>	270174
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	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 (other care), as represented by a code.
Data Element Concept:	Hospital service – care type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																		
<i>Data type:</i>	Number																																		
<i>Format:</i>	N[N].N																																		
<i>Maximum character length:</i>	3																																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1.0</td><td>Acute care (Admitted care)</td></tr><tr><td>2.0</td><td>Rehabilitation care (Admitted care)</td></tr><tr><td>2.1</td><td>Rehabilitation care delivered in a designated unit (optional)</td></tr><tr><td>2.2</td><td>Rehabilitation care according to a designated program (optional)</td></tr><tr><td>2.3</td><td>Rehabilitation care is the principal clinical intent (optional)</td></tr><tr><td>3.0</td><td>Palliative care</td></tr><tr><td>3.1</td><td>Palliative care delivered in a designated unit (optional)</td></tr><tr><td>3.2</td><td>Palliative care according to a designated program (optional)</td></tr><tr><td>3.3</td><td>Palliative care is the principal clinical intent (optional)</td></tr><tr><td>4.0</td><td>Geriatric evaluation and management</td></tr><tr><td>5.0</td><td>Psychogeriatric care</td></tr><tr><td>6.0</td><td>Maintenance care</td></tr><tr><td>7.0</td><td>Newborn care</td></tr><tr><td>8.0</td><td>Other admitted patient care</td></tr><tr><td>9.0</td><td>Organ procurement - posthumous (Other care)</td></tr><tr><td>10.0</td><td>Hospital boarder (Other care)</td></tr></tbody></table>	Value	Meaning	1.0	Acute care (Admitted care)	2.0	Rehabilitation care (Admitted care)	2.1	Rehabilitation care delivered in a designated unit (optional)	2.2	Rehabilitation care according to a designated program (optional)	2.3	Rehabilitation care is the principal clinical intent (optional)	3.0	Palliative care	3.1	Palliative care delivered in a designated unit (optional)	3.2	Palliative care according to a designated program (optional)	3.3	Palliative care is the principal clinical intent (optional)	4.0	Geriatric evaluation and management	5.0	Psychogeriatric care	6.0	Maintenance care	7.0	Newborn care	8.0	Other admitted patient care	9.0	Organ procurement - posthumous (Other care)	10.0	Hospital boarder (Other care)
Value	Meaning																																		
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9.0	Organ procurement - posthumous (Other care)																																		
10.0	Hospital boarder (Other care)																																		

Collection and usage attributes

Guide for use:

Persons with mental illness may receive any one of the care types (except newborn and organ procurement). Classification depends on the principal clinical intent of the care received.

Admitted care can be one of the following:

CODE 1.0 Acute care (Admitted care)

Acute care is care in which the clinical intent 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 2.0 Rehabilitation care (Admitted care)

Rehabilitation care is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. It includes care provided:

- in a designated rehabilitation unit (code 2.1), or
- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the state health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation (code 2.2), or
- under the principal clinical management of a rehabilitation physician or, in the opinion of the treating doctor, when the principal clinical intent of care is rehabilitation (code 2.3).

Optional:

CODE 2.1 Rehabilitation care delivered in a designated unit (optional)

A designated rehabilitation care unit is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care.

CODE 2.2 Rehabilitation care according to a designated program (optional)

In a designated rehabilitation care program, care is delivered by a specialised team of staff who provide rehabilitation care to

patients in beds that may or may not be dedicated to rehabilitation care. The program may, or may not be funded through identified rehabilitation care funding. Code 2.1 should be used instead of code 2.2 if care is being delivered in a designated rehabilitation care program and a designated rehabilitation care unit.

CODE 2.3 Rehabilitation care is the principal clinical intent (optional)

Rehabilitation as principal clinical intent (code 2.3) occurs when the patient is primarily managed by a medical practitioner who is a specialist in rehabilitation care or when, in the opinion of the treating medical practitioner, the care provided is rehabilitation care even if the doctor is not a rehabilitation care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 2.1 or 2.2 should be used, respectively.

Code 3.0 Palliative care

Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided:

- in a palliative care unit (code 3.1); or
- in a designated palliative care program (code 3.2); or
- under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation (code 3.3).

Optional:

CODE 3.1 Palliative care delivered in a designated unit (optional)

A designated palliative care unit is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for palliative care and/or primarily delivers palliative care.

CODE 3.2 Palliative care according to a designated program (optional)

In a designated palliative care program, care is delivered by a specialised team of staff who provide palliative care to patients in beds that may or may not be dedicated to palliative care. The program may, or may not be funded through identified palliative care funding. Code 3.1 should be used instead of code 3.2 if care is being delivered in a designated palliative care program and a designated palliative care unit.

CODE 3.3 Palliative care is the principal clinical intent (optional)

Palliative care as principal clinical intent occurs when the patient is primarily managed by a medical practitioner who is a specialist in palliative care or when, in the opinion of the treating medical practitioner, the care provided is palliative care even if the doctor

is not a palliative care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case code 3.1 or 3.2 should be used, respectively. For example, code 3.3 would apply to a patient dying of cancer who was being treated in a geriatric ward without specialist input by palliative care staff.

CODE 4.0 Geriatric evaluation and management

Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and management unit; or
- in a designated geriatric evaluation and management program; or
- under the principal clinical management of a geriatric evaluation and management physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

CODE 5.0 Psychogeriatric care

Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age-related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. It includes care provided:

- in a psychogeriatric care unit;
- in a designated psychogeriatric care program; or
- under the principal clinical management of a psychogeriatric physician or,
- in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatric care.

CODE 6.0 Maintenance care

Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or

stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting, e.g. at home, or in a residential aged care service, by a relative or carer, that is unavailable in the short term.

CODE 7.0 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 (e.g. transferred from another hospital) are admitted with newborn care type
- patients aged greater than 9 days not previously admitted (e.g. 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 8.0 Other admitted patient care

Other admitted patient care is care where the principal clinical intent does meet the criteria for any of the above.

Other care can be one of the following:

CODE 9.0 Organ procurement - posthumous (Other care)

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 10.0 Hospital boarder (Other care)

Hospital boarder is a person who is receiving food and/or accommodation 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 of 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 under the Australian Health Care Agreements, and they are ineligible for health insurance benefit purposes.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Care type, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (33.1 KB)

Is used in the formation of [Episode of care – number of psychiatric care days, total N\[NNNN\]](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Carer participation arrangements—carer consultants employed

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation— carer participation arrangements status (carer consultants employed), code N
<i>METeOR identifier:</i>	288833
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Whether a specialised mental health service organisation has carer consultants employed on a paid basis to represent the interests of carers and advocate for their needs, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation— carer participation arrangements status (carer consultants employed)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated
Value	Meaning								
1	Yes								
2	No								
9	Not stated								
<i>Supplementary values:</i>									

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation— carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation— carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation— carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

See also [Specialised mental health service organisation – carer participation arrangements status \(regular discussion groups\), code N](#) Health, Standard 08/12/2004

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Carer participation arrangements—carer satisfaction surveys

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation – carer participation arrangements status (carer satisfaction surveys), code N
<i>METeOR identifier:</i>	290367
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Whether a specialised mental health service organisation periodically conducts carer satisfaction surveys, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation – carer participation arrangements status (carer satisfaction surveys)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated
Value	Meaning								
1	Yes								
2	No								
9	Not stated								
<i>Supplementary values:</i>									

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation – carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

See also [Specialised mental health service organisation – carer participation arrangements status \(carer consultants employed\), code N](#) Health, Standard 08/12/2004

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Carer participation arrangements—formal complaints mechanism

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism), code N
<i>METeOR identifier:</i>	290370
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Whether a specialised mental health service organisation has a formal internal complaints mechanism in which complaints made by carers are regularly reviewed by a committee that includes carers, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation—carer participation arrangements status (formal complaints mechanism)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated
Value	Meaning								
1	Yes								
2	No								
9	Not stated								
<i>Supplementary values:</i>									

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation—carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004 See also Specialised mental health service organisation—carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004
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Implementation in Data Set Specifications:

See also [Specialised mental health service organisation – carer participation arrangements status \(regular discussion groups\), code N](#) Health, Standard 08/12/2004

See also [Specialised mental health service organisation – carer participation arrangements status \(carer consultants employed\), code N](#) Health, Standard 08/12/2004

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Carer participation arrangements—formal participation policy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation— carer participation arrangements status (formal participation policy), code N
<i>METeOR identifier:</i>	290365
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Whether a specialised mental health service organisation has developed a formal and documented policy on participation by carers, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation— carer participation arrangements status (formal participation policy)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated
Value	Meaning								
1	Yes								
2	No								
9	Not stated								
<i>Supplementary values:</i>									

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation— carer participation arrangements status (carer consultants employed), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation— carer participation arrangements status (regular discussion groups), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation— carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

See also [Specialised mental health service organisation – carer participation arrangements status \(formal complaints mechanism\), code N](#) Health, Standard 08/12/2004

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Carer participation arrangements—regular discussion groups

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation— carer participation arrangements status (regular discussion groups), code N
<i>METeOR identifier:</i>	290359
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Whether the service holds regular discussion groups to seek the views of carers about the service, to promote the participation of mental health carers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation— carer participation arrangements status (regular discussion groups)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated
Value	Meaning								
1	Yes								
2	No								
9	Not stated								
<i>Supplementary values:</i>									

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
---------------------------------	--

Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation— carer participation arrangements status (formal complaints mechanism), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation— carer participation arrangements status (carer satisfaction surveys), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation— carer participation arrangements status (formal participation policy), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

See also [Specialised mental health service organisation – carer participation arrangements status \(carer consultants employed\), code N](#) Health, Standard 08/12/2004

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Cataract—history

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – cataract status, code N
<i>METeOR identifier:</i>	270252
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether the individual has a cataract present in either or both eyes or has had a cataract previously removed from either or both eyes, as represented by a code.
Data Element Concept:	Person – cataract status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Cataract currently present or has been previously removed from the right eye</td></tr><tr><td>2</td><td>Cataract currently present or has been previously removed from the left eye</td></tr><tr><td>3</td><td>Cataract currently present or has been previously removed from both eyes</td></tr><tr><td>4</td><td>No cataract present or has not been previously removed from either eye</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Cataract currently present or has been previously removed from the right eye	2	Cataract currently present or has been previously removed from the left eye	3	Cataract currently present or has been previously removed from both eyes	4	No cataract present or has not been previously removed from either eye	9	Not stated/inadequately described
Value	Meaning												
1	Cataract currently present or has been previously removed from the right eye												
2	Cataract currently present or has been previously removed from the left eye												
3	Cataract currently present or has been previously removed from both eyes												
4	No cataract present or has not been previously removed from either eye												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Examination of the lens of the eye through a dilated pupil (visible through the pupil by the use of an ophthalmoscope) by an ophthalmologist or optometrist, as a part of the ophthalmological assessment. Ask the individual if he/she has a cataract in either or both eyes or has had a cataract removed from either or both eyes previously. Alternatively obtain information from an ophthalmologist or optometrist or from appropriate documentation.
<i>Comments:</i>	Cataract is a clouding of the lens of the eye or its capsule sufficient to reduce vision. The formation of cataract occurs more rapidly in patients with a history of ocular trauma, uveitis, or

diabetes mellitus. Cataract is an associated diabetic eye problem that could lead to blindness.

Regular eye checkups are important for patients suffering from diabetes mellitus. This helps to early detect abnormalities and to avoid or postpone vision-threatening complications. A comprehensive ophthalmological examination includes:

- check visual acuity with Snellen chart -correct with pinhole if indicated
- examine for cataract
- examine fundi with pupils dilated.

Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes [Cataract - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.4 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Category reassignment date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective care waiting list episode – category reassignment date, DDMMYYYY
<i>METeOR identifier:</i>	270010
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a patient awaiting elective hospital care is assigned to a different urgency category as a result of clinical review for the awaited procedure, or is assigned to a different patient listing status category.
Data Element Concept:	Elective care waiting list episode – category reassignment date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The date needs to be recorded each time a patient's urgency classification or listing status changes.
<i>Comments:</i>	This date is necessary for the calculation of the waiting time at admission and the waiting time at a census date.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Category reassignment date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB)
	Is used in the formation of Elective surgery waiting list episode – waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005
	Is used in the formation of Elective surgery waiting list episode – waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005

Census date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Hospital census (of elective surgery waitlist patients) – census date, DDMMYYYY
<i>METeOR identifier:</i>	270153
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list.
Data Element Concept:	Hospital census (of elective surgery waitlist patients) – census date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This date is recorded when a census is done of the patients on a waiting list.
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Census date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.4 KB)
	Is used in the formation of Elective surgery waiting list episode – waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005
<i>Implementation in Data Set Specifications:</i>	Elective surgery waiting times (census data) NMDS Health, Superseded 07/12/2005
	<i>Implementation start date:</i> 30/09/2002
	<i>Implementation end date:</i> 30/06/2006
	Elective surgery waiting times (census data) NMDS 2006-2009 Health, Superseded 03/12/2008
	<i>Implementation start date:</i> 30/09/2006
	<i>Implementation end date:</i> 31/03/2009
	Elective surgery waiting times (census data) NMDS 2009- Health, Standard 03/12/2008
	<i>Implementation start date:</i> 30/06/2009

Centrelink customer reference number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – government funding identifier, Centrelink customer reference number {N(9)A}
<i>Synonymous names:</i>	CRN; Centrelink reference number
<i>METeOR identifier:</i>	270098
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Recorded 27/03/2007
<i>Definition:</i>	A personal identifier assigned by Centrelink for the purposes of identifying people (and organisations) eligible for specific services, including some public health care services, such as oral health services.
Data Element Concept:	Person – government funding identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	{N(9)A}
<i>Maximum character length:</i>	10

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The CRN should only be collected from persons eligible to receive health services that are to be funded by Centrelink. The number may be reported to a Centrelink agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.
<i>Collection methods:</i>	The Centrelink Customer Reference Number (CRN) is provided on 'Health Care Cards' and 'Pensioner Concession Cards'.
<i>Comments:</i>	When a person accesses health services on the basis of being a Centrelink customer, collection of the CRN is usually necessary. This data should not be collected and recorded if it is not needed to support the provision of such health services.

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	AS5017 Health Care Client Identification

Relational attributes

Related metadata references:

Supersedes [Centrelink customer reference number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf](#) (14.5 KB)

Implementation in Data Set Specifications:

[Health care client identification](#) Health, Superseded 04/05/2005

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

Cerebral stroke due to vascular disease (history)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – cerebral stroke due to vascular disease (history), code N
<i>METeOR identifier:</i>	270355
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether the individual has had a cerebral stroke due to vascular disease, as represented by a code.
Data Element Concept:	Person – cerebral stroke due to vascular disease

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Cerebral stroke - occurred in the last 12 months</td></tr><tr><td>2</td><td>Cerebral stroke - occurred prior to the last 12 months</td></tr><tr><td>3</td><td>Cerebral stroke - occurred both in and prior to the last 12 months</td></tr><tr><td>4</td><td>No history of cerebral stroke due to vascular disease</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Cerebral stroke - occurred in the last 12 months	2	Cerebral stroke - occurred prior to the last 12 months	3	Cerebral stroke - occurred both in and prior to the last 12 months	4	No history of cerebral stroke due to vascular disease	9	Not stated/inadequately described
Value	Meaning												
1	Cerebral stroke - occurred in the last 12 months												
2	Cerebral stroke - occurred prior to the last 12 months												
3	Cerebral stroke - occurred both in and prior to the last 12 months												
4	No history of cerebral stroke due to vascular disease												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Obtain this information from appropriate documentation or from the patient.
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Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

<i>Related metadata references:</i>	Supersedes Cerebral stroke due to vascular disease - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)
<i>Implementation in Data Set Specifications:</i>	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Change to body structure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – nature of impairment of body structure, code (ICF 2001) N
<i>METeOR identifier:</i>	320171
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The qualitative or quantitative change of a person's impairment in a specified body structure, as represented by a code.
Data Element Concept:	Person – nature of impairment of body structure

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001	
<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	0	No change in structure
	1	Total absence
	2	Partial absence
	3	Additional part
	4	Aberrant dimensions
	5	Discontinuity
	6	Deviating position
	7	Qualitative changes in structure
<i>Supplementary values:</i>	8	Not specified
	9	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	This metadata item contributes to the definition of the concept ' Disability ' and gives an indication of the experience of disability for a person. <i>Impairments of body structure</i> are problems in body structure such as a loss or significant departure from population standards or averages. CODE 0 No change in structure Used when the structure of the body part is within the range of the population standard.
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CODE 1 Total absence

Used when the body structure is not present. For example total absence of the structures of the lower leg following a thorough knee amputation.

CODE 2 Partial absence

Used when only part of a body structure is present. For example partial absence of the bones of the lower leg following below knee amputation.

CODE 3 Additional part

Used when a structure, not usually present in the population is present, for example a sixth lumbar vertebra or an sixth digit on one hand.

CODE 4 Aberrant dimensions

Used when the shape and size of a body structure is significantly different from the population standard. For example radial aplasia where the shape and size of the radial bone does not develop.

CODE 5 Discontinuity

Used when parts of a body structure are separated, for example cleft palate or fracture.

CODE 6 Deviating position

Used when the location of a structure is not according to population standard; for example, transposition of the great vessels, where the aorta arises from the right ventricle and the pulmonary vessels from the left ventricle.

CODE 7 Qualitative changes in structure

Used when the structure of a body part is altered from the population standard. This includes accumulation of fluid, changes in bone structure as a result of osteoporosis or Paget's disease.

CODE 8 Not specified

Used when there is a change to a body structure, but the nature of the change is not described.

CODE 9 Not applicable

Used when it is not appropriate to code the nature of the change to a body structure.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide

(AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.cfm>

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used in conjunction with specified body structures, for example 'partial absence of structures related to movement'. This data element may also be used in conjunction with Person – extent of impairment of body structure, code (ICF 2001) N and Person – location of impairment of body structure, code (ICF 2001) N.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also [Person – location of impairment of body structure, code \(ICF 2001\) N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also [Person – extent of impairment of body structure, code \(ICF 2001\) N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

[Body structures cluster](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Chest pain pattern category

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – chest pain pattern, code N
<i>METeOR identifier:</i>	356738
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The person's chest pain pattern, as represented by a code.
Data Element Concept:	Person – chest pain pattern

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Atypical chest pain</td></tr><tr><td>2</td><td>Stable chest pain pattern</td></tr><tr><td>3</td><td>Unstable chest pain pattern: rest &/or prolonged</td></tr><tr><td>4</td><td>Unstable chest pain pattern: new & severe</td></tr><tr><td>5</td><td>Unstable chest pain pattern: accelerated & severe</td></tr></tbody></table>	Value	Meaning	1	Atypical chest pain	2	Stable chest pain pattern	3	Unstable chest pain pattern: rest &/or prolonged	4	Unstable chest pain pattern: new & severe	5	Unstable chest pain pattern: accelerated & severe
Value	Meaning												
1	Atypical chest pain												
2	Stable chest pain pattern												
3	Unstable chest pain pattern: rest &/or prolonged												
4	Unstable chest pain pattern: new & severe												
5	Unstable chest pain pattern: accelerated & severe												
<i>Supplementary values:</i>	9 Not stated/inadequately described												

Collection and usage attributes

<i>Guide for use:</i>	<p>Chest pain or discomfort of myocardial ischaemic origin is usually described as pain, discomfort or pressure in the chest or the upper body (neck and throat, jaw, shoulders, back, either or both arms, wrists and hands) or other equivalent discomfort suggestive of cardiac ischaemia. Ask the person when the symptoms first occurred or obtain this information from appropriate documentation.</p> <p>CODE 1 Atypical chest pain</p> <p>Use this code for pain, pressure, or discomfort in the chest, or upper body not clearly exertional or not otherwise consistent with pain or discomfort of myocardial ischaemic origin.</p> <p>CODE 2 Stable chest pain pattern</p> <p>Use this code for chest pain without a change in frequency or pattern for the 6 weeks before this presentation or procedure. Chest pain is controlled by rest and/or sublingual/oral/transcutaneous medications.</p> <p>CODE 3 Unstable chest pain pattern: rest and/or prolonged</p> <p>Use this code for chest pain that occurred at rest and was prolonged, usually lasting for at least 10 minutes</p>
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CODE 4 Unstable chest pain pattern: new and severe

Use this code for new-onset chest pain that could be described as at least Canadian Cardiovascular Society (CCS) classification 3 severity.

CODE 5 Unstable chest pain pattern: accelerated and severe

Use this code for recent acceleration of chest pain pattern that could be described by an increase in severity of at least 1 CCS class to at least CCS class 3.

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes [Person – chest pain pattern, code N](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Cholesterol—HDL (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – high-density lipoprotein cholesterol level (measured), total millimoles per litre [N].NN
<i>METeOR identifier:</i>	270401
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person’s high-density lipoprotein cholesterol (HDL-C), measured in mmol/L.
Data Element Concept:	Person – high-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	[N].NN				
<i>Maximum character length:</i>	3				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9.99</td><td>Not measured/inadequately described</td></tr></tbody></table>	Value	Meaning	9.99	Not measured/inadequately described
Value	Meaning				
9.99	Not measured/inadequately described				
<i>Unit of measure:</i>	Millimole per litre (mmol/L)				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>When reporting, record whether or not the measurement of High-density Lipoprotein Cholesterol (HDL-C) was performed in a fasting specimen.</p> <p>In settings where the monitoring of a person’s health is ongoing and where a measure can change over time (such as general practice), the date of assessment should be recorded.</p>
<i>Collection methods:</i>	<p>When reporting, record absolute result of the most recent HDL-Cholesterol measurement in the last 12 months to the nearest 0.01 mmol/L.</p> <p>Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.</p> <ul style="list-style-type: none">• To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.• Prolonged tourniquet use can artefactually increase levels by up to 20%.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group
National Diabetes Data Working Group

Origin: National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88.

Relational attributes

Related metadata references: Supersedes [Cholesterol-HDL - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

Is used in the formation of [Person – low-density lipoprotein cholesterol level \(calculated\), total millimoles per litre N\[N\].N](#) Health, Standard 01/10/2008

Is used in the formation of [Person – low-density lipoprotein cholesterol level \(calculated\), total millimoles per litre N\[N\].N](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Cholesterol—LDL (calculated)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – low-density lipoprotein cholesterol level (calculated), total millimoles per litre N[N].N
<i>METeOR identifier:</i>	359262
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's calculated low-density lipoprotein cholesterol (LDL-C) in millimoles per litre.
Data Element Concept:	Person – low-density lipoprotein cholesterol level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[N].N
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning 99.9 Not stated/inadequately described
<i>Unit of measure:</i>	Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Formula: LDL-C = (plasma total cholesterol) - (high density lipoprotein cholesterol) - (fasting plasma triglyceride divided by 2.2).
<i>Collection methods:</i>	<p>The LDL-C is usually calculated from the Friedwald Equation (Friedwald et al. 1972), which depends on knowing the blood levels of the total cholesterol and HDL-C and the fasting level of the triglyceride.</p> <p>Note that the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L.</p> <p>Note also that while cholesterol levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 8 weeks after an event.</p> <ul style="list-style-type: none">• Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.• To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.

Comments:

High blood cholesterol is a key factor in heart, stroke and vascular disease, especially coronary heart disease (CHD).

Poor nutrition can be a contributing factor to heart, stroke and vascular disease as a population's level of saturated fat intake is the prime determinant of its level of blood cholesterol.

The majority of the cholesterol in plasma is transported as a component of LDL-C. Recent trials support a target LDL-C of <2.0 mmol/L for high risk patients with existing coronary heart disease.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88.

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Position Statement on Lipid Management - 2005, Heart, Lung and Circulation 2005; 14: 275-291.

Relational attributes

Related metadata references:

Supersedes [Person – low-density lipoprotein cholesterol level \(calculated\), total millimoles per litre N\[N\].N](#) Health, Superseded 01/10/2008

Is formed using [Person – cholesterol level \(measured\), total millimoles per litre N\[N\].N](#) Health, Superseded 01/10/2008

Is formed using [Person – high-density lipoprotein cholesterol level \(measured\), total millimoles per litre \[N\].NN](#) Health, Standard 01/03/2005

Is formed using [Person – triglyceride level \(measured\), total millimoles per litre N\[N\].N](#) Health, Superseded 01/10/2008

Is formed using [Health service event – fasting indicator, code N](#) Health, Standard 21/09/2005

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Cholesterol—total (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – cholesterol level (measured), total millimoles per litre N[N].N
<i>METeOR identifier:</i>	359245
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person’s total cholesterol (TC), measured in millimoles per litre.
Data Element Concept:	Person – cholesterol level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[N].N
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning 99.9 Not stated/inadequately described.
<i>Unit of measure:</i>	Millimole per litre (mmol/L)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Measurement in mmol/L to 1 decimal place. Record the absolute result of the total cholesterol measurement. When reporting, record whether or not the measurement of Cholesterol-total - measured was performed in a fasting specimen.
<i>Collection methods:</i>	When reporting, record absolute result of the most recent Cholesterol-total - measured in the last 12 months to the nearest 0.1 mmol/L. Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities. <ul style="list-style-type: none">• To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed.• Prolonged tourniquet use can artefactually increase levels by up to 20%.
<i>Comments:</i>	In settings where the monitoring of a person’s health is ongoing and where a measure can change over time (such as general practice), the Service contact – service contact date, DDMMYYYY should be recorded.

High blood cholesterol is a key factor in heart, stroke and vascular disease, especially coronary heart disease.

Poor nutrition can be a contributing factor to heart, stroke and vascular disease as a population's level of saturated fat intake is the prime determinant of its level of blood cholesterol.

Large clinical trials have shown that people at highest risk of cardiovascular events (e.g. pre-existing ischaemic heart disease) will derive the greatest benefit from lipid lowering drugs. Recent trials have suggested that there should be no cholesterol level threshold for the initiation of treatment in this group of patients. In October 2006, the PBS criteria for lipid-lowering drugs was expanded to include all patients identified as high-risk (based on PBS criteria) regardless of their cholesterol level.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Lipid Management Guidelines - 2001, MJA 2001; 175: S57-S88

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand, Position Statement on Lipid Management - 2005, Heart Lung and Circulation 2005; 14: 275-291.

National Health Priority Areas Report: Cardiovascular Health 1998. AIHW Cat. No. PHE 9. HEALTH and AIHW, Canberra.

The Royal College of Pathologists of Australasia web based Manual of Use and Interpretation of Pathology Tests. Version 4.0.

Relational attributes

Related metadata references:

Supersedes [Person – cholesterol level \(measured\), total millimoles per litre N\[N\].N](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Classification of health labour force job

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Health professional – occupation, code ANN
<i>METeOR identifier:</i>	270140
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The position or job classification of a health professional, as represented by a code.
Data Element Concept:	Health professional – occupation

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																						
<i>Data type:</i>	String																																						
<i>Format:</i>	ANN																																						
<i>Maximum character length:</i>	3																																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>A01</td><td>Medicine - General practitioner working mainly in general practice</td></tr><tr><td>A02</td><td>Medicine - General practitioner working mainly in a special interest area</td></tr><tr><td>A03</td><td>Medicine - Salaried non-specialist hospital practitioner: Resident medical officer or intern</td></tr><tr><td>A04</td><td>Medicine - Salaried non-specialist hospital practitioner: other hospital career medical officer</td></tr><tr><td>A05</td><td>Medicine - Specialist</td></tr><tr><td>A06</td><td>Medicine - Specialist in training (e.g. registrar)</td></tr><tr><td>B01</td><td>Dentistry (private practice only) - Solo practitioner</td></tr><tr><td>B02</td><td>Dentistry (private practice only) - Solo principal with assistant(s)</td></tr><tr><td>B03</td><td>Dentistry (private practice only) - Partnership</td></tr><tr><td>B04</td><td>Dentistry (private practice only) - Associateship</td></tr><tr><td>B05</td><td>Dentistry (private practice only) - Assistant</td></tr><tr><td>B06</td><td>Dentistry (private practice only) - Locum</td></tr><tr><td>C01</td><td>Nursing - Enrolled nurse</td></tr><tr><td>C02</td><td>Nursing - Registered nurse</td></tr><tr><td>C03</td><td>Nursing - Clinical nurse</td></tr><tr><td>C04</td><td>Nursing - Clinical nurse consultant/supervisor</td></tr><tr><td>C05</td><td>Nursing - Nurse manager</td></tr><tr><td>C06</td><td>Nursing - Nurse educator</td></tr></tbody></table>	Value	Meaning	A01	Medicine - General practitioner working mainly in general practice	A02	Medicine - General practitioner working mainly in a special interest area	A03	Medicine - Salaried non-specialist hospital practitioner: Resident medical officer or intern	A04	Medicine - Salaried non-specialist hospital practitioner: other hospital career medical officer	A05	Medicine - Specialist	A06	Medicine - Specialist in training (e.g. registrar)	B01	Dentistry (private practice only) - Solo practitioner	B02	Dentistry (private practice only) - Solo principal with assistant(s)	B03	Dentistry (private practice only) - Partnership	B04	Dentistry (private practice only) - Associateship	B05	Dentistry (private practice only) - Assistant	B06	Dentistry (private practice only) - Locum	C01	Nursing - Enrolled nurse	C02	Nursing - Registered nurse	C03	Nursing - Clinical nurse	C04	Nursing - Clinical nurse consultant/supervisor	C05	Nursing - Nurse manager	C06	Nursing - Nurse educator
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C04	Nursing - Clinical nurse consultant/supervisor																																						
C05	Nursing - Nurse manager																																						
C06	Nursing - Nurse educator																																						

C07	Nursing - Nurse researcher
C08	Nursing - Assistant director of nursing
C09	Nursing - Deputy director of nursing
C10	Nursing - Director of nursing
C11	Nursing - Tutor/lecturer/senior lecturer in nursing (tertiary institution)
C12	Nursing - Associate professor/professor in nursing (tertiary institution)
C98	Nursing - Other (specify)
D01	Pharmacy (community pharmacist) - Sole proprietor
D02	Pharmacy (community pharmacist) - Partner-proprietor
D03	Pharmacy (community pharmacist) - Pharmacist-in-charge
D04	Pharmacy (community pharmacist) - Permanent assistant
D05	Pharmacy (community pharmacist) - Reliever, regular location
D06	Pharmacy (community pharmacist) - Reliever, various locations
E01	Pharmacy (Hospital/clinic pharmacist) - Director/deputy director
E02	Pharmacy (Hospital/clinic pharmacist) - Grade III pharmacist
E03	Pharmacy (Hospital/clinic pharmacist) - Grade II pharmacist
E04	Pharmacy (Hospital/clinic pharmacist) - Grade I pharmacist
E05	Pharmacy (Hospital/clinic pharmacist) - Sole pharmacist
F01	Podiatry - Own practice (or partnership)
F02	Podiatry - Own practice and sessional appointments elsewhere
F03	Podiatry - Own practice and fee-for-service elsewhere
F04	Podiatry - Own practice, sessional and fee-for-service appointments elsewhere
F05	Podiatry - Salaried podiatrist
F06	Podiatry - Locum, regular location
F07	Podiatry - Locum, various locations
F08	Podiatry - Other (specify)
G01	Physiotherapy - Own practice (or partnership)
G02	Physiotherapy - Own practice and sessional appointments elsewhere

	G03	Physiotherapy - Own practice and fee-for-service elsewhere
	G04	Physiotherapy - Own practice, sessional and fee-for-service appointments elsewhere
	G05	Physiotherapy - Salaried physiotherapist
	G06	Physiotherapy - Locum, regular location
	G07	Physiotherapy - Locum, various locations
<i>Supplementary values:</i>	C99	Nursing - Unknown/inadequately described/not stated

Data element attributes

Collection and usage attributes

Comments:

Position or job classifications are specific to each profession and may differ by state or territory. The classifications above are simplified so that comparable data presentation is possible and possible confounding effects of enterprise specific structures are avoided. For example, for medicine, the job classification collected in the national health labour force collection is very broad. State/territory health authorities have more detailed classifications for salaried medical practitioners in hospitals.

These classifications separate interns, the resident medical officer levels, registrar levels, career medical officer positions, and supervisory positions including clinical and medical superintendents. Space restrictions do not at present permit these classes to be included in the National Health Labour Force Collection questionnaire.

Source and reference attributes

Submitting organisation:

National Health Labour Force Data Working Group

Relational attributes

Related metadata references:

Supersedes [Classification of health labour force job, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (24.7 KB)

Implementation in Data Set Specifications:

[Health labour force NMDS](#) Health, Standard 01/03/2005

Implementation start date: 01/07/2005

Client type (alcohol and other drug treatment services)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – client type, code N
<i>METeOR identifier:</i>	270083
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs – client type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Own alcohol or other drug use</td></tr><tr><td>2</td><td>Other's alcohol or other drug use</td></tr></tbody></table>	Value	Meaning	1	Own alcohol or other drug use	2	Other's alcohol or other drug use
Value	Meaning						
1	Own alcohol or other drug use						
2	Other's alcohol or other drug use						

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Own alcohol or other drug use</p> <p>Use this code for a client who receives treatment or assistance concerning their own alcohol and/or other drug use.</p> <p>Use this code where a client is receiving treatment or assistance for both their own alcohol and/or other drug use and the alcohol and/or other drug use of another person.</p> <p>CODE 2 Other's alcohol or other drug use</p> <p>Use this code for a client who receives support and/or assistance in relation to the alcohol and/or other drug use of another person.</p>
<i>Collection methods:</i>	To be collected on commencement of a treatment episode with a service.

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Where Code 2 Other's alcohol or other drug use is reported, do not collect the following data elements:</p> <p>Episode of treatment for alcohol and other drugs – drug of concern (principal), code (ASCDC 2000 extended) NNNN;</p>
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Comments:

Episode of treatment for alcohol and other drugs – drug of concern (other), code (ASCDC 2000 extended) NNNN;
Client – injecting drug use status, code N; and
Client – method of drug use (principal drug of concern), code N.
Required to differentiate between clients according to whether the treatment episode concerns their own alcohol and/or other drug use or that of another person to provide a basis for description of the people accessing alcohol and other drug treatment services.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes [Client type - alcohol and other drug treatment services, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.5 KB)

Implementation in Data Set Specifications:

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Clinical evidence of acute coronary syndrome related medical history

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – clinical evidence status (acute coronary syndrome related medical history), yes/no code N
<i>METeOR identifier:</i>	356777
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An indicator of whether there is objective evidence for a person's history of an acute coronary syndrome related medical condition, as represented by a code.
Data Element Concept:	Person – clinical evidence status (acute coronary syndrome related medical history)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes Use this code where there is objective evidence to support a history of an acute coronary syndrome related medical condition. CODE 2 No Use this code where the history is not supported by objective evidence. Objective evidence for acute coronary syndrome related medical conditions are classified as: Chronic lung disease: Diagnosis supported by current use of chronic lung disease pharmacological therapy (e.g. inhalers, theophylline,
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aminophylline, or steroids), or a forced expiratory volume in 1 second (FEV1) less than 80% predicted FEV1/forced vital capacity (FVC) less than 0.7 (post bronchodilator). Respiratory failure partial pressure of oxygen (PaO₂) less than 60 mmHg (8kPa), or partial pressure of carbon dioxide (PaCO₂) greater than 50 mmHg (6.7 kPa).

Heart failure:

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

Stroke:

Diagnosis for ischaemic: non-haemorrhagic cerebral infarction or haemorrhagic: intracerebral haemorrhage supported by cerebral imaging (CT or MRI).

Peripheral arterial disease:

- Peripheral artery disease: diagnosis is derived from and substantiated by clinical documentation for a person with a history of either chronic or acute occlusion or narrowing of the arterial lumen in the aorta or extremities.
- Aortic aneurysm: diagnosis of aneurysmal dilatation of the aorta (thoracic and or abdominal) supported and substantiated by appropriate documentation of objective testing.
- Renal artery stenosis: diagnosis of functional stenosis of one or both renal arteries is present and is supported and substantiated by appropriate documentation of objective testing.

Sleep apnoea:

Diagnosis derived from and substantiated by clinical documentation of sleep apnoea syndrome (SAS). SAS has been diagnosed from the results of a sleep study.

Other vascular conditions:

- Atrial fibrillation: diagnosis supported by electrocardiogram findings.
- Other cardiac arrhythmias and conductive disorders: diagnosis supported by electrocardiogram findings.
- Left ventricular hypertrophy: diagnosis supported by echocardiograph evidence.

Collection methods:

For each of the following medical conditions the clinical evidence status must also be recorded:

- Chronic lung disease
- Heart failure
- Stroke
- Peripheral arterial disease

- Sleep apnoea syndrome
- Other vascular conditions

Comments:

Heart failure:

Chronic heart failure is a complex clinical syndrome with typical symptoms (e.g. shortness of breath, fatigue) that can occur at rest or on effort, and is characterised by objective evidence of an underlying structural abnormality of cardiac dysfunction that impairs the ability of the ventricle to fill with or eject blood (particularly during physical activity).

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

Other modalities include:

- transoesophageal echocardiography (TOE)
- gated radionuclide angiocardiology
- angiographic left ventriculography

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

- cardiac auscultation (S3, cardiac murmurs),
- cardiomegaly,
- elevated jugular venous pressure (JVP),
- chest X-ray evidence of pulmonary congestion

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Reference documents:

The Thoracic Society of Australia & New Zealand and the Australian Lung Foundation, Chronic Obstructive Pulmonary Disease (COPD) Australian & New Zealand Management Guidelines and the COPD Handbook. Version 1, November 2002.

National Heart Foundation of Australia and the Cardiac Society of Australia and New Zealand (Chronic Heart Failure Guidelines Expert Writing Panel). Guidelines for the prevention, detection and management of chronic heart failure in Australia, 2006.

Relational attributes

Related metadata references:

Supersedes [Person – clinical evidence status \(chronic lung disease\), code N](#) Health, Superseded 01/10/2008

Supersedes [Person – clinical evidence status \(heart failure\), code N](#) Health, Superseded 01/10/2008

Supersedes [Person – clinical evidence status \(peripheral arterial disease\), code N](#) Health, Superseded 01/10/2008

Supersedes [Person – clinical evidence status \(sleep apnoea syndrome\), code N](#) Health, Superseded 01/10/2008

Supersedes [Person – clinical evidence status \(stroke\), code N](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Clinical procedure timing (status)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – clinical procedure timing, code N
<i>METeOR identifier:</i>	356827
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of the provision of a clinical procedure, as represented by a code.
Data Element Concept:	Person – clinical procedure timing

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Procedure performed prior to this hospital presentation</td></tr><tr><td>2</td><td>Procedure performed during this hospital presentation</td></tr></tbody></table>	Value	Meaning	1	Procedure performed prior to this hospital presentation	2	Procedure performed during this hospital presentation
Value	Meaning						
1	Procedure performed prior to this hospital presentation						
2	Procedure performed during this hospital presentation						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record only for those procedure codes that apply.
<i>Collection methods:</i>	This data element should be recorded for each type of procedure performed that is pertinent to the treatment of acute coronary syndrome.

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Related metadata references:</i>	See also Person – acute coronary syndrome procedure type, code NN Health, Standard 01/10/2008 Supersedes Person – clinical procedure timing, code N Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Clinical urgency

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – clinical urgency, code N
<i>METeOR identifier:</i>	270008
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A clinical assessment of the urgency with which a patient requires elective hospital care, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode – clinical urgency

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency</td></tr><tr><td>2</td><td>Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency</td></tr><tr><td>3</td><td>Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency</td></tr></tbody></table>	Value	Meaning	1	Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency	2	Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency	3	Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency
Value	Meaning								
1	Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency								
2	Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency								
3	Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency								

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The classification employs a system of urgency categorisation based on factors such as the degree of pain, dysfunction and disability caused by the condition and its potential to deteriorate quickly into an emergency. All patients ready for care must be assigned to one of the urgency categories, regardless of how long it is estimated they will need to wait for surgery.
<i>Comments:</i>	A patient's classification may change if he or she undergoes clinical review during the waiting period. 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 Elective care waiting list episode – category reassignment date, DDMMYYYY).

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Clinical urgency, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.4 KB)

See also [Elective surgery waiting list episode – overdue patient status, code N](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Elective surgery waiting times \(census data\) NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(census data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

[Elective surgery waiting times \(census data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(removals data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Clonidogrel therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – clonidogrel therapy status, code NN
<i>METeOR identifier:</i>	284873
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The person's clonidogrel therapy status, as represented by a code.
Data Element Concept:	Person – clonidogrel therapy status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																						
<i>Data type:</i>	Number																						
<i>Format:</i>	NN																						
<i>Maximum character length:</i>	2																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>10</td><td>Given</td></tr><tr><td>21</td><td>Not given - therapy not indicated</td></tr><tr><td>22</td><td>Not given - patient refusal</td></tr><tr><td>23</td><td>Not given - true allergy to clonidogrel</td></tr><tr><td>24</td><td>Not given - active bleeding</td></tr><tr><td>25</td><td>Not given - bleeding risk</td></tr><tr><td>26</td><td>Not given - thrombocytopenia</td></tr><tr><td>27</td><td>Not given - severe hepatic dysfunction</td></tr><tr><td>29</td><td>Not given - other</td></tr><tr><td>90</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	10	Given	21	Not given - therapy not indicated	22	Not given - patient refusal	23	Not given - true allergy to clonidogrel	24	Not given - active bleeding	25	Not given - bleeding risk	26	Not given - thrombocytopenia	27	Not given - severe hepatic dysfunction	29	Not given - other	90	Not stated/inadequately described
Value	Meaning																						
10	Given																						
21	Not given - therapy not indicated																						
22	Not given - patient refusal																						
23	Not given - true allergy to clonidogrel																						
24	Not given - active bleeding																						
25	Not given - bleeding risk																						
26	Not given - thrombocytopenia																						
27	Not given - severe hepatic dysfunction																						
29	Not given - other																						
90	Not stated/inadequately described																						
<i>Supplementary values:</i>	90 Not stated/inadequately described																						

Collection and usage attributes

<i>Guide for use:</i>	CODES 21 - 29 Not given If recording 'Not given', record the principal reason if more than one code applies.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes [Clopidogrel therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

Co-location status of mental health service

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service – co-location with acute care hospital, code N
<i>METeOR identifier:</i>	286995
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Whether a mental health service is co-located with an acute care hospital, as represented by a code.
Data Element Concept:	Specialised mental health service – co-location with acute care hospital

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Co-located</td></tr><tr><td>2</td><td>Not co-located</td></tr></tbody></table>	Value	Meaning	1	Co-located	2	Not co-located
Value	Meaning						
1	Co-located						
2	Not co-located						

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Co-located
	<p>Co-located health services are those that are established physically and organisationally as part of an acute care hospital service. There are two forms of co-location:</p> <ul style="list-style-type: none">• a health service that is built and managed as a ward or unit within an acute care hospital; or• the health service operates in a separate building but is located on, or immediately adjoining, the acute care hospital campus. <p>In the second option, units and wards within a psychiatric hospital may be classified as co-located when all the following criteria apply:</p> <ul style="list-style-type: none">• a single organisational or management structure covers the acute care hospital and the psychiatric hospital;• a single employer covers the staff of the acute care hospital and the psychiatric hospital;• the location of the acute care hospital and psychiatric hospital can be regarded as part of a single overall hospital campus; and• the patients of the psychiatric hospital are regarded as patients of the single integrated health service.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Collection methods: To be reported for mental health services that primarily provide overnight admitted patient care. Excludes residential mental health services and ambulatory mental health services.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Compensable status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Patient – compensable status, code N
<i>METeOR identifier:</i>	270100
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a patient is a compensable patient , as represented by a code.
Data Element Concept:	Patient – compensable status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Compensable</td></tr><tr><td>2</td><td>Non-compensable</td></tr><tr><td>9</td><td>Not stated/not known</td></tr></tbody></table>	Value	Meaning	1	Compensable	2	Non-compensable	9	Not stated/not known
Value	Meaning								
1	Compensable								
2	Non-compensable								
9	Not stated/not known								
<i>Supplementary values:</i>									

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This definition of compensable patient excludes eligible beneficiaries (Department of Veterans' Affairs), Defence Force personnel and persons covered by the Motor Accident Compensation Scheme, Northern Territory.
<i>Comments:</i>	To assist in the analyses of utilisation and health care funding.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Compensable status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)
<i>Implementation in Data Set Specifications:</i>	Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Complication of labour and delivery

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – complication, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	391338
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	Medical and obstetric complications (necessitating intervention) arising after the onset of labour and before the completed delivery of the baby and placenta, as represented by a code.
Data Element Concept:	Birth event – complication

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Collection and usage attributes

<i>Guide for use:</i>	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	There is no arbitrary limit on the number of conditions specified.
<i>Comments:</i>	Complications of labour and delivery may cause maternal morbidity and may affect the health status of the baby at birth.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Birth event – complication, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009
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Complications of pregnancy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Pregnancy (current) – complication, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	405823
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	Complications arising up to the period immediately preceding delivery that are directly attributable to the pregnancy and may have significantly affected care during the current pregnancy and/or pregnancy outcome, as represented by a code
Data Element Concept:	Pregnancy (current) – complication

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Collection and usage attributes

<i>Guide for use:</i>	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Examples of these conditions include threatened abortion, antepartum haemorrhage, pregnancy-induced hypertension and gestational diabetes. There is no arbitrary limit on the number of complications specified.
<i>Comments:</i>	Complications often influence the course and outcome of pregnancy, possibly resulting in hospital admissions and/or adverse effects on the fetus and perinatal morbidity.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Pregnancy (current) – complication, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009
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Condition onset flag

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – condition onset flag, code N
<i>METeOR identifier:</i>	354816
<i>Registration status:</i>	Health, Standard 05/02/2008
<i>Definition:</i>	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

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Condition with onset during the episode of admitted patient care</td></tr><tr><td>2</td><td>Condition not noted as arising during the episode of admitted patient care</td></tr><tr><td>9</td><td>Not reported</td></tr></tbody></table>	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	9	Not reported
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								
9	Not reported								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	<ol style="list-style-type: none">Condition with onset during the episode of admitted patient care<ul style="list-style-type: none">a condition which arises during the episode of admitted patient care and would not have been present on admission <p>Includes:</p> <p>Conditions resulting from misadventure during medical or surgical care during the episode of admitted patient care.</p> <p>Abnormal reactions to, or later complication of, surgical or medical care arising during the episode of admitted patient care.</p> <p>Conditions arising during the episode of admitted patient care not related to surgical or medical care (for example, pneumonia).</p> <ol style="list-style-type: none">Condition not noted as arising during the episode of admitted patient care<ul style="list-style-type: none">a condition present on admission such as the presenting problem, a comorbidity, chronic disease or disease status.a previously existing condition not diagnosed until the episode of admitted patient care.
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Includes:

In the case of neonates, the conditions present at birth.

A previously existing condition that is exacerbated during the episode of admitted patient care.

Conditions that are suspected at the time of admission and subsequently confirmed during the episode of admitted patient care.

Conditions that were not diagnosed at the time of admission but clearly did not develop after admission (for example malignant neoplasm).

Conditions where the onset relative to the beginning of the episode of admitted patient care is unclear or unknown.

9 Not reported

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

Data element attributes

Collection and usage attributes

Guide for use:

Assign the relevant condition onset flag to ICD-10-AM diagnosis codes assigned in the principal diagnosis and additional diagnosis fields for the National Hospital Morbidity Database collection.

The sequencing of diagnosis codes must comply with the Australian Coding Standards and therefore diagnosis codes should not be re-sequenced in an attempt to list diagnosis codes with the same condition onset flag together.

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 value of 2 - Condition not noted as arising during this episode of care.

The principal diagnosis should always have a condition onset flag value of 2.

Explanatory notes:

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

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

When a single diagnosis code describes a condition and that code contains more than one concept (e.g. diabetes with renal complications) and each concept within that code has a different condition onset flag, then assign a value of 2.

When a condition requires more than one diagnosis code to describe it, it is possible for each diagnosis code to have a different condition onset flag.

The flag on Z codes related to the outcome of delivery on the mother's record (Z37), should always be assigned a value of 2.

The flag on Z codes related to the outcome of delivery on the baby's record (Z38), should always be assigned a value of 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, or arose 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 what arises during the episode of care. A better understanding of those conditions arising during the episode of 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 – diagnosis onset type, code N](#) Health, Superseded 05/02/2008

Implementation in Data Set Specifications:

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Congenital malformations

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – congenital malformation, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	393436
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care, as represented by an ICD-10-AM code.
<i>Context:</i>	Admitted patient care
Data Element Concept:	Person – congenital malformation

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Source and reference attributes

<i>Origin:</i>	International Classification of Diseases - 10th Revision, Australian Modification National Centre for Classification in Health, Sydney.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients.
<i>Comments:</i>	Required to monitor trends in the reported incidence of congenital malformations, to detect new drug and environmental teratogens, to analyse possible causes in epidemiological studies, and to determine survival rates and the utilisation of paediatric services.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Person – congenital malformation, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009
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Congenital malformations—BPA code

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – congenital malformation, code (BPA 1979) ANN.N[N]
<i>METeOR identifier:</i>	270408
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Structural abnormalities (including deformations) that are present at birth and diagnosed prior to separation from care, as represented by a BPA code.
<i>Context:</i>	Perinatal statistics
<i>Data Element Concept:</i>	Person – congenital malformation

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	British Paediatric Association Classification of Diseases 1979
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN.N[N]
<i>Maximum character length:</i>	5

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Coding to the disease classification of ICD-10-AM is the preferred method of coding admitted patients. For perinatal data collections, the use of British Paediatric Association (BPA) Classification of Diseases is preferred as this is more detailed.
<i>Comments:</i>	There is no arbitrary limit on the number of conditions specified. Most perinatal data groups and birth defects registers in the states and territories have used the 5-digit BPA Classification of Diseases to code congenital malformations since the early 1980s.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
<i>Origin:</i>	British Paediatric Association Classification of Diseases (1979)

Relational attributes

<i>Related metadata references:</i>	Supersedes Congenital malformations - BPA code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
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Consumer committee representation arrangements

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation – consumer committee representation arrangements, code N
<i>METeOR identifier:</i>	288855
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Extent to which a specialised mental health service organisation has formal committee mechanisms in place to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation – consumer committee representation arrangements

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers</td></tr><tr><td>2</td><td>Specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation</td></tr><tr><td>3</td><td>Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation</td></tr><tr><td>4</td><td>Consumers participate on a broadly based advisory committee which include a mixture of organisations and groups representing a wide range of interests</td></tr><tr><td>5</td><td>Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required</td></tr><tr><td>6</td><td>No specific arrangements exist for consumer participation in planning and evaluation of services</td></tr></tbody></table>	Value	Meaning	1	Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers	2	Specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation	3	Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation	4	Consumers participate on a broadly based advisory committee which include a mixture of organisations and groups representing a wide range of interests	5	Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required	6	No specific arrangements exist for consumer participation in planning and evaluation of services
Value	Meaning														
1	Formal position(s) for consumers exist on the organisation's management committee for the appointment of person(s) to represent the interests of consumers														
2	Specific consumer advisory committee(s) exists to advise on all relevant mental health services managed by the organisation														
3	Specific consumer advisory committee(s) exists to advise on some but not all relevant mental health services managed by the organisation														
4	Consumers participate on a broadly based advisory committee which include a mixture of organisations and groups representing a wide range of interests														
5	Consumers are not represented on any advisory committee but are encouraged to meet with senior representatives of the organisation as required														
6	No specific arrangements exist for consumer participation in planning and evaluation of services														

Collection and usage attributes

Guide for use:

Select the option above that best describes the type of formal committee mechanisms within your organisation for ensuring participation by mental health consumers in the planning and evaluation of services.

Data element attributes

Collection and usage attributes

Guide for use:

Select the option above that best describes the type of formal committee mechanisms with in your organisation for ensuring participation by mental health consumers in the planning and evaluation of services.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Consumer participation arrangements—consumer consultants employed

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation – consumer participation arrangements (consumer consultants employed), code N
<i>METeOR identifier:</i>	288866
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Whether the service employs consumer consultants on a paid basis to represent the interests of consumers and advocate for their needs, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation – consumer participation arrangements (consumer consultants employed)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Boolean								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Don't know</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Don't know
Value	Meaning								
1	Yes								
2	No								
9	Don't know								
<i>Supplementary values:</i>									

Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation – consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Consumer participation arrangements—consumer satisfaction surveys

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation – consumer participation arrangements (consumer satisfaction surveys), code N
<i>METeOR identifier:</i>	290418
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Whether the service conducts consumer satisfaction surveys, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation – consumer participation arrangements (consumer satisfaction surveys)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Don't know</td></tr></tbody></table>	9	Don't know				
9	Don't know						

Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation – consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Consumer participation arrangements—formal complaints mechanism

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation— consumer participation arrangements (formal complaints mechanism), code N
<i>METeOR identifier:</i>	290415
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Whether the service has developed a formal internal complaints mechanism in which complaints can be made by consumers and are regularly reviewed by a committee that includes consumers, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation— consumer participation arrangements (formal internal complaints mechanism)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Don't know</td></tr></tbody></table>	9	Don't know				
9	Don't know						

Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation— consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation— consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation— consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation— consumer participation arrangements (consumer consultants

Implementation in Data Set Specifications:

[employed\), code N Health, Standard 08/12/2004](#)

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Consumer participation arrangements—formal participation policy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation – consumer participation arrangements (formal participation policy), code N
<i>METeOR identifier:</i>	290410
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Whether the service has developed a formal and documented policy on participation by consumers, in order to promote the participation of mental health consumers in the planning, delivery and evaluation of the service, as represented by a code.
Data Element Concept:	Specialised mental health service organisation – consumer participation arrangements (formal participation policy)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Don't know</td></tr></tbody></table>	9	Don't know				
9	Don't know						

Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation – consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (regular discussion groups), code N Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Consumer participation arrangements—regular discussion groups

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation – consumer participation arrangements (regular discussion groups), code N
<i>METeOR identifier:</i>	290408
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Data Element Concept:</i>	Specialised mental health service organisation – consumer participation arrangements (regular discussion groups)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Boolean								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Don't know</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Don't know
Value	Meaning								
1	Yes								
2	No								
9	Don't know								
<i>Supplementary values:</i>									

Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation – consumer participation arrangements (formal participation policy), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (formal complaints mechanism), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (consumer satisfaction surveys), code N Health, Standard 08/12/2004
	See also Specialised mental health service organisation – consumer participation arrangements (consumer consultants employed), code N Health, Standard 08/12/2004
<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005
	<i>Implementation start date:</i> 01/07/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Contract establishment identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Contracted hospital care – organisation identifier, NNX[X]NNNNN
<i>METeOR identifier:</i>	270013
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The unique establishment identifier of the other hospital involved in the contracted care.
Data Element Concept:	Contracted hospital care – organisation identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	NNX[X]NNNNN
<i>Maximum character length:</i>	9

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The contracted hospital will record the establishment identifier of the contracting hospital. The contracting hospital will record the establishment identifier of the contracted hospital.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Contract establishment identifier, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
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Contract procedure flag

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care (procedure) – contracted procedure flag, code N
<i>METeOR identifier:</i>	270473
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Designation that a procedure was not performed in this hospital but was performed by another hospital as a contracted service, as represented by a code.
Data Element Concept:	Episode of care (procedure) – contracted procedure flag

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	[N]						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Contracted admitted procedure</td></tr><tr><td>2</td><td>Contracted non-admitted procedure</td></tr></tbody></table>	Value	Meaning	1	Contracted admitted procedure	2	Contracted non-admitted procedure
Value	Meaning						
1	Contracted admitted procedure						
2	Contracted non-admitted procedure						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Procedures performed at another hospital under contract (Hospital B) are recorded by both hospitals, but flagged by the contracting hospital only (Hospital A). This flag is to be used by the contracting hospital to indicate a procedure performed by a contracted hospital. It also indicates whether the procedure was performed as an admitted or non-admitted service.</p> <p>Allocation of procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.</p> <p>Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate. Some jurisdictions may require these to be separately identified and they could be distinguished from contracted hospital procedures through the use of an additional code in the contract procedure flag data item.</p>
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Relational attributes

<i>Related metadata references:</i>	Supersedes Contract procedure flag, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.3 KB)
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Contract role

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Hospital – contract role, code A
<i>METeOR identifier:</i>	270114
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether the hospital is the purchaser of hospital care or the provider of an admitted or non-admitted service, as represented by a code.
Data Element Concept:	Hospital – contract role

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	String						
<i>Format:</i>	A						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>A</td><td>Hospital A</td></tr><tr><td>B</td><td>Hospital B</td></tr></tbody></table>	Value	Meaning	A	Hospital A	B	Hospital B
Value	Meaning						
A	Hospital A						
B	Hospital B						

Collection and usage attributes

<i>Guide for use:</i>	CODE A Hospital A Hospital A is the contracting hospital (purchaser). CODE B Hospital B Hospital B is the contracted hospital (provider).
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Data element attributes

Relational attributes

<i>Related metadata references:</i>	Supersedes Contract role, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB) Is used in the formation of Episode of admitted patient care – inter-hospital contracted patient status, code N Health, Standard 01/03/2005
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Contract type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Hospital – contract type, code N
<i>METeOR identifier:</i>	270475
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of contract arrangement between contractor and the contracted hospital, as represented by a code.
Data Element Concept:	Hospital – contract type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Contract type B</td></tr><tr><td>2</td><td>Contract type ABA</td></tr><tr><td>3</td><td>Contract type AB</td></tr><tr><td>4</td><td>Contract type (A)B</td></tr><tr><td>5</td><td>Contract type BA</td></tr></tbody></table>	Value	Meaning	1	Contract type B	2	Contract type ABA	3	Contract type AB	4	Contract type (A)B	5	Contract type BA
Value	Meaning												
1	Contract type B												
2	Contract type ABA												
3	Contract type AB												
4	Contract type (A)B												
5	Contract type BA												

Collection and usage attributes

<i>Guide for use:</i>	<p>The contracting hospital (purchaser) is termed Hospital A. The contracted hospital (provider) is termed Hospital B.</p> <p>CODE 1 Contract Type B</p> <p>A health authority / other external purchaser contracts hospital B for admitted service which is funded outside the standard funding arrangements.</p> <p>CODE 2 Contract Type ABA</p> <p>Patient admitted by Hospital A. Hospital A contracts Hospital B for admitted or non-admitted patient service. Patient returns to Hospital A on completion of service by Hospital B.</p> <p>For example, a patient has a hip replacement at Hospital A, then receives aftercare at Hospital B, under contract to Hospital A. Complications arise and the patient returns to Hospital A for the remainder of care.</p> <p>CODE 3 Contract Type AB</p> <p>Patient admitted by Hospital A. Hospital A contracts Hospital B for admitted or non-admitted patient service. Patient does not return to Hospital A on completion of service by Hospital B.</p>
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For example, a patient has a hip replacement at Hospital A and then receives aftercare at Hospital B, under contract to Hospital A. Patient is separated from Hospital B.

CODE 4 Contract Type (A)B

This contract type occurs where a Hospital A contracts Hospital B for the whole episode of care. The patient does not attend Hospital A. For example, a patient is admitted for endoscopy at Hospital B under contract to Hospital A.

CODE 5 Contract Type BA

Hospital A contracts Hospital B for an admitted patient service following which the patient moves to Hospital A for remainder of care. For example, a patient is admitted to Hospital B for a gastric resection procedure under contract to Hospital A and Hospital A provides after care.

Data element attributes

Relational attributes

Related metadata references:

Supersedes [Contract type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.4 KB)

Is used in the formation of [Episode of admitted patient care—inter-hospital contracted patient status, code N](#) Health, Standard 01/03/2005

Contracted care commencement date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Contracted hospital care – contracted care commencement date, DDMMYYYY
<i>METeOR identifier:</i>	270105
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date the period of contracted care commenced.
<i>Data Element Concept:</i>	Contracted hospital care – contracted care commencement date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This metadata item is to be used by the contracting hospital to record the commencement date of the contracted hospital care and will be the admission date for the contracted hospital.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Contracted care commencement date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)
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Contracted care completion date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Contracted hospital care – contracted care completed date, DDMMYYYY
<i>METeOR identifier:</i>	270106
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date the period of contracted care is completed.
<i>Data Element Concept:</i>	Contracted hospital care – contracted care completed date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This metadata item is to be used by the contracting hospital to record the date of completion of the contracted hospital care and will be the separation date for the contracted hospital.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Contracted care completion date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)
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Coordinator of volunteers indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – coordinator of volunteers indicator, yes/no code N
<i>METeOR identifier:</i>	352862
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	An indicator of whether a service provider organisation has at least one designated person to coordinate their volunteer labour force, as represented by a code.
Data Element Concept:	Service provider organisation – coordinator of volunteers indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A coordinator of volunteers may be employed part-time or full-time and may be engaged on a paid or unpaid basis.</p> <p>The duties of a volunteer coordinator may include:</p> <ul style="list-style-type: none">• managing the workloads of volunteer staff;• liaising with clinical staff regarding clients' needs;• assessing human resource needs of the organisation;• recruiting volunteers;• developing orientation kits and programs;• developing volunteer policies;• arranging training and development opportunities; and• maintaining volunteer records. <p>CODE 1 Yes</p> <p>The organisation has a designated coordinator of volunteers.</p> <p>CODE 2 No</p> <p>The organisation does not have a designated coordinator of volunteers.</p>
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Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: [Palliative care performance indicators DSS](#) Health, Standard
05/12/2007

Coronary artery bypass graft location

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – coronary artery bypass graft location, code N
<i>METeOR identifier:</i>	347161
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The location of the artery where a coronary artery bypass graft has been performed, as represented by a code.
Data Element Concept:	Person – coronary artery bypass graft location

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	N																		
<i>Maximum character length:</i>	1																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Left anterior descending artery (LAD)</td></tr><tr><td>2</td><td>Diagonal artery</td></tr><tr><td>3</td><td>Left circumflex artery (LCx)</td></tr><tr><td>4</td><td>Inferior surface artery</td></tr><tr><td>5</td><td>Posterior descending artery</td></tr><tr><td>6</td><td>Right coronary artery</td></tr><tr><td>8</td><td>Other artery</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Left anterior descending artery (LAD)	2	Diagonal artery	3	Left circumflex artery (LCx)	4	Inferior surface artery	5	Posterior descending artery	6	Right coronary artery	8	Other artery	9	Not stated/inadequately described
Value	Meaning																		
1	Left anterior descending artery (LAD)																		
2	Diagonal artery																		
3	Left circumflex artery (LCx)																		
4	Inferior surface artery																		
5	Posterior descending artery																		
6	Right coronary artery																		
8	Other artery																		
9	Not stated/inadequately described																		
<i>Supplementary values:</i>																			

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A bypass may be performed on more than one artery. In these cases more than one code may be recorded.</p> <p>For each graft location the data elements Person-coronary artery stenosis location, code N; Person-maximum stenosis coronary artery, percentage N[NN] must also be recorded.</p>
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	<p>Coronary artery cluster Health, Standard 01/10/2008</p> <p><i>Conditional obligation:</i> Record when a coronary artery bypass graft is performed.</p>
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Coronary artery disease—history of intervention or procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – coronary artery disease intervention (history), code N
<i>METeOR identifier:</i>	270227
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether the individual has undergone a coronary artery by-pass grafting (CABG), angioplasty or stent, as represented by a code.
Data Element Concept:	Person – coronary artery disease intervention

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>CABG, angioplasty or stent - undertaken in last 12 months</td></tr><tr><td>2</td><td>CABG, angioplasty or stent - undertaken prior to the last 12 months</td></tr><tr><td>3</td><td>CABG, angioplasty or stent - both within and prior to the last 12 months</td></tr><tr><td>4</td><td>No CABG, angioplasty or stent undertaken</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	CABG, angioplasty or stent - undertaken in last 12 months	2	CABG, angioplasty or stent - undertaken prior to the last 12 months	3	CABG, angioplasty or stent - both within and prior to the last 12 months	4	No CABG, angioplasty or stent undertaken	9	Not stated/inadequately described
Value	Meaning												
1	CABG, angioplasty or stent - undertaken in last 12 months												
2	CABG, angioplasty or stent - undertaken prior to the last 12 months												
3	CABG, angioplasty or stent - both within and prior to the last 12 months												
4	No CABG, angioplasty or stent undertaken												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Collection and usage attributes

<i>Comments:</i>	<p>CABG is known as ‘bypass surgery’ when a piece of vein (taken from the leg) or of an artery (taken from the chest or wrist) is used to form a connection between the aorta and the coronary artery distal to the obstructive lesion, making a bypass around the blockage. Angioplasty is an elective surgery technique of blood vessels reconstruction.</p> <p>Stenting is a non-surgical treatment used with balloon angioplasty or after, to treat coronary artery disease to widen a coronary artery. A stent is a small, expandable wire mesh tube that is inserted. The purpose of the stent is to help hold the newly treated artery open, reducing the risk of the artery re-closing (re-stenosis) over time.</p> <p>Angioplasty with stenting typically leaves less than 10% of the original blockage in the artery (Heart Center Online).</p>
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These three procedures are commonly used to improve blood flow to the heart muscle when the heart's arteries are narrowed or blocked.

The sooner procedures are done, the greater the chances of saving heart muscle.

Data element attributes

Collection and usage attributes

Collection methods: Ask the individual if he/she has had a CABG, angioplasty or coronary stent. If so determine when it was undertaken within or prior to the last 12 months (or both).

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references: Supersedes [Coronary artery disease - history of intervention or procedure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)

Implementation in Data Set Specifications: [Diabetes \(clinical\) DSS Health](#), Superseded 21/09/2005
[Diabetes \(clinical\) DSS Health](#), Standard 21/09/2005

Coronary artery stenosis location

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – coronary artery stenosis location, code N
<i>METeOR identifier:</i>	361087
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The coronary artery in which stenosis is located, as represented by a code.
Data Element Concept:	Person – coronary artery stenosis location

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	N																		
<i>Maximum character length:</i>	1																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Left anterior descending artery (LAD)</td></tr><tr><td>2</td><td>Diagonal artery</td></tr><tr><td>3</td><td>Left circumflex artery (LCx)</td></tr><tr><td>4</td><td>Left main coronary artery</td></tr><tr><td>5</td><td>Inferior surface artery</td></tr><tr><td>6</td><td>Posterior descending artery</td></tr><tr><td>7</td><td>Right coronary artery</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Left anterior descending artery (LAD)	2	Diagonal artery	3	Left circumflex artery (LCx)	4	Left main coronary artery	5	Inferior surface artery	6	Posterior descending artery	7	Right coronary artery	9	Not stated/inadequately described
Value	Meaning																		
1	Left anterior descending artery (LAD)																		
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4	Left main coronary artery																		
5	Inferior surface artery																		
6	Posterior descending artery																		
7	Right coronary artery																		
9	Not stated/inadequately described																		
<i>Supplementary values:</i>																			

Data element attributes

Collection and usage attributes

Guide for use: More than one code may be recorded.
Record all codes that apply.
For each coronary artery where stenosis is located the data element Person-maximum stenosis coronary artery, percentage N[NN] must also be recorded.

Collection methods: This data is derived from visual reporting by the physician reporting the angiogram.

Relational attributes

Related metadata references: See also [Person – maximum stenosis coronary artery, percentage N\[NN\]](#) Health, Standard 01/10/2008

Implementation in Data Set Specifications: [Coronary artery cluster](#) Health, Standard 01/10/2008

Country of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – country of birth, code (SACC 2008) NNNN
<i>METeOR identifier:</i>	370943
<i>Registration status:</i>	Health, Standard 01/10/2008 Community services, Standard 02/06/2008 Housing assistance, Standard 24/11/2008
<i>Definition:</i>	The country in which the person was born, as represented by a code.
Data Element Concept:	Person – country of birth

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Standard Australian Classification of Countries 2008
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

Collection and usage attributes

<i>Guide for use:</i>	<p>The Standard Australian Classification of Countries 2008 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country.</p> <p>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.</p>
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>Some data collections ask respondents to specify their country of birth. In others, a pre-determined set of countries is specified as part of the question, usually accompanied by an 'other (please specify)' category.</p> <p>Recommended questions are:</p> <p>In which country were you/was the person/was (name) born?</p> <p>Australia</p> <p>Other (please specify)</p>
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Alternatively, a list of countries may be used based on, for example common Census responses.

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

Australia

England

New Zealand

Italy

Viet Nam

India

Scotland

Philippines

Greece

Germany

Other (please specify)

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

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

Comments:

This metadata item is consistent with that used in the [ABS collection methods](#) and is recommended for use whenever there is a requirement for comparison with ABS data (last viewed 2/6/2008).

Relational attributes

Related metadata references:

Supersedes [Person – country of birth, code \(SACC 1998\) NNNN](#) Health, Superseded 01/10/2008, Community services, Superseded 02/06/2008, Housing assistance, Superseded 24/11/2008

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#)
Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard
22/12/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Computer Assisted Telephone Interview demographic module
DSS](#) Health, Standard 03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Non-admitted patient emergency department care NMDS 2010-
2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Registered chiropractic labour force DSS](#) Health, Standard
10/12/2009

[Registered dental and allied dental health professional labour
force DSS](#) Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health,
Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard
10/12/2009

[Registered nursing professional labour force DSS](#) Health,
Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard
10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard
10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard
10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard
10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard
10/12/2009

[Registered psychology labour force DSS](#) Health, Standard
10/12/2009

[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Country of employment in registered profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – country of employment in registered profession, Australia/other country code N
<i>METeOR identifier:</i>	383407
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The country in which a registered health professional is working in their profession, as represented by a code.
Data Element Concept:	Registered health professional – country of employment in registered profession

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Australia</td></tr><tr><td>2</td><td>Other country</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Australia	2	Other country	9	Not stated/inadequately described
Value	Meaning								
1	Australia								
2	Other country								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 AUSTRALIA The definition of Australia is based on the Standard Australian Classification of Countries (SACC). It includes Australia, Norfolk Island and Australian External Territories n.f.d. CODE 2 OTHER COUNTRY This includes all countries in the Standard Australian Classification of Countries (SACC) not included in Code 1 above.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This data element is applicable to registered health professionals who are employed in the registered profession only. Data is self-reported based on the country of employment in the registered profession in the week before registration. Where a health professional works in their profession in Australia and another country, then code one should selected.
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Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Labour force status cluster](#) Health, Standard 10/12/2009

Creatine kinase MB isoenzyme level (index code)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatine kinase myocardial band isoenzyme level (measured), index code X[XXX]
<i>Synonymous names:</i>	Creatine kinase MB isoenzyme (CK-MB) - measured
<i>METeOR identifier:</i>	284903
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme level, as represented by an index.
Data Element Concept:	Person – creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code				
<i>Data type:</i>	Number				
<i>Format:</i>	X[XXX]				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	9999	Not stated/inadequately described
Value	Meaning				
9999	Not stated/inadequately described				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 88888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB) Supersedes Creatine kinase MB isoenzyme (CK-MB) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
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Implementation in Data Set Specifications:

See also [Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, index code X\[XXX\]](#) Health, Standard 04/06/2004

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (kCat per litre)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatine kinase myocardial band isoenzyme level (measured), total kCat per litre N[NNN]
<i>Synonymous names:</i>	Creatine kinase MB isoenzyme (CK-MB) - measured
<i>METeOR identifier:</i>	284915
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme in kCat per litre.
Data Element Concept:	Person – creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>8888</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	8888	Not measured	9999	Not stated/inadequately described
Value	Meaning						
8888	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Catalytic rate of an enzyme (kCat/L)						

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 8888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

See also [Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total kCat per litre N\[NNN\]](#) Health, Standard 04/06/2004

Supersedes [Creatine kinase MB isoenzyme \(CK-MB\) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.0 KB)

Supersedes [Creatine kinase MB isoenzyme \(CK-MB\) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.4 KB)

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (micrograms per litre)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNN]
<i>METeOR identifier:</i>	356833
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in micrograms per litre.
Data Element Concept:	Person – creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9998</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	9998	Not measured	9999	Not stated/inadequately described
Value	Meaning						
9998	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Microgram per litre (µg/L)						

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 9998 if test for CK-MB was not done for this hospital presentation.</p> <p>Measured in different units dependent upon laboratory methodology.</p> <p>When only one CK-MB level is recorded, this should be the peak level.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Person – creatine kinase-myocardial band isoenzyme level (measured), total micrograms per litre N[NNNN] Health, Superseded 01/10/2008
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Implementation in Data Set Specifications:

See also [Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N\[NNN\]](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Creatine kinase MB isoenzyme level (nanograms per decilitre)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatine kinase myocardial band isoenzyme level (measured), total nanograms per decilitre N[NNN]
<i>Synonymous names:</i>	Creatine kinase MB isoenzyme (CK-MB) - measured
<i>METeOR identifier:</i>	284923
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme in nanograms per decilitre.
Data Element Concept:	Person – creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>8888</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	8888	Not measured	9999	Not stated/inadequately described
Value	Meaning						
8888	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Nanogram per decilitre (ng/dl)						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 8888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)
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*Implementation in Data Set
Specifications:*

Supersedes [Creatine kinase MB isoenzyme \(CK-MB\) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#)
(14.4 KB)

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
07/12/2005

Creatine kinase MB isoenzyme level (percentage)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatine kinase myocardial band isoenzyme level (measured), percentage N[NNN]
<i>Synonymous names:</i>	Creatine kinase MB isoenzyme (CK-MB) - measured
<i>METeOR identifier:</i>	284913
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	A person's measured creatine kinase myocardial band (CK-MB) isoenzyme as a percentage.
Data Element Concept:	Person – creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Percentage						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>8888</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	8888	Not measured	9999	Not stated/inadequately described
Value	Meaning						
8888	Not measured						
9999	Not stated/inadequately described						

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 8888 if test for CK-MB was not done on this admission. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level during admission.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)
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Supersedes [Creatine kinase MB isoenzyme \(CK-MB\) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.4 KB)

See also [Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, percentage N\[NNN\]](#) Health, Standard 04/06/2004

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme level (units per litre)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN]
<i>Synonymous names:</i>	Creatine kinase MB isoenzyme (CK-MB) - measured
<i>METeOR identifier:</i>	356830
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's measured creatine kinase-myocardial band (CK-MB) isoenzyme level in units per litre.
Data Element Concept:	Person – creatine kinase-myocardial band isoenzyme level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9998</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	9998	Not measured	9999	Not stated/inadequately described
Value	Meaning						
9998	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Units per litre (U/L)						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 9998 if test for CK-MB was not done for this hospital presentation. Measured in different units dependent upon laboratory methodology. When only one CK-MB level is recorded, this should be the peak level.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Person – creatine kinase-myocardial band isoenzyme level (measured), total international units N[NNN] Health, Superseded 01/10/2008 See also Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN] Health, Standard 01/10/2008
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*Implementation in Data Set
Specifications:*

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard
01/10/2008

Creatine kinase MB isoenzyme—upper limit of normal range (units per litre)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total units per litre N[NNN]
<i>METeOR identifier:</i>	356596
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in units per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9998</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	9998	Not measured	9999	Not stated/inadequately described
Value	Meaning						
9998	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Units per litre (U/L)						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total international units N[NNN] Health, Superseded 01/10/2008 See also Person – creatine kinase-myocardial band isoenzyme level (measured), total units per litre N[NNN] Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme—upper limit of normal range (index code)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, index code X[XXX]
<i>Synonymous names:</i>	Creatine kinase MB isoenzyme (CK-MB) - units
<i>METeOR identifier:</i>	284931
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured as an index that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code				
<i>Data type:</i>	Number				
<i>Format:</i>	X[XXX]				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	9999	Not stated/inadequately described
Value	Meaning				
9999	Not stated/inadequately described				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB) See also Person – creatine kinase myocardial band isoenzyme level (measured), index code X[XXX] Health, Standard 04/06/2004
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (kCat per litre)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total kCat per litre N[NNN]
<i>METeOR identifier:</i>	284963
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme in kCat per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>8888</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	8888	Not measured	9999	Not stated/inadequately described
Value	Meaning						
8888	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Catalytic rate of an enzyme (kCat/L)						

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB) See also Person – creatine kinase myocardial band isoenzyme level (measured), total kCat per litre N[NNN] Health, Standard 04/06/2004
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*Implementation in Data Set
Specifications:*

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
07/12/2005

Creatine kinase MB isoenzyme—upper limit of normal range (micrograms per litre)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN]
<i>METeOR identifier:</i>	359287
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in micrograms per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9998</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	9998	Not measured	9999	Not stated/inadequately described
Value	Meaning						
9998	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Microgram per litre (µg/L)						

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total micrograms per litre N[NNN] Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase MB isoenzyme—upper limit of normal range (nanograms per decilitre)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, total nanograms per decilitre N[NNN]
<i>METeOR identifier:</i>	285957
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured in nanograms per decilitre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>8888</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	8888	Not measured	9999	Not stated/inadequately described
Value	Meaning						
8888	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Nanogram per decilitre (ng/dl)						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Creatine kinase MB isoenzyme (CK-MB) - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)
	Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)

*Implementation in Data Set
Specifications:*

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
07/12/2005

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

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme, percentage N[NNN]
<i>METeOR identifier:</i>	284961
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Laboratory standard for the value of creatine kinase myocardial band (CK-MB) isoenzyme measured as a percentage that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme

Value domain attributes

Representational attributes

<i>Representation class:</i>	Percentage						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>8888</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	8888	Not measured	9999	Not stated/inadequately described
Value	Meaning						
8888	Not measured						
9999	Not stated/inadequately described						

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the creatine kinase myocardial band (CK-MB) normal reference range for the testing laboratory.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group.
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Relational attributes

<i>Related metadata references:</i>	See also Person – creatine kinase myocardial band isoenzyme level (measured), percentage N[NNN] Health, Standard 04/06/2004 Supersedes Creatine kinase MB isoenzyme (CK-MB) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
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*Implementation in Data Set
Specifications:*

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
07/12/2005

Creatine kinase isoenzyme—upper limit of normal range (U/L)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for creatine kinase isoenzyme, total units per litre N[NNN]
<i>METeOR identifier:</i>	349630
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Laboratory standard for the value of creatine kinase (CK) isoenzyme measured in units per litre that is the upper boundary of the normal reference range.
<i>Data Element Concept:</i>	Laboratory standard – upper limit of normal range for creatine kinase isoenzyme

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9998</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	9998	Not measured	9999	Not stated/inadequately described
Value	Meaning						
9998	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Units per litre (U/L)						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the creatine kinase normal reference range for the testing laboratory.
<i>Comments:</i>	There are three different CK isoenzyme sub-forms: <ul style="list-style-type: none">- CK-MM (skeletal muscle)- CK-MB (cardiac muscle)- CK-BB (brain tissue)

Relational attributes

<i>Related metadata references:</i>	See also Person – creatine kinase isoenzyme level (measured), total units per litre N[NNN] Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Creatine kinase level (U/L)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatine kinase isoenzyme level (measured), total units per litre N[NNN]
<i>Synonymous names:</i>	CK measured (U/L)
<i>METeOR identifier:</i>	349536
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's measured creatine kinase (CK) isoenzyme level in units per litre.
Data Element Concept:	Person – creatine kinase isoenzyme level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9998</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	9998	Not measured	9999	Not stated/inadequately described
Value	Meaning						
9998	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Units per litre (U/L)						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 8888 if test for CK was not done for this hospital presentation.</p> <p>Where possible, several CK measures should be recorded and their associated date and time. At a minimum, an initial, peak and late value should be recorded.</p> <p>When only one CK level is recorded, this should be the peak level.</p>
<i>Comments:</i>	<p>Elevation of CK isoenzyme is an indication of damage to muscle.</p> <p>There are three different CK isoenzyme sub-forms:</p> <ul style="list-style-type: none">- CK-MM (skeletal muscle)- CK-MB (cardiac muscle)- CK-BB (brain tissue)

Relational attributes

Related metadata references:

See also [Laboratory standard – upper limit of normal range for creatine kinase isoenzyme, total units per litre N\[NNN\]](#) Health, Standard 01/10/2008

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Creatinine serum level (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatinine serum level, total micromoles per litre NN[NN]
<i>METeOR identifier:</i>	360936
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's serum creatinine level measured in micromoles per litre.
Data Element Concept:	Person – creatinine serum level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	String
<i>Format:</i>	NN[NN]
<i>Maximum character length:</i>	4
<i>Unit of measure:</i>	Micromole per litre ($\mu\text{mol/L}$)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>There is no agreed standard as to which units serum creatinine should be recorded in.</p> <p>Note: If the measurement is obtained in mmol/L it is to be multiplied by 1000.</p>
<i>Collection methods:</i>	<p>Measurement of creatinine should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.</p> <ul style="list-style-type: none">• Single venous blood test taken at the time of other screening blood tests.• Fasting not required.
<i>Comments:</i>	<p>Serum creatinine can be used to help determine renal function. Serum creatinine by itself is an insensitive measure of renal function because it does not increase until more than 50% of renal function has been lost.</p> <p>Serum creatinine together with a patient's age, weight and sex can be used to calculate glomerular filtration rate (GFR), which is an indicator of renal status/ function. The calculation uses the Cockcroft-Gault formula.</p> <p>Creatinine is normally produced in fairly constant amounts in the muscles, as a result the breakdown of phosphocreatine. It passes into the blood and is excreted in the urine. Serum creatinine can</p>

be used to help determine renal function. The elevation in the creatinine level in the blood indicates disturbance in kidney function.

GFR decreases with age, but serum creatinine remains relatively stable. When serum creatinine is measured, renal function in the elderly tends to be overestimated, and GFR should be used to assess renal function, according to the Cockcroft-Gault formula:

$$\text{GFR (ml/min)} = \frac{(140 - \text{age [yrs]}) \times \text{body wt (kg)}}{814 \times \text{serum creatinine (mmol/l)}} \quad [\times 0.85 \text{ (for women)}]$$

An alternative formula is derived from the Modification of Diet in Renal Disease (MDRD) study and does not rely on knowledge of body weight:

$$\text{GFR (ml/min/1.73m}^2\text{)} = 32788 \times \text{creatinine}^{-1.154} \text{ (umol/L)} \times \text{age}^{-0.203} \times (\text{males: 1, females: 0.742}).$$

To determine the degree of chronic renal impairment

GFR > 90ml/min - normal

GFR >60 - 90ml/min - mild renal impairment

GFR >30 - 60ml/min - moderate renal impairment

GFR 0 - 30 ml/min - severe renal impairment

Note: The above GFR measurement should be for a period greater than 3 months. GFR may also be assessed by 24-hour creatinine clearance adjusted for body surface area.

In general, patients with GFR < 30 ml/min are at high risk of progressive deterioration in renal function and should be referred to a nephrology service for specialist management of renal failure.

Patients should be assessed for the complications of chronic renal impairment including anaemia, hyperparathyroidism and be referred for specialist management if required.

Patients with rapidly declining renal function or clinical features to suggest that residual renal function may decline rapidly (ie. hypertensive, proteinuric (>1g/24hours), significant comorbid illness) should be considered for referral to a nephrologist well before function declines to less than 30ml/min. (Draft CARI Guidelines 2002. Australian Kidney Foundation). Patients in whom the cause of renal impairment is uncertain should be referred to a nephrologist for assessment.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Origin:

Caring for Australians with Renal Impairment (CARI)
Guidelines. Australian Kidney Foundation

Relational attributes

Related metadata references:

Supersedes [Person – creatinine serum level, micromoles per litre NN\[NN\]](#) Health, Superseded 01/10/2008

*Implementation in Data Set
Specifications:*

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard
01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard
22/12/2009

Date C-reactive protein level measured

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – C-reactive protein level measured date, DDMMYYYY
<i>Synonymous names:</i>	CRP measured date
<i>METeOR identifier:</i>	338280
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date a person's C-reactive protein (CRP) level is measured.
<i>Data Element Concept:</i>	Person – C-reactive protein level measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	The date C-reactive protein (CRP) is measured should be recorded from the laboratory report.
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Relational attributes

<i>Related metadata references:</i>	See also Person – C-reactive protein level measured time, hhmm Health, Standard 01/10/2008
	See also Person – C-reactive protein level (measured), total milligrams per litre N[NN].N Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date accuracy indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Date—accuracy indicator, code AAA
<i>METeOR identifier:</i>	294429
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	An indicator of the accuracy of the components of a reported date, as represented by a code.
Data Element Concept:	Date—accuracy indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																		
<i>Data type:</i>	String																																		
<i>Format:</i>	AAA																																		
<i>Maximum character length:</i>	3																																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>AAA</td><td>Day, month and year are accurate</td></tr><tr><td>AAE</td><td>Day and month are accurate, year is estimated</td></tr><tr><td>AAU</td><td>Day and month are accurate, year is unknown</td></tr><tr><td>AEE</td><td>Day is accurate, month and year are estimated</td></tr><tr><td>AEU</td><td>Day is accurate, month is estimated, year is unknown</td></tr><tr><td>AUU</td><td>Day is accurate, month and year are unknown</td></tr><tr><td>AUA</td><td>Day is accurate, month is unknown, year is accurate</td></tr><tr><td>AUE</td><td>Day is accurate, month is unknown, year is estimated</td></tr><tr><td>AEA</td><td>Day is accurate, month is estimated, year is accurate</td></tr><tr><td>EAA</td><td>Day is estimated, month and year are accurate</td></tr><tr><td>EAE</td><td>Day is estimated, month is accurate, year is estimated</td></tr><tr><td>EAU</td><td>Day is estimated, month is accurate, year is unknown</td></tr><tr><td>EEA</td><td>Day and month are estimated, year is accurate</td></tr><tr><td>EEE</td><td>Day, month and year are estimated</td></tr><tr><td>EEU</td><td>Day and month are estimated, year is unknown</td></tr><tr><td>EUA</td><td>Day is estimated, month is unknown, year is accurate</td></tr></tbody></table>	Value	Meaning	AAA	Day, month and year are accurate	AAE	Day and month are accurate, year is estimated	AAU	Day and month are accurate, year is unknown	AEE	Day is accurate, month and year are estimated	AEU	Day is accurate, month is estimated, year is unknown	AUU	Day is accurate, month and year are unknown	AUA	Day is accurate, month is unknown, year is accurate	AUE	Day is accurate, month is unknown, year is estimated	AEA	Day is accurate, month is estimated, year is accurate	EAA	Day is estimated, month and year are accurate	EAE	Day is estimated, month is accurate, year is estimated	EAU	Day is estimated, month is accurate, year is unknown	EEA	Day and month are estimated, year is accurate	EEE	Day, month and year are estimated	EEU	Day and month are estimated, year is unknown	EUA	Day is estimated, month is unknown, year is accurate
Value	Meaning																																		
AAA	Day, month and year are accurate																																		
AAE	Day and month are accurate, year is estimated																																		
AAU	Day and month are accurate, year is unknown																																		
AEE	Day is accurate, month and year are estimated																																		
AEU	Day is accurate, month is estimated, year is unknown																																		
AUU	Day is accurate, month and year are unknown																																		
AUA	Day is accurate, month is unknown, year is accurate																																		
AUE	Day is accurate, month is unknown, year is estimated																																		
AEA	Day is accurate, month is estimated, year is accurate																																		
EAA	Day is estimated, month and year are accurate																																		
EAE	Day is estimated, month is accurate, year is estimated																																		
EAU	Day is estimated, month is accurate, year is unknown																																		
EEA	Day and month are estimated, year is accurate																																		
EEE	Day, month and year are estimated																																		
EEU	Day and month are estimated, year is unknown																																		
EUA	Day is estimated, month is unknown, year is accurate																																		

EUE	Day is estimated, month is unknown, year is estimated
EUU	Day is estimated, month and year are unknown
UAA	Day is unknown, month and year are accurate
UAE	Day is unknown, month is accurate, year is estimated
UAU	Day is unknown, month is accurate, year is unknown
UEA	Day is unknown, month is estimated, year is accurate
UEE	Day is unknown, month and year are estimated
UEU	Day is unknown, month is estimated, year is unknown
UUA	Day and month are unknown, year is accurate
UUE	Day and month are unknown, year is estimated
UUU	Day, month and year are unknown

Collection and usage attributes

Guide for use:

Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

This data element consists of a combination of three codes, each of which denotes the accuracy of one date component:

A - the referred date component is accurate

E - the referred date component is not known but is estimated

U - the referred date component is not known and not estimated.

This data element contains positional fields (DMY) that reflects the order of the date components in the format (DDMMYYYY) of the reported date:

Field 1 (D) - refers to the accuracy of the day component;

Field 2 (M) - refers to the accuracy of the month component;

Field 3 (Y) - refers to the accuracy of the year component.

Data domain	Date component (for a format DDMMYYYY)		
	(D)ay	(M)onth	(Y)ear
Accurate	A	A	A
Estimated	E	E	E
Unknown	U	U	U

This data element is valid only for use with dates that are reported/exchanged in the format (DDMMYYYY).

Example 1: A date has been sourced from a reliable source and is known as accurate then the Date accuracy indicator should be informed as (AAA).

Example 2: If only the age of the person is known and there is no certainty of the accuracy of this, then the Date accuracy indicator should be informed as (UUE). That is the day and month are “unknown” and the year is “estimated”.

Example 3: If a person was brought in unconscious to an emergency department of a hospital and the only information available was from a relative who was certain of the age and the birthday’s ‘month’ then the Date accuracy indicator should be informed as (UAA). A year derived from an accurate month and accurate age is always an accurate year.

The Date accuracy indicator can be useful for operational purposes to indicate the level of accuracy that a date has been collected at any point in time. It can indicate whether the stored date needs to be followed up until it reaches the intended minimal required accuracy. For example, if a person was brought in unconscious to an emergency department of a hospital the level of accuracy of the date collected at that point may not be satisfactory. It is likely that the correct date of birth can be obtained at a later date. The Date accuracy indicator provides information on the accuracy of the entered dates that may require further action.

For future users of the data it may also be essential they know the accuracy of the date components of a reported date.

Data element attributes

Collection and usage attributes

Collection methods:

Collection constraints:

If constraints for the collection of the date are imposed, such as ‘a valid date must be input in an information system for unknown date components’, the Date accuracy indicator should be used along with the date as a way of avoiding the contamination of the valid dates with the same value on the respective date components.

Example:

Some jurisdictions use 0107YYYY and some use 0101YYYY when only the year is known. When month and year are known some use the 15th day as the date i.e. 15MMYYYY. Where this occurs in a data collection that is used for reporting or analysis purposes there will be dates in the collection with the attributes 0107YYYY etc that are accurate and some that are not accurate. Without a corresponding flag to determine this accuracy the analysis or report will be contaminated by those estimated dates.

Comments:

Provision of a date is often a mandatory requirement in data collections.

Most computer systems require a valid date to be recorded in a date field i.e. the month part must be an integer between 1 and 12, the day part must be an integer between 1 and 31 with rules about the months with less than 31 days, and the year part should include the century. Also in many systems, significant dates (e.g. date of birth) are mandatory requirements.

However, in actual practice, the date or date components are often not known (e.g. date of birth, date of injury) but, as stated above, computer systems require a valid date. This means that a date MUST be included and it MUST follow the rules for a valid date. It therefore follows that, while such a date will contain valid values according to the rules for a date, the date is in fact an 'unknown' or 'estimated' date. For future users of the data it is essential they know that a date is accurate, unknown or estimated and which components of the date are accurate, unknown or estimated.

Source and reference attributes

Submitting organisation:

Standards Australia

Reference documents:

AS5017 Health Care Client Identification, 2002, Sydney:
Standards Australia

Relational attributes

Related metadata references:

See also [Individual service provider – occupation start date, DDMMYYYY](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

See also [Individual service provider – occupation end date, DDMMYYYY](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

See also [Person – date of birth, MMYYYY](#) Health, Standard 10/12/2009

See also [Person – date of birth, DDMMYYYY](#) Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Date creatine kinase MB isoenzyme measured

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatine kinase myocardial band isoenzyme measured date, DDMMYYYY
<i>METeOR identifier:</i>	284973
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The date on which the person's creatine kinase myocardial band isoenzyme (CK-MB) is measured.
Data Element Concept:	Person – creatine kinase myocardial band isoenzyme measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This metadata item pertains to the measuring of creatine kinase myocardial band (CK-MB) isoenzyme at any time point during this current event.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Date creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date creatinine serum level measured

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatinine serum level measured date, DDMMYYYY
<i>METeOR identifier:</i>	343843
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when the person's creatinine serum level was measured.
<i>Data Element Concept:</i>	Person – creatinine serum level measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Record the date of the most recent creatinine serum level measurement taken in the last 12 months. Date to be recorded from documentation on the laboratory test results and/or the medical record.
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Relational attributes

<i>Related metadata references:</i>	See also Person – creatinine serum level, micromoles per litre NN[NN] Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of acute coronary syndrome related clinical event

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with acute coronary syndrome – acute coronary syndrome related clinical event date, DDMMYYYY
<i>METeOR identifier:</i>	349645
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date a person experienced an acute coronary syndrome related clinical event.
Data Element Concept:	Person with acute coronary syndrome – acute coronary syndrome related clinical event date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	A date should be recorded for each of the specified clinical events that the person experiences while in hospital.
<i>Comments:</i>	<p>An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS.</p> <p>Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.</p>

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008
	<i>Conditional obligation:</i> If a clinical event has occurred, record the date when it was experienced by the person.

Date of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – date of birth, DDMMYYYY
<i>METeOR identifier:</i>	287007
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
<i>Definition:</i>	The date of birth of the person.
Data Element Concept:	Person – date of birth

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>If date of birth is not known or cannot be obtained, provision should be made to collect or estimate age. Collected or estimated age would usually be in years for adults, and to the nearest three months (or less) for children aged less than two years. Additionally, an estimated date flag or a date accuracy indicator should be reported in conjunction with all estimated dates of birth.</p> <p>For data collections concerned with children's services, it is suggested that the estimated date of birth of children aged under 2 years should be reported to the nearest 3 month period, i.e. 0101, 0104, 0107, 0110 of the estimated year of birth. For example, a child who is thought to be aged 18 months in October of one year would have his/her estimated date of birth reported as 0104 of the previous year. Again, an estimated date flag or date accuracy indicator should be reported in conjunction with all estimated dates of birth.</p>
<i>Collection methods:</i>	<p>Information on date of birth can be collected using the one question:</p> <p>What is your/(the person's) date of birth?</p> <p>In self-reported data collections, it is recommended that the following response format is used:</p> <p>Date of birth: __ / __ / ____</p> <p>This enables easy conversion to the preferred representational layout (DDMMYYYY).</p>

For record identification and/or the derivation of other metadata items that require accurate date of birth information, estimated dates of birth should be identified by a date accuracy indicator to prevent inappropriate use of date of birth data. The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of an indicator of the accuracy of the date may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date – accuracy indicator, code AAA also be recorded at the time of record creation to flag the accuracy of the data.

Comments:

Privacy issues need to be taken into account in asking persons their date of birth.

Wherever possible and wherever appropriate, date of birth should be used rather than age because the actual date of birth allows a more precise calculation of age.

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

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

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes [Person – date of birth, DDMMYYYY](#) Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

See also [Date – accuracy indicator, code AAA](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of [Record – linkage key, code 581 XXXXDDMMYYYYN](#) Community services, Standard 21/05/2010

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v 6\) NN](#) Health, Standard 22/12/2009

Implementation in Data Set Specifications:

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v 6\) ANNA](#) Health, Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v5.1\) ANNA](#) Health, Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v5.1\) NN](#) Health, Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – length of stay \(including leave days\) \(postnatal\), total N\[NN\]](#) Health, Standard 04/07/2007

Is used in the formation of [Episode of admitted patient care – length of stay \(including leave days\) \(antenatal\), total N\[NN\]](#) Health, Standard 04/07/2007

Is used in the formation of [Episode of admitted patient care \(postnatal\) – length of stay \(including leave days\), total N\[NN\]](#) Health, Superseded 04/07/2007

Is used in the formation of [Episode of admitted patient care \(antenatal\) – length of stay \(including leave days\), total N\[NN\]](#) Health, Superseded 04/07/2007

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

[Alcohol and other drug treatment services NMDS](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#)
Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#)
Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#)
Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard
22/12/2009

[Community mental health care 2004-2005](#) Health, Superseded
08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

[Community mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Computer Assisted Telephone Interview demographic module DSS](#) Health, Superseded 03/12/2008

[Computer Assisted Telephone Interview demographic module DSS](#) Health, Standard 03/12/2008

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

[Health labour force NMDS](#) Health, Standard 01/03/2005

Implementation start date: 01/07/2005

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Perinatal NMDS](#) Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Residential mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Date of cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – treatment cessation date, DDMMYYYY
<i>METeOR identifier:</i>	270067
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a treatment episode for alcohol and other drugs ceases.
Data Element Concept:	Episode of treatment for alcohol and other drugs – treatment cessation date

Value domain attributes

Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYYY
<i>Maximum character length:</i>	8

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Refers to the date of the last service contact in a treatment episode between the client and staff of the treatment provider. In situations where the client has had no contact with the treatment provider for three months, nor is there a plan in place for further contact, the date of last service contact should be used. Refer to the glossary item Cessation of treatment episode for alcohol and other drugs to determine when a treatment episode ceases. The date must be later than or the same as the treatment commencement date for the episode of treatment for alcohol and other drugs.
<i>Comments:</i>	Required to identify the cessation of a treatment episode by an alcohol and other drug treatment service.

Source and reference attributes

<i>Submitting organisation:</i>	Intergovernmental Committee on Drugs National Minimum Data Set Working Group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Date of cessation of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)
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Implementation in Data Set Specifications:

[Alcohol and other drug treatment services NMDS Health](#), Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS Health](#), Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Date of change to qualification status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care (newborn) – date of change to qualification status, DDMMYYYY
<i>METeOR identifier:</i>	270034
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date, within a newborn episode of care, on which the newborn's Qualification status changes from acute (qualified) to unqualified or vice versa.
Data Element Concept:	Episode of admitted patient care (newborn) – date of change to qualification status

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the date or dates on which the newborn's Qualification status changes from acute (qualified) to unqualified or vice versa. If more than one change of qualification status occurs on a single day, the day is counted against the final qualification status. Must be greater than or equal to admission date.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Date of change to qualification status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB) Is used in the formation of Episode of admitted patient care (newborn) – number of qualified days, total N[NNNN] Health, Standard 01/03/2005
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Date of commencement of treatment episode for alcohol and other drugs

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – treatment commencement date, DDMMYYYY
<i>METeOR identifier:</i>	270069
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which the first service contact within the treatment episode when assessment and/or treatment occurs.
Data Element Concept:	Episode of treatment for alcohol and other drugs – treatment commencement date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A client is identified as commencing a treatment episode if one or more of the following apply:</p> <ul style="list-style-type: none">• they are a new client,• they are a client recommencing treatment after they have had had no contact with the treatment provider for a period of three months or had any plan in place for further contact,• their principal drug of concern for alcohol and other drugs has changed,• their main treatment type for alcohol and other drugs has changed,• their treatment delivery setting for alcohol and other drugs has changed.
<i>Comments:</i>	Required to identify the commencement of a treatment episode by an alcohol and other drug treatment service.

Source and reference attributes

<i>Submitting organisation:</i>	Intergovernmental Committee on Drugs National Minimum Data Set Working Group
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Relational attributes

Related metadata references:

Supersedes [Date of commencement of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Supersedes [Commencement of treatment episode for alcohol and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (13.5 KB)

Implementation in Data Set Specifications:

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Date of completion of last previous pregnancy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Pregnancy (last previous) – pregnancy completion date, DDMMYYYY
<i>METeOR identifier:</i>	270002
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date on which the pregnancy preceding the current pregnancy was completed.
Data Element Concept:	Pregnancy (last previous) – pregnancy completion date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Estimate day of month (DD), if first day is unknown.
<i>Comments:</i>	<p>This metadata item is recommended by the World Health Organization. It is currently collected in some states and territories.</p> <p>Interval between pregnancies may be an important risk factor for the outcome of the current pregnancy, especially for preterm birth and low birthweight.</p>

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Date of completion of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)
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Date of coronary artery bypass graft

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – coronary artery bypass graft date, DDMMYYYY
<i>Synonymous names:</i>	CABG date
<i>METeOR identifier:</i>	344424
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date on which a coronary artery bypass graft (CABG) procedure is performed on a person.
Data Element Concept:	Person – coronary artery bypass graft date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the date of each CABG if more than one has been performed. CABG includes grafts and valve replacement, but does not include valve replacement alone.
<i>Collection methods:</i>	The date/s should be recorded from the medical record.

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Coronary artery cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> Record when a coronary artery bypass graft is performed.
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Date of death

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – date of death, DDMMYYYY
<i>METeOR identifier:</i>	287305
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The date of death of the person.
Data Element Concept:	Person – date of death

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Recorded for persons who have died. Where Date of birth is collected, Date of death must be equal to or greater than Date of birth for the same person.
<i>Collection methods:</i>	It is recommended that in cases where all components of the date of death are not known or where an estimate is arrived at from age, a valid date be used together with a flag to indicate that it is an estimate. For record identification and/or the derivation of other metadata items that require accurate date of death information, estimated dates of death should be identified by a date accuracy indicator to prevent inappropriate use of date of death data. The linking of client records from diverse sources, the sharing of patient data, and data analysis for research and planning all rely heavily on the accuracy and integrity of the collected data. In order to maintain data integrity and the greatest possible accuracy an indication of the accuracy of the date collected is critical. The collection of Date accuracy indicator may be essential in confirming or refuting the positive identification of a person. For this reason it is strongly recommended that the data element Date accuracy indicator also be recorded at the time of record creation to flag the accuracy of the data.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare
Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes [Date of death, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (13.5 KB)

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Date of diagnosis

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Patient – diagnosis date, DDMMYYYY
<i>METeOR identifier:</i>	270544
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a patient is diagnosed with a particular condition or disease.
Data Element Concept:	Patient – diagnosis date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Comments:</i>	Classification systems, which enable the allocation of a code to the diagnostic information, can be used in conjunction with this metadata item.
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Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular Data Working Group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Date of diagnosis, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (13.9 KB)
<i>Implementation in Data Set Specifications:</i>	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Date of diagnosis of cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Patient – diagnosis date (cancer), DDMMYYYY
<i>METeOR identifier:</i>	270061
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date when the cancer was first diagnosed (whether at its primary site or as a metastasis).
<i>Context:</i>	Patient administration system, cancer notification system, population cancer statistics, research.
Data Element Concept:	Patient – diagnosis date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Date of diagnosis must be: >= date of birth <= date of death Diagnosis of cancer after death: If the patient is first diagnosed with the cancer in an autopsy report the date of diagnosis is the date of death as stated on the patient's death certificate. Incidental diagnosis of cancer: If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date the cancer was diagnostically determined, not the admission date.
<i>Collection methods:</i>	Reporting rules: The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence:

Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer.

Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital.

Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).

If components of the date are not known, an estimate should be provided where possible with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be used with a flag to indicate the date is not known.

Source and reference attributes

<i>Origin:</i>	International agency for research on cancer World Health Organisation International Association of Cancer Registries
<i>Reference documents:</i>	Modified from the definition presented by the New South Wales Inpatient Statistics Collection Manual 2000/2001

Relational attributes

<i>Related metadata references:</i>	Supersedes Date of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)
<i>Implementation in Data Set Specifications:</i>	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009 Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009 Cancer (clinical) DSS Health, Superseded 22/12/2009 Cancer (clinical) DSS Health, Standard 22/12/2009

Date of diagnosis of first recurrence

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Patient – diagnosis date (first recurrence of cancer), DDMMYYYY
<i>METeOR identifier:</i>	288596
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The date a medical practitioner confirms the diagnosis of a recurrent or metastatic cancer of the same histology.
Data Element Concept:	Patient – diagnosis date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The term ‘recurrence’ defines the return, reappearance or metastasis of cancer (of the same histology) after a disease free period.
<i>Comments:</i>	This item is collected for determining the time interval from diagnosis to recurrence, from treatment to recurrence and from recurrence to death.

Source and reference attributes

<i>Origin:</i>	Commission on Cancer, American College of Surgeons
<i>Reference documents:</i>	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

<i>Related metadata references:</i>	Supersedes Date of diagnosis of first recurrence, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)
<i>Implementation in Data Set Specifications:</i>	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009 Cancer (clinical) DSS Health, Superseded 22/12/2009 Cancer (clinical) DSS Health, Standard 22/12/2009

Date of diagnostic cardiac catheterisation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – diagnostic cardiac catheterisation date, DDMMYYYY
<i>Synonymous names:</i>	Date of coronary angiography
<i>METeOR identifier:</i>	359791
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when cardiac catheterisation is performed for diagnostic purposes.
Data Element Concept:	Person – diagnostic cardiac catheterisation date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This metadata item includes coronary angiography which is performed using a catheter.
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Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Date of electrocardiogram

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Electrocardiogram – electrocardiogram date, DDMMYYYY
<i>Synonymous names:</i>	Date of ECG
<i>METeOR identifier:</i>	343820
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date an electrocardiogram (ECG) is performed for a person.
<i>Data Element Concept:</i>	Electrocardiogram – electrocardiogram date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	The date of ECG should be recorded irrespective of the setting (e.g. pre-hospital setting, emergency department or inpatient ward). The date of ECG should be recorded each time an ECG is performed.
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Electrocardiogram cluster Health, Standard 01/10/2008
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Date of first contact

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Community nursing service episode – first contact date, DDMMYYYY
<i>METeOR identifier:</i>	270190
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date of first contact with the community nursing service for an episode of care, between a staff member and a person or a person's family.
Data Element Concept:	Community nursing service episode – first contact date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This should occur after a previous last contact date of a previous care episode and prior to or on the same as first service delivery date.</p> <p>Includes:</p> <ul style="list-style-type: none">visits made to a person in institutional settings such as liaison visits or discharge planning visits, made in a hospital or residential aged care service with the intent of planning for the future delivery of service at home;telephone contacts when these are in lieu of a first home or hospital visit for the purpose of preliminary assessment for care at home;visits made to the person's home prior to admission for the purpose of assessing the suitability of the home environment for the person's care. <p>This applies irrespective of whether the person is present or not.</p> <p>Excludes:</p> <ul style="list-style-type: none">first visits where the visit objective is not met, such as first visit made where no one is home.
<i>Collection methods:</i>	<p>The first contact date can be the same as first service delivery date and apply whether a person is entering care for the first time or any subsequent episode. This date should be recorded when it is the same as the first delivery of service date.</p>

Comments:

This metadata item is recommended for use in community services which are funded for liaison or discharge planning positions or provide specialist consultancy or assessment services. Further developments in community care, including casemix and coordinated care will require collection of data relating to resource expenditure across the sector.

To enable analysis of time periods throughout a care episode, especially the pre-admission period and associated activities. This metadata item enables the capture of the commencement of care irrespective of the setting in which the activities took place.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Relational attributes

Related metadata references:

Supersedes [Date of first contact, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.9 KB)

Date of first delivery of service

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care (community setting) – first service delivery date, DDMMYYYY
<i>METeOR identifier:</i>	270210
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date of first delivery of service to a person in a non-institutional setting.
Data Element Concept:	Episode of care – first service delivery date (community setting)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This date may occur on the same day or prior to the Date of last delivery of service, but must never occur after that date within the current episode of care. The date may be the same as the Community nursing service episode – first contact date, DDMMYYYY.
<i>Collection methods:</i>	As long as contact is made with the person in a non-institutional setting, the Episode of care (community setting) – first service delivery date, DDMMYYYY must be recorded. Normally this will be the first home or clinic visit and is the date most often referred to in a service agency as the admission. This date applies whether a person is being admitted for the first time, or is being re-admitted for care.
<i>Comments:</i>	<p>This metadata item is used for the analysis of time periods within a care episode and to locate that episode in time. The date relates to the first delivery of formal services within the community setting.</p> <p>This date marks the most standard event, which occurs at the beginning of an episode of care in community setting. It should not be confused with the Date of first contact with a community nursing service; although they could be the same, the dates for both items must be recorded. Agencies providing hospital-in-the-home services should develop their own method of distinguishing between the period the person remains a formal patient of the hospital, with funding to receive services at home,</p>

and the discharge of the person into the care of the community service.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Relational attributes

Related metadata references:

Supersedes [Date of first delivery of service, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.2 KB)

Date of functional stress test

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Functional stress test – test date, DDMMYYYY
<i>METeOR identifier:</i>	347054
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when a functional stress test is performed on a person.
Data Element Concept:	Functional stress test – test date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The date should always be recorded when a functional stress test is performed.
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Functional stress test cluster Health, Standard 01/10/2008
	<i>Conditional obligation:</i> To be provided when a functional stress test is performed.

Date of implantable cardiac defibrillator procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – implantable cardiac defibrillator procedure date, DDMMYYYY
<i>Synonymous names:</i>	ICD procedure date
<i>METeOR identifier:</i>	359611
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when a procedure is performed for insertion of an implantable cardiac defibrillator (ICD).
Data Element Concept:	Person – implantable cardiac defibrillator procedure date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Date of intra-aortic balloon pump procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – intra-aortic balloon pump procedure date, DDMMYYYY
<i>METeOR identifier:</i>	359623
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when a procedure is performed for insertion of an intra-aortic balloon pump.
Data Element Concept:	Person – intra-aortic balloon pump procedure date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Date of intravenous fibrinolytic therapy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – intravenous fibrinolytic therapy date, DDMMYYYY
<i>METeOR identifier:</i>	356921
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date intravenous (IV) fibrinolytic therapy was first administered or initiated.
Data Element Concept:	Person – intravenous fibrinolytic therapy date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the date the initial bolus was administered should be recorded.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Person – intravenous fibrinolytic therapy date, DDMMYYYY Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008
	<i>Conditional obligation:</i> If prescribed, provide the date when the fibrinolytic therapy is administered.

Date of last contact

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Community nursing service episode – last contact date, DDMMYYYY
<i>METeOR identifier:</i>	270191
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date of the last contact between a staff member of the community service and a person in any setting.
Data Element Concept:	Community nursing service episode – last contact date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This could be the same as the date of discharge.</p> <p>Includes:</p> <ul style="list-style-type: none">visits made to persons in institutional settings for the purpose of handing over or otherwise completing a care episode;bereavement visits in any setting;visits made to the person's home to complete the service, including the collection of equipment. <p>Excludes:</p> <ul style="list-style-type: none">visits made by liaison/discharge planning staff of a community service for the purpose of assessment of need related to a subsequent episode of care.
<i>Comments:</i>	<p>If service agencies are committed to monitoring all resource utilisation associated with an episode of care, this post-discharge date and the corresponding pre-admission metadata item Date of first contact, have a place within an agency information system. This is particularly true for those agencies providing discharge planning service or specialist consultancy or assessment services.</p> <p>To enable analysis of time periods throughout a care episode, especially the bereavement period. This date has been included in order to capture the end of a care episode in terms of involvement of the community nursing service.</p>

Source and reference attributes

Submitting organisation: Australian Council of Community Nursing Services

Relational attributes

Related metadata references: Supersedes [Date of last contact, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Date of most recent stroke

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – most recent stroke date, DDMMYYYY
<i>Synonymous names:</i>	CVA date
<i>METeOR identifier:</i>	338263
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date of the most recent cerebrovascular accident or stroke experienced by a person.
Data Element Concept:	Person – most recent stroke date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	The date should be self-reported by the person or recorded by the clinician based on the notes in the medical record. The occurrence of a stroke should be evidenced by a record of cerebral imaging (CT or MRI).
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Relational attributes

<i>Related metadata references:</i>	See also Person – clinical evidence status (stroke), code N Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Date of non-invasive ventilation administration

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – non-invasive ventilation administration date, DDMMYYYY
<i>METeOR identifier:</i>	359637
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when non-invasive ventilation is administered.
Data Element Concept:	Person – non-invasive ventilation administration date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Date of onset of acute coronary syndrome symptoms

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – acute coronary syndrome symptoms onset date, DDMMYYYY
<i>Synonymous names:</i>	Date of onset of ACS symptoms
<i>METeOR identifier:</i>	321201
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date on which a person experienced acute coronary syndrome symptoms that prompted the person to seek medical attention, either at the hospital or from a general practitioner.
Data Element Concept:	Person – acute coronary syndrome symptoms onset date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Acute coronary syndrome symptoms may include:</p> <ul style="list-style-type: none">• tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrist and hands• dyspnoea, nausea/vomiting, cold sweat or syncope. <p>Seeking medical attention could include the person presenting to their GP who then refers them to hospital or the person presenting directly to hospital (via ambulance or own form of transport).</p> <p>If the person is already a patient at the hospital for another reason then the date would be when they advised hospital staff of their symptoms.</p>
<i>Collection methods:</i>	Record the date that the person identifies as being when the most significant acute coronary syndrome symptom/s occurred that prompted them to seek medical attention.

Relational attributes

<i>Related metadata references:</i>	See also Person – acute coronary syndrome risk stratum, code N Health, Superseded 01/10/2008
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*Implementation in Data Set
Specifications:*

See also [Person—acute coronary syndrome symptoms onset time, hhmm](#) Health, Standard 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Date of pacemaker insertion

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – pacemaker insertion date, DDMMYYYY
<i>METeOR identifier:</i>	359591
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when a procedure is performed for insertion of a pacemaker.
Data Element Concept:	Person – pacemaker insertion date

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Date of primary percutaneous coronary intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – primary percutaneous coronary intervention date, DDMMYYYY
<i>Synonymous names:</i>	Primary PCI date
<i>METeOR identifier:</i>	359175
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Date of the primary percutaneous coronary intervention (PCI).
<i>Data Element Concept:</i>	Person – primary percutaneous coronary intervention date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Primary PCI relates to the first balloon angioplasty inflation and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI). The date or the first balloon angioplasty inflation should be recorded, even if this includes implantation of a stent.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Person – first angioplasty balloon inflation or stenting date, DDMMYYYY Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Coronary artery cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> Record when a primary percutaneous coronary intervention is performed.

Date of procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care (procedure) – procedure commencement date, DDMMYYYY
<i>METeOR identifier:</i>	270298
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a procedure commenced during an inpatient episode of care.
Data Element Concept:	Episode of admitted patient care (procedure) – procedure commencement date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Admitted patients: Record date of procedure for all procedures undertaken during an episode of care in accordance with the current edition of ICD-10-AM.
<i>Collection methods:</i>	Date of procedure >= admission date Date of procedure <= separation date
<i>Comments:</i>	The National Centre for Classification in Health advises the Health Data Standards Committee of relevant changes to the ICD-10-AM. Required to provide information on the timing of the procedure in relation to the episode of care.

Source and reference attributes

<i>Origin:</i>	National Centre for Classification in Health National Health Data Committee
<i>Reference documents:</i>	Australian Institute of Health and Welfare (AIHW) 2000. Australian hospital statistics 1998-1999. AIHW cat. no. HSE 11. Canberra: AIHW (Health Services Series no. 15)

Relational attributes

<i>Related metadata references:</i>	Supersedes Date of procedure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
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Date of referral to rehabilitation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Health service event – referral to rehabilitation service date, DDMMYYYY
<i>METeOR identifier:</i>	269993
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a person is referred to a rehabilitation service.
Data Element Concept:	Health service event – referral to rehabilitation service date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	If date of referral is not known then provision should be made to collect month and year as a minimum, using 01 as DD (as the date part) if only the month and year are known.
<i>Collection methods:</i>	To be collected at the time of commencement of rehabilitation.

Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular Data Working Group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Date of referral to rehabilitation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB)
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005
	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard
22/12/2009

Date of rescue percutaneous coronary intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – rescue percutaneous coronary intervention date, DDMMYYYY
<i>Synonymous names:</i>	Rescue PCI date
<i>METeOR identifier:</i>	359580
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when rescue percutaneous coronary intervention (PCI) is performed.
Data Element Concept:	Person – rescue percutaneous coronary intervention date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Rescue PCI relates to balloon angioplasty inflation and/or stent implantation performed following failed fibrinolysis in patients with continuing or recurrent myocardial ischaemia.
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Source and reference attributes

<i>Reference documents:</i>	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Coronary artery cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> Record when a rescue percutaneous coronary intervention is performed.
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Date of revascularisation percutaneous coronary intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – revascularisation percutaneous coronary intervention date, DDMMYYYY
<i>Synonymous names:</i>	Revascularisation PCI date
<i>METeOR identifier:</i>	359731
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when a percutaneous coronary intervention (PCI) is performed for revascularisation.
Data Element Concept:	Person – revascularisation percutaneous coronary intervention date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Revascularisation PCI relates to balloon angioplasty inflation and/or stent implantation performed for subsequent restoration of blood flow.
<i>Comments:</i>	Routine revascularisation PCI may be performed after ST-segment-elevation myocardial infarction for people with objective evidence of recurrent myocardial infarction in whom there is spontaneous or inducible ischaemia or haemodynamic instability. Revascularisation PCI may also be performed for treatment of high-risk non-ST-segment-elevation acute coronary syndrome.

Source and reference attributes

<i>Reference documents:</i>	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Coronary artery cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> Record when a percutaneous coronary intervention is performed for revascularisation.
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Date of surgical treatment for cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – surgical procedure date, DDMMYYYY
<i>METeOR identifier:</i>	288632
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The date on which the cancer-directed surgical treatment was performed.
Data Element Concept:	Cancer treatment – surgical procedure date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The date of each surgical treatment episode should be entered separately. Collected for curative and palliative surgery prior to the first recurrence.
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Source and reference attributes

<i>Submitting organisation:</i>	National Cancer Control Initiative
<i>Origin:</i>	Commission on Cancer, American College of Surgeons
<i>Reference documents:</i>	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

<i>Related metadata references:</i>	Supersedes Date of surgical treatment for cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)
<i>Implementation in Data Set Specifications:</i>	Cancer (clinical) DSS Health, Superseded 07/12/2005
	Cancer (clinical) DSS Health, Superseded 06/03/2009
	Cancer (clinical) DSS Health, Superseded 22/12/2009
	Cancer (clinical) DSS Health, Standard 22/12/2009

Date of triage

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – triage date, DDMMYYYY
<i>METeOR identifier:</i>	313815
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	The date on which the patient is triaged .
<i>Data Element Concept:</i>	Non-admitted patient emergency department service episode – triage date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Collected in conjunction with non-admitted patient emergency department service episode – triage time.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Government Department of Health and Ageing
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Relational attributes

<i>Related metadata references:</i>	Supersedes Triage – triage date, DDMMYYYY Health, Superseded 07/12/2005
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006
	<i>Implementation start date:</i> 01/07/2005
	<i>Implementation end date:</i> 30/06/2006
	Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006
	<i>Implementation start date:</i> 01/07/2006
	<i>Implementation end date:</i> 30/06/2007

Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

Non-admitted patient emergency department care NMDS 2008-2010 Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Date of ventricular ejection fraction test

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Ventricular ejection fraction test – test date, DDMMYYYY
<i>Synonymous names:</i>	Date EF measured
<i>METeOR identifier:</i>	344274
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when a person's ventricular ejection fraction is measured.
Data Element Concept:	Ventricular ejection fraction test – test date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Ventricular ejection fraction cluster Health, Standard 01/10/2008
	<i>Conditional obligation:</i> To be provided when the ventricular ejection fraction is measured.

Date patient presents

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Health service event – presentation date, DDMMYYYY
<i>METeOR identifier:</i>	270393
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which the patient/client presents for the delivery of a service.
Data Element Concept:	Health service event – presentation date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For community health care, outreach services and services provided via telephone or telehealth, this may be the date on which the service provider presents to the patient or the telephone/telehealth session commences.</p> <p>The date of patient presentation at the Emergency department is the earliest occasion of being registered clerically or triaged.</p> <p>The date that the patient presents is not necessarily:</p> <ul style="list-style-type: none">• the listing date for care (see listing date for care), nor• the date on which care is scheduled to be provided, nor• the date on which commencement of care actually occurs (for admitted patients see admission date, for hospital non-admitted patient care and community health care see service commencement date).
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Source and reference attributes

<i>Submitting organisation:</i>	National Institution Based Ambulatory Model Reference Group
<i>Origin:</i>	National Health Data Committee

Relational attributes

<i>Related metadata references:</i>	<p>Supersedes Date patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.3 KB)</p> <p>Is used in the formation of Non-admitted patient emergency department service episode – waiting time (to service delivery),</p>
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Implementation in Data Set Specifications:

[total minutes NNNNN](#) Health, Superseded 22/12/2009

Is used in the formation of [Non-admitted patient emergency department service episode – service episode length, total minutes NNNNN](#) Health, Standard 01/03/2005

Is used in the formation of [Non-admitted patient emergency department service episode – waiting time \(to hospital admission\), total hours and minutes NNNN](#) Health, Standard 01/03/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Date troponin measured

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – troponin level measured date, DDMMYYYY
<i>METeOR identifier:</i>	359422
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Date the person's troponin assay is measured.
Data Element Concept:	Person – troponin level measured date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This metadata item pertains to the measuring of troponin at any time point during this current event.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Person – troponin level measured date, DDMMYYYY Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Day program attendances

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of day centre attendances, total N[NNNN]
<i>METeOR identifier:</i>	270245
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the number of patient/client visits to day centres.
Data Element Concept:	Establishment – number of day centre attendances

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNN]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Attendance

Data element attributes

Collection and usage attributes

<i>Comments:</i>	<p>This metadata item is derived from components that are not currently specified in METeOR, but which are recorded in various ways by hospitals and/or outpatient departments. Examples include identifiers of individual consultations/visits, diagnostic tests, etc.</p> <p>Required to measure adequately non-admitted patient services in psychiatric hospitals and alcohol and drug hospitals.</p> <p>Difficulties were envisaged in using the proposed definitions of an individual or group occasion of service for clients attending psychiatric day care centres. These individuals may receive both types of services during a visit to a centre.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Day program attendances, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
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Degree of spread of cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – degree of spread of a cancer, code N
<i>METeOR identifier:</i>	270180
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Degree of spread of cancer is a measure of the progression/extent of cancer at a particular point in time, as represented by a code.
Data Element Concept:	Person with cancer – degree of spread of a cancer

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Localised to the tissue of origin</td></tr><tr><td>2</td><td>Invasion of adjacent tissue or organs</td></tr><tr><td>3</td><td>Regional lymph nodes</td></tr><tr><td>4</td><td>Distant metastases</td></tr><tr><td>5</td><td>Not Applicable</td></tr><tr><td>9</td><td>Unknown</td></tr></tbody></table>	Value	Meaning	1	Localised to the tissue of origin	2	Invasion of adjacent tissue or organs	3	Regional lymph nodes	4	Distant metastases	5	Not Applicable	9	Unknown
Value	Meaning														
1	Localised to the tissue of origin														
2	Invasion of adjacent tissue or organs														
3	Regional lymph nodes														
4	Distant metastases														
5	Not Applicable														
9	Unknown														
<i>Supplementary values:</i>															

Collection and usage attributes

<i>Guide for use:</i>	<p>The valid values for the variable are listed below.</p> <p>CODE 1 Localised to the tissue of origin</p> <p>Includes a primary cancer where the spread is contained within the organ of origin. Note: this includes in situ breast (D05.0-D05.9) and in situ melanoma (D03.0-D03.9)</p> <p>Example 1: For colon cancer, the cancer has not progressed into the adventitia (peritoneal layer) surrounding the colon.</p> <p>Example 2: For breast cancer, the cancer has not progressed into the underlying muscle layer (pectoral) or externally to the skin.</p> <p>Example 3: For melanoma of the skin, the cancer has not invaded the subcutaneous fat layer (that is, it is contained within the dermis and epidermis).</p> <p>Example 4: For lung cancer, the cancer has not invaded the pleura.</p> <p>CODE 2 Invasion of adjacent tissue or organs</p> <p>A primary cancer has spread to adjacent organs or tissue not forming part of the organ of origin. This category includes</p>
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sub-cutaneous fat or muscle and organs adjacent to the primary cancer site.

Example 1: For colon cancer, the cancer has progressed into the adventitia (peritoneal layer) surrounding the colon.

Example 2: For breast cancer, the degree of spread has progressed into the underlying muscle layer (pectoral) or externally into the skin.

Example 3: For melanoma of the skin, the cancer has invaded into subcutaneous fat or muscle.

Example 4: For lung cancer, the cancer has invaded the pleura or tissues of the mediastinum.

CODE 3 Regional lymph nodes

The primary cancer has metastasised to the nearby draining lymph nodes. The list below shows the regional lymph nodes by site of primary cancer (International Union Against Cancer's definition).

Head and neck - Cervical nodes

Larynx - Cervical nodes

Thyroid - Cervical and upper mediastinal nodes

Stomach - Perigastric nodes along the lesser and greater curvatures

Colon and Rectum - Pericolic, perirectal, and those located along the ileocolic, right colic, middle colic, left colic, inferior mesenteric and superior rectal

Anal - Perirectal, internal iliac, and inguinal lymph nodes

Liver - Hilar nodes, e.g. the hepatoduodenal ligament

Pancreas - Peripancreatic nodes

Lung - Intrathoracic, scalene and supraclavicular

Breast - Axillary, interpectoral, internal mammary

Cervix - Paracervical, parametrial, hypogastric, common, internal and external iliac, presacral and sacral

Ovary - Hypogastric (obturator), common iliac, external iliac, lateral, sacral, para-aortic and inguinal

Prostate and bladder - Pelvic nodes below the bifurcation of the common iliac arteries

Testes - Abdominal, para-aortic and paracaval nodes, the intrapelvic and inguinal nodes

Kidney - Hilar, abdominal, para-aortic or paracaval.

CODE 4 Distant metastases

The primary cancer has spread to sites distant to the primary site, for example liver and lung and bone, or any lymph nodes not stated as regional to the site (see '3 - Regional lymph nodes' above).

CODE 5 Not applicable

This category applies for lymphatic and haematopoietic cancers, e.g. myelomas, leukaemias and lymphomas (C81.0 - C96.9) only.

CODE 9 Unknown

No information is available on the degree of spread at this episode or the available information is insufficient to allow classification into one of the preceding categories.

Data element attributes

Source and reference attributes

Submitting organisation:

World Health Organization
New South Wales Health Department

Origin:

International Classification of Diseases for Oncology, Second Edition (ICD-O-2) New South Wales Inpatient Statistics Collection Manual-2000/2001

Relational attributes

Related metadata references:

Supersedes [Degree of spread of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.6 KB)

Department of Veterans' Affairs file number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – government funding identifier, Department of Veterans' Affairs file number AAXXNNNNA
<i>METeOR identifier:</i>	339127
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 31/08/2007
<i>Definition:</i>	A unique personal identifier issued to a veteran by the Department of Veterans' Affairs.
Data Element Concept:	Person – government funding identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	AAXXNNNN[A]
<i>Maximum character length:</i>	9

Collection and usage attributes

<i>Guide for use:</i>	<p>1st character is the state code (an alphabetic character) - N, V, Q, W, S or T for the appropriate state/territory. Australian Capital Territory is included in New South Wales (N) and Northern Territory with South Australia (S).</p> <p>Next 7 characters are the file number, made up of: War code + numeric digits, where: if War code is 1 alphabetic character, add 6 numeric characters (ANNNNNN) Where there is no war code as is the case with World War 1 veterans, insert a blank and add 6 numeric characters (NNNNNN) if War code is 2 alphabetic characters, add 5 numeric characters (AANNNNN) if War code is 3 alphabetic characters, add 4 numeric characters (AAANNNN)</p> <p>The 9th character is the segment link. For dependents of veterans, the 9th character is always an alphabetic character. The alphabetic code is generated in the order by which the cards are issued. For example A, B, C, D etc.</p> <p>CAUTIONARY NOTE: For veterans the 9th character is left blank</p>
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Data element attributes

Collection and usage attributes

Collection methods:

The Department of Veterans' Affairs file number should only be collected from persons eligible to receive health services that are to be funded by the DVA. The number may be reported to the appropriate government agency to reconcile payment for the service provided.

DVA card number:

This number is the digitised version of the file number. If paper claims are optically scanned by the Health Insurance Commission, the digitised version of the file number is picked up by the scanner and converted to the normal file number format. For manual claims, the gold and white cards may be used in conjunction with the data element and an imprinter. This method records the DVA file number and other card details on a manual voucher.

The data should not be used by private sector organisations for any purpose unless specifically authorised by law. For example, private sector organisations should not use the DVA file number for data linking unless specifically authorised by relevant privacy legislation.

This number must be recorded by a service provider each time a service is provided to a person who holds the entitlement for reimbursement purposes.

Comments:

All veterans and veteran community clients are issued with a DVA file number. The veteran community may access many different benefits, ranging from pensions to health services, through their DVA file number.

Note that Veterans may have a Medicare card number and a Department of Veterans Affairs (DVA) number or only a DVA number.

DVA has three (3) types of health cards:

- Gold Card
- White Card
- Repatriation Pharmaceutical Benefits Card.

Each card indicates, to the health provider, the level of health services the holder is eligible for, at the DVA expense.

The Gold card enables the holder to access a comprehensive range of health care and related services, for all conditions, whether they are related to war service or not.

The White card enables the holder to access health care and associated services for war or service-related conditions. Veterans of Australian forces may also be issued this card to receive treatment for malignant cancer, pulmonary tuberculosis and post traumatic stress disorder and, for Vietnam veterans only, anxiety or depression, irrespective of whether these conditions are related to war service or not.

The white card holders are eligible to receive, for specific conditions, treatment from registered medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA has arrangements.

A white card is also issued to eligible ex-service personnel who are from other countries, which enter into arrangements with the Australian government for the treatment of the conditions that these countries accept as war related.

When a gold/white card holder accesses health services at DVA expense, the DVA File Number is critical and should be used. The person's Medicare card number is not required or relevant.

It should be noted that there are a number of gold card holders who do not have a Medicare card.

The Repatriation Pharmaceutical Benefits card is an orange coloured card issued to eligible veterans and merchant mariners from Britain and the Commonwealth and other allied countries. This card enables the holder to access the range of pharmaceutical items available under the Repatriation Pharmaceutical Benefits Scheme. It does not provide access to other health services.

Source and reference attributes

Origin:

Department of Veterans' Affairs

Relational attributes

Related metadata references:

Supersedes [Person – government funding identifier, Department of Veterans' Affairs file number AAXNNNN\[A\]](#) Health,
Superseded 29/11/2006

Department of Veterans' Affairs patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – funding eligibility indicator (Department of Veterans Affairs), code N
<i>METeOR identifier:</i>	270092
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether an eligible person's charges for this hospital admission are met by the Department of Veterans' Affairs (DVA), as represented by a code.
<i>Context:</i>	Health services
<i>Data Element Concept:</i>	Episode of care – funding eligibility indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Refer to the Veterans' Entitlements Act 1986 for details of eligible DVA beneficiaries.
<i>Collection methods:</i>	Whether or not charges for this episode of care are met by the DVA is routinely established as part of hospital admission processes.
<i>Comments:</i>	<p>Eligible veterans and war widow/widowers can receive free treatment at any public hospital, former Repatriation Hospitals (RHs) or a Veteran Partnering (VP) contracted private hospital as a private patient in a shared ward, with the doctor of their choice. Admission to a public hospital does not require prior approval from the DVA.</p> <p>When treatment cannot be provided within a reasonable time in the public health system at a former RH or a private VP hospital, there is a system of contracted non-VP private hospitals which will provide care.</p> <p>Admission to a contracted private hospital requires prior financial authorisation from DVA. Approval may be given to</p>

attend a non-contracted private hospital when the service is not available at a public or contracted non-VP private hospital.

In an emergency a Repatriation patient can be admitted to the nearest hospital, public or private, without reference to DVA.

If an eligible veteran or war widow/widower chooses to be treated under Veterans' Affairs arrangements, which includes obtaining prior approval for non-VP private hospital care, DVA will meet the full cost of their treatment.

To assist in analyses of utilisation and health care funding.

Relational attributes

Related metadata references:

Supersedes [Department of Veterans' Affairs patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.9 KB)

Implementation in Data Set Specifications:

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Dependency in activities of daily living—bathing

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dependency in activities of daily living (bathing), code N
<i>METeOR identifier:</i>	270413
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a person’s need for assistance with bathing, as represented by a code.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – dependency in activities of daily living

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Independent</td></tr><tr><td>2</td><td>Requires observation or rare physical assistance</td></tr><tr><td>3</td><td>Cannot perform the activity without some assistance</td></tr><tr><td>4</td><td>Full assistance required (totally dependent)</td></tr></tbody></table>	Value	Meaning	1	Independent	2	Requires observation or rare physical assistance	3	Cannot perform the activity without some assistance	4	Full assistance required (totally dependent)
Value	Meaning										
1	Independent										
2	Requires observation or rare physical assistance										
3	Cannot perform the activity without some assistance										
4	Full assistance required (totally dependent)										

Data element attributes

Collection and usage attributes

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

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—bed mobility

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dependency in activities of daily living (bed mobility), code N
<i>METeOR identifier:</i>	270416
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the level of a person’s need for assistance with bed mobility, as represented by a code.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – dependency in activities of daily living

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Independent</td></tr><tr><td>2</td><td>Requires observation or rare physical assistance</td></tr><tr><td>3</td><td>Cannot perform the activity without some assistance</td></tr><tr><td>4</td><td>Full assistance required (totally dependent) - a hoist is used</td></tr><tr><td>5</td><td>2 persons physical assist is required</td></tr></tbody></table>	Value	Meaning	1	Independent	2	Requires observation or rare physical assistance	3	Cannot perform the activity without some assistance	4	Full assistance required (totally dependent) - a hoist is used	5	2 persons physical assist is required
Value	Meaning												
1	Independent												
2	Requires observation or rare physical assistance												
3	Cannot perform the activity without some assistance												
4	Full assistance required (totally dependent) - a hoist is used												
5	2 persons physical assist is required												

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available,
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such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores. Code 4: A hoist is used. Code 5: 2 persons physical assist is required.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—bladder continence

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dependency in activities of daily living (bladder continence), code N
<i>METeOR identifier:</i>	270417
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the level of a person’s bladder continence, as represented by a code.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – dependency in activities of daily living

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Continent of urine (includes independence in use of device)</td></tr><tr><td>2</td><td>Incontinent less than daily</td></tr><tr><td>3</td><td>Incontinent once per 24 hour period</td></tr><tr><td>4</td><td>Incontinent 2-6 times per 24 hour period</td></tr><tr><td>5</td><td>Incontinent more than 6 times per 24 hour period</td></tr><tr><td>6</td><td>Incontinent more than once at night only</td></tr></tbody></table>	Value	Meaning	1	Continent of urine (includes independence in use of device)	2	Incontinent less than daily	3	Incontinent once per 24 hour period	4	Incontinent 2-6 times per 24 hour period	5	Incontinent more than 6 times per 24 hour period	6	Incontinent more than once at night only
Value	Meaning														
1	Continent of urine (includes independence in use of device)														
2	Incontinent less than daily														
3	Incontinent once per 24 hour period														
4	Incontinent 2-6 times per 24 hour period														
5	Incontinent more than 6 times per 24 hour period														
6	Incontinent more than once at night only														

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc. Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.
<i>Collection methods:</i>	Commencement of care episode (there may be several visits in which assessment data are gathered).
<i>Comments:</i>	There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use. The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Council of Community Nursing Services
<i>Reference documents:</i>	ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

<i>Related metadata references:</i>	Supersedes Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.7 KB)
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Dependency in activities of daily living—bowel continence

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dependency in activities of daily living (bowel continence), code N
<i>METeOR identifier:</i>	270418
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the level of a person’s bowel continence, as represented by a code.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – dependency in activities of daily living

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Continent of faeces (includes independence in use of device)</td></tr><tr><td>2</td><td>Incontinent less than daily</td></tr><tr><td>3</td><td>Incontinent once per 24 hour period</td></tr><tr><td>4</td><td>Incontinent regularly, more than once per 24 hour period</td></tr><tr><td>5</td><td>Incontinent more than once at night only</td></tr></tbody></table>	Value	Meaning	1	Continent of faeces (includes independence in use of device)	2	Incontinent less than daily	3	Incontinent once per 24 hour period	4	Incontinent regularly, more than once per 24 hour period	5	Incontinent more than once at night only
Value	Meaning												
1	Continent of faeces (includes independence in use of device)												
2	Incontinent less than daily												
3	Incontinent once per 24 hour period												
4	Incontinent regularly, more than once per 24 hour period												
5	Incontinent more than once at night only												

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available,
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such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—day-time technical nursing care requirement

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – technical nursing care requirement (day-time), total minutes NNN
<i>METeOR identifier:</i>	270420
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a person’s need for day-time technical nursing care per week measured in minutes.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – technical nursing care requirement

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning
	1 No technical care requirements
<i>Unit of measure:</i>	Minute (m)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the minutes of day-time technical care required per week. Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these
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activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

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

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—dressing

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dependency in activities of daily living (dressing), code N
<i>METeOR identifier:</i>	270414
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a person’s need for assistance with dressing, as represented by a code.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – dependency in activities of daily living

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Independent</td></tr><tr><td>2</td><td>Requires observation or rare physical assistance</td></tr><tr><td>3</td><td>Cannot perform the activity without some assistance</td></tr><tr><td>4</td><td>Full assistance required (totally dependent)</td></tr></tbody></table>	Value	Meaning	1	Independent	2	Requires observation or rare physical assistance	3	Cannot perform the activity without some assistance	4	Full assistance required (totally dependent)
Value	Meaning										
1	Independent										
2	Requires observation or rare physical assistance										
3	Cannot perform the activity without some assistance										
4	Full assistance required (totally dependent)										

Data element attributes

Collection and usage attributes

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

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—eating

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dependency in activities of daily living (eating), code N
<i>METeOR identifier:</i>	270415
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a person’s need for assistance with eating, as represented by a code.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – dependency in activities of daily living

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Independent</td></tr><tr><td>2</td><td>Requires observation or rare physical assistance</td></tr><tr><td>3</td><td>Cannot perform the activity without some assistance</td></tr><tr><td>4</td><td>Full assistance required (totally dependent)</td></tr><tr><td>5</td><td>Tube-fed only</td></tr></tbody></table>	Value	Meaning	1	Independent	2	Requires observation or rare physical assistance	3	Cannot perform the activity without some assistance	4	Full assistance required (totally dependent)	5	Tube-fed only
Value	Meaning												
1	Independent												
2	Requires observation or rare physical assistance												
3	Cannot perform the activity without some assistance												
4	Full assistance required (totally dependent)												
5	Tube-fed only												

Data element attributes

Collection and usage attributes

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

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—evening technical nursing care requirement

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – technical nursing care requirement (evening), total minutes NNN
<i>METeOR identifier:</i>	270421
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's need for evening technical nursing care per week measured in minutes.
<i>Context:</i>	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – technical nursing care requirement

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning
	1 No technical care requirements
<i>Unit of measure:</i>	Minute (m)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the minutes of evening technical care required per week. Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the community nursing setting, carers may undertake some of these
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activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

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

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—extra surveillance

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dependency in activities of daily living (extra surveillance), code N
<i>METeOR identifier:</i>	270419
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a person’s need for additional individual attention and/or planned intervention in carrying out activities of daily living, as represented by a code.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – dependency in activities of daily living

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>No additional attention required</td></tr><tr><td>2</td><td>Less than 30 minutes individual attention per day</td></tr><tr><td>3</td><td>More than 30 and more than or equal to 90 minutes individual attention per day</td></tr><tr><td>4</td><td>Requires at least two hours intervention per week on an episodic basis</td></tr><tr><td>5</td><td>More than 90 minutes but less than almost constant individual attention</td></tr><tr><td>6</td><td>Requires almost constant individual attention</td></tr><tr><td>7</td><td>Cannot be left alone at all</td></tr></tbody></table>	Value	Meaning	1	No additional attention required	2	Less than 30 minutes individual attention per day	3	More than 30 and more than or equal to 90 minutes individual attention per day	4	Requires at least two hours intervention per week on an episodic basis	5	More than 90 minutes but less than almost constant individual attention	6	Requires almost constant individual attention	7	Cannot be left alone at all
Value	Meaning																
1	No additional attention required																
2	Less than 30 minutes individual attention per day																
3	More than 30 and more than or equal to 90 minutes individual attention per day																
4	Requires at least two hours intervention per week on an episodic basis																
5	More than 90 minutes but less than almost constant individual attention																
6	Requires almost constant individual attention																
7	Cannot be left alone at all																

Data element attributes

Collection and usage attributes

Guide for use:

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

- aggressiveness
- wandering
- impaired memory or attention
- disinhibition and other cognitive impairment.

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—infrequent technical nursing care requirement

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – technical nursing care requirement (infrequent), total minutes NNN
<i>METeOR identifier:</i>	270423
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person’s need for infrequent technical nursing care per month measured in minutes.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – technical nursing care requirement

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning
	1 No technical care requirements
<i>Unit of measure:</i>	Minute (m)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the minutes of infrequent technical care required per month. Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the
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community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

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

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—mobility

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dependency in activities of daily living (mobility), code N
<i>METeOR identifier:</i>	270410
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a person’s need for assistance with mobility, as represented by a code.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – dependency in activities of daily living

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Independent</td></tr><tr><td>2</td><td>Requires observation or rare physical assistance</td></tr><tr><td>3</td><td>Cannot perform the activity without some assistance</td></tr><tr><td>4</td><td>Full assistance required (totally dependent)</td></tr></tbody></table>	Value	Meaning	1	Independent	2	Requires observation or rare physical assistance	3	Cannot perform the activity without some assistance	4	Full assistance required (totally dependent)
Value	Meaning										
1	Independent										
2	Requires observation or rare physical assistance										
3	Cannot perform the activity without some assistance										
4	Full assistance required (totally dependent)										

Data element attributes

Collection and usage attributes

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

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCN

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—night-time technical nursing care requirement

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – technical nursing care requirement (night-time), total minutes NNN
<i>METeOR identifier:</i>	270422
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's need for night-time technical nursing care per week measured in minutes.
<i>Context:</i>	Dependency reflects the person's need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person's functional status and care allocated is not direct. The involvement of 'informal' carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a 'standard' view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency 'measure' may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – technical nursing care requirement

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning
	1 No technical care requirements
<i>Unit of measure:</i>	Minute (m)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the minutes of night-time technical care required per week. Technical care refers to technical tasks and procedures for which nurses receive specific education and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. In the
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community nursing setting, carers may undertake some of these activities within, and under surveillance, of a nursing care-plan. Some examples of technical care activities are:

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

Services may elect to adopt the measures as defined in this metadata item or adopt one of the following tools now available, such as the Bryan, Barthel, Katz, Functional Independence Measure, Resource Utilisation Groups etc.

Each agency should seek to adopt a dependency classification, which can be mapped to other classifications and produce equivalent scores.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—toileting

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dependency in activities of daily living (toileting), code N
<i>METeOR identifier:</i>	270411
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a person’s need for assistance with toileting, as represented by a code.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – dependency in activities of daily living

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Independent</td></tr><tr><td>2</td><td>Requires observation or rare physical assistance</td></tr><tr><td>3</td><td>Cannot perform the activity without some assistance</td></tr><tr><td>4</td><td>Full assistance required (totally dependent)</td></tr></tbody></table>	Value	Meaning	1	Independent	2	Requires observation or rare physical assistance	3	Cannot perform the activity without some assistance	4	Full assistance required (totally dependent)
Value	Meaning										
1	Independent										
2	Requires observation or rare physical assistance										
3	Cannot perform the activity without some assistance										
4	Full assistance required (totally dependent)										

Data element attributes

Collection and usage attributes

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

Collection methods:

Commencement of care episode (there may be several visits in which assessment data is gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in the Guide for Use.

The Person - Dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Reference documents:

ACCNS 1997. Community nursing minimum data set Australian version 2.0: data dictionary and guidelines. Melbourne: ACCNS.

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Dependency in activities of daily living—transferring

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dependency in activities of daily living (transferring), code N
<i>METeOR identifier:</i>	270412
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a person’s need for assistance with transferring, as represented by a code.
<i>Context:</i>	Dependency reflects the person’s need, rather than the actual service provision which addresses that need. This is essential information in the community environment, where the relationship between a person’s functional status and care allocated is not direct. The involvement of ‘informal’ carers, the possibility of resource allocation being driven by availability rather than need, and the vulnerability of system to inequity, all require a ‘standard’ view of the person. It is against this background that resource allocation and carer burden can then be monitored. It is important to distinguish between this view of dependency and that of the institutional system, where a dependency ‘measure’ may be used to predict or dictate staffing needs or to allocate funding.
Data Element Concept:	Person – dependency in activities of daily living

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Independent</td></tr><tr><td>2</td><td>Requires observation or rare physical assistance</td></tr><tr><td>3</td><td>Cannot perform the activity without some assistance</td></tr><tr><td>4</td><td>Full assistance required (totally dependent)</td></tr><tr><td>5</td><td>Person is bedfast</td></tr></tbody></table>	Value	Meaning	1	Independent	2	Requires observation or rare physical assistance	3	Cannot perform the activity without some assistance	4	Full assistance required (totally dependent)	5	Person is bedfast
Value	Meaning												
1	Independent												
2	Requires observation or rare physical assistance												
3	Cannot perform the activity without some assistance												
4	Full assistance required (totally dependent)												
5	Person is bedfast												

Data element attributes

Collection and usage attributes

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

Code 5: Person is bedfast.

Collection methods:

Commencement of care episode (there may be several visits in which assessment data are gathered).

Comments:

There are a significant number of dependency instruments in use in the community and institutional care. The Community Nursing Minimum Data Set Australia recommends the adoption of a dependency tool from a limited range of options as outlined in Guide for use.

The Person dependency in activities of daily living metadata items consist of a number of standard elements, which can be used to map to and/or score from the majority of dependency instruments.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Reference documents:

ACCNS 1997. Community nursing minimum data set Australia version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Dependency in activities of daily living, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.7 KB)

Diabetes status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – diabetes mellitus status, code NN
<i>METeOR identifier:</i>	270194
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether a person has or is at risk of diabetes, as represented by a code.
Data Element Concept:	Person – diabetes mellitus status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	String																				
<i>Format:</i>	NN																				
<i>Maximum character length:</i>	2																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Type 1 diabetes</td></tr><tr><td>02</td><td>Type 2 diabetes</td></tr><tr><td>03</td><td>Gestational diabetes mellitus (GDM)</td></tr><tr><td>04</td><td>Other (secondary diabetes)</td></tr><tr><td>05</td><td>Previous gestational diabetes mellitus (GDM)</td></tr><tr><td>06</td><td>Impaired fasting glucose (IFG)</td></tr><tr><td>07</td><td>Impaired glucose tolerance (IGT)</td></tr><tr><td>08</td><td>Not diagnosed with diabetes</td></tr><tr><td>09</td><td>Not assessed</td></tr></tbody></table>	Value	Meaning	01	Type 1 diabetes	02	Type 2 diabetes	03	Gestational diabetes mellitus (GDM)	04	Other (secondary diabetes)	05	Previous gestational diabetes mellitus (GDM)	06	Impaired fasting glucose (IFG)	07	Impaired glucose tolerance (IGT)	08	Not diagnosed with diabetes	09	Not assessed
Value	Meaning																				
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07	Impaired glucose tolerance (IGT)																				
08	Not diagnosed with diabetes																				
09	Not assessed																				
<i>Supplementary values:</i>	99 Not stated/inadequately described																				

Collection and usage attributes

<i>Guide for use:</i>	<p>Note that where there is a Gestational diabetes mellitus (GDM) or Previous GDM (i.e. permissible values 3 & 5) and a current history of Type 2 diabetes then record 'Code 2' Type 2 diabetes.</p> <p>This same principle applies where a history of either Impaired fasting glycaemia (IFG) or Impaired glucose tolerance (IGT) and a current history and Type 2 diabetes, then record 'Code 2' Type 2 diabetes.</p> <p>CODE 01 Type 1 diabetes</p> <p>Beta-cell destruction, usually leading to absolute insulin deficiency. Includes those cases attributed to an autoimmune process, as well as those with beta-cell destruction and who are prone to ketoacidosis for which neither an aetiology nor pathogenesis is known (idiopathic). It does not include those</p>
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forms of beta-cell destruction or failure to which specific causes can be assigned (e.g. cystic fibrosis, mitochondrial defects). Some subjects with Type 1 diabetes can be identified at earlier clinical stages than 'diabetes mellitus'.

CODE 02 Type 2 diabetes

Type 2 includes the common major form of diabetes, which results from defect(s) in insulin secretion, almost always with a major contribution from insulin resistance.

CODE 03 Gestational diabetes mellitus (GDM)

GDM is a carbohydrate intolerance resulting in hyperglycaemia of variable severity with onset or first recognition during pregnancy. The definition applies irrespective of whether or not insulin is used for treatment or the condition persists after pregnancy. Diagnosis is to be based on the Australian Diabetes in Pregnancy Society (ADIPS) Guidelines.

CODE 04 Other (secondary diabetes)

This categorisation include less common causes of diabetes mellitus, but are those in which the underlying defect or disease process can be identified in a relatively specific manner. They include, for example, genetic defects of beta-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, endocrinopathies, drug or chemical-induced, infections, uncommon forms of immune-mediated diabetes, other genetic syndromes sometimes associated with diabetes.

CODE 05 Previous GDM

Where the person has a history of GDM.

CODE 06 Impaired fasting glycaemia (IFG)

IFG or 'non-diabetic fasting hyperglycaemia' refers to fasting glucose concentrations, which are lower than those required to diagnose diabetes mellitus but higher than the normal reference range. An individual is considered to have IFG if they have a fasting plasma glucose of 6.1 or greater and less than 7.0 mmol/L if challenged with an oral glucose load, they have a fasting plasma glucose concentration of 6.1 mmol/L or greater, but less than 7.0 mmol/L, AND the 2 hour value in the Oral Glucose Tolerance Test (OGTT) is less than 7.8 mmol/L.

CODE 07 Impaired glucose tolerance (IGT)

IGT is categorised as a stage in the natural history of disordered carbohydrate metabolism; subjects with IGT have an increased risk of progressing to diabetes. IGT refers to a metabolic state intermediate between normal glucose homeostasis and diabetes. Those individuals with IGT manifest glucose intolerance only when challenged with an oral glucose load. IGT is diagnosed if the 2 hour value in the OGTT is greater than 7.8 mmol/L. and less than 11.1 mmol/L AND the fasting plasma glucose concentration is less than 7.0 mmol/L.

CODE 08 Not diagnosed with diabetes

The subject has no known diagnosis of Type 1, Type 2, GDM, Previous GDM, IFG, IGT or Other (secondary diabetes).

CODE 09 Not assessed

The subject has not had their diabetes status assessed.

CODE 99 Not stated/inadequately described

This code is for unknown or information unavailable.

Collection methods:

The diagnosis is derived from and must be substantiated by clinical documentation.

Source and reference attributes

Origin:

Developed based on Definition, Diagnosis and Classification of Diabetes Mellitus and its Complications Part 1: Diagnosis and Classifications of Diabetes Mellitus Provisional Report of a World Health Organization Consultation (Alberti & Zimmet 1998).

Data element attributes

Collection and usage attributes

Collection methods:

Diabetes (clinical):

A type of diabetes should be recorded and coded for each episode of patient care.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

National Diabetes Data Working Group

Relational attributes

Related metadata references:

Supersedes [Diabetes status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (27.3 KB)

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Diabetes therapy type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – diabetes therapy type, code NN
<i>METeOR identifier:</i>	270236
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of diabetes therapy the person is currently receiving, as represented by a code.
Data Element Concept:	Person – diabetes therapy type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																										
<i>Data type:</i>	String																										
<i>Format:</i>	NN																										
<i>Maximum character length:</i>	2																										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Diet and exercise only</td></tr><tr><td>02</td><td>Oral hypoglycaemic - sulphonylurea only</td></tr><tr><td>03</td><td>Oral hypoglycaemic - biguanide (eg metformin) only</td></tr><tr><td>04</td><td>Oral hypoglycaemic - alpha-glucosidase inhibitor only</td></tr><tr><td>05</td><td>Oral hypoglycaemic - thiazolidinedione only</td></tr><tr><td>06</td><td>Oral hypoglycaemic - meglitinide only</td></tr><tr><td>07</td><td>Oral hypoglycaemic - combination (eg biguanide & sulphonylurea)</td></tr><tr><td>08</td><td>Oral hypoglycaemic - other</td></tr><tr><td>09</td><td>Insulin only</td></tr><tr><td>10</td><td>Insulin plus oral hypoglycaemic</td></tr><tr><td>98</td><td>Nil - not currently receiving diabetes treatment</td></tr><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	01	Diet and exercise only	02	Oral hypoglycaemic - sulphonylurea only	03	Oral hypoglycaemic - biguanide (eg metformin) only	04	Oral hypoglycaemic - alpha-glucosidase inhibitor only	05	Oral hypoglycaemic - thiazolidinedione only	06	Oral hypoglycaemic - meglitinide only	07	Oral hypoglycaemic - combination (eg biguanide & sulphonylurea)	08	Oral hypoglycaemic - other	09	Insulin only	10	Insulin plus oral hypoglycaemic	98	Nil - not currently receiving diabetes treatment	99	Not stated/inadequately described
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01	Diet and exercise only																										
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08	Oral hypoglycaemic - other																										
09	Insulin only																										
10	Insulin plus oral hypoglycaemic																										
98	Nil - not currently receiving diabetes treatment																										
99	Not stated/inadequately described																										
<i>Supplementary values:</i>																											

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 01 Diet & exercise only</p> <p>This code includes the options of generalised prescribed diet; avoid added sugar/simple carbohydrates (CHOs); low joule diet; portion exchange diet and uses glycaemic index and a recommendation for increased exercise.</p> <p>CODE 98 Nil - not currently receiving diabetes treatment</p> <p>This code is used when there is no current diet, tablets or insulin therapy(ies).</p>
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CODE 99 Not stated/inadequately described
Use this code when missing information.

Data element attributes

Collection and usage attributes

Collection methods: To be collected at the commencement of treatment and at each review.

Comments: In settings where the monitoring of a person's health is ongoing and where management can change over time (such as general practice), the Service contact – service contact date, DDMMYYYY should be recorded.

The main use of this data element is to enable categorisation of management regimes against best practice for diabetes.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group
Cardiovascular Data Working Group

Reference documents: Berkow R, editor. The Merck Manual. 16th ed. Rahway (New Jersey, USA): Merck Research Laboratories; 1992.

Relational attributes

Related metadata references: Supersedes [Diabetes therapy type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.1 KB)

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Diagnosis related group

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – diagnosis related group, code (AR-DRG v 6) ANNA
<i>METeOR identifier:</i>	391295
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	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

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

Data element attributes

Collection and usage attributes

<i>Comments:</i>	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.
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Source and reference attributes

<i>Origin:</i>	National Centre for Classification in Health
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Relational attributes

<i>Related metadata references:</i>	See also Episode of admitted patient care – major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009 Supersedes Episode of admitted patient care – diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009 Is formed using Person – sex, code N Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006 Is formed using Episode of admitted patient care – separation date, DDMMYYYY Health, Standard 01/03/2005 Is formed using Episode of admitted patient care – separation mode, code N Health, Standard 01/03/2005
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Is formed using [Episode of admitted patient care – intended length of hospital stay, code N](#) Health, Standard 01/03/2005

Is formed using [Episode of admitted patient care – admission date, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Person – date of birth, DDMMYYYY](#) Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Is formed using [Person – weight \(measured\), total grams NNNN](#) Health, Standard 01/03/2005

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 care – mental health legal status, code N](#) Health, Standard 01/03/2005

Is formed using [Episode of admitted patient care – procedure, code \(ACHI 7th edn\) NNNNN-NN](#) Health, Standard 22/12/2009

Is formed using [Episode of care – principal diagnosis, code \(ICD-10-AM 7th edn\) ANN{.N\[N\]}](#) Health, Standard 22/12/2009

Is formed using [Episode of care – additional diagnosis, code \(ICD-10-AM 7th edn\) ANN{.N\[N\]}](#) Health, Standard 22/12/2009

Implementation in Data Set Specifications:

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Difficulty with activities

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – level of difficulty with activities in life areas, code (ICF 2001) N
<i>METeOR identifier:</i>	320120
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The level of difficulty a person has in performing the tasks and actions involved in specified life areas, as represented by a code.
<i>Context:</i>	Human functioning and disability
<i>Data Element Concept:</i>	Person – level of difficulty with activities in a life area

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001	
<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	0	No difficulty
	1	Mild difficulty
	2	Moderate difficulty
	3	Severe difficulty
	4	Complete difficulty
<i>Supplementary values:</i>	8	Not specified
	9	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.</p> <p>In the context of health, an activity is the execution of a task or action by an individual. Activity limitations are difficulties an individual may have in executing an activity.</p> <p>Difficulties with activities can arise when there is a qualitative or quantitative alteration in the way in which these activities are carried out. Difficulty includes matters such as 'with pain', 'time taken', 'number of errors', 'clumsiness', 'modification of manner in which an activity is performed' e.g. sitting to get dressed instead of standing. 'Difficulty' is a combination of the frequency</p>
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with which the problem exists, the duration of the problem and the intensity of the problem. Activity limitations are assessed against a generally accepted population standard, relative to cultural and social expectations.

Activity limitation varies with the environment and is assessed in relation to a particular environment; the absence or presence of **assistance**, including aids and equipment, is an aspect of the environment.

The user will select the code that most closely summarises, in terms of duration, frequency, manner or outcome, the level of difficulty of the person for whom the data is recorded.

CODE 0 No difficulty in this life area

Is used when there is no difficulty in performing this activity. This scale has a margin of error of 5%. [0-4%]

CODE 1 Mild difficulty

Is recorded for example, when the level of difficulty is below the threshold for medical intervention, the difficulty is experienced less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days. [5-24%]

CODE 2 Moderate difficulty

Is used for example when the level of difficulty is experienced less than 50% of the time and/or with a significant, but moderate effect on functioning (Up to half the scale of total performance) which may happen regularly over the last 30 days. [25-49%]

CODE 3 Severe difficulty

Is used for example when performance in this life area can be achieved, but with only extreme difficulty, and/or with an extreme effect on functioning which may happen often over the last 30 days. [50-95%]

CODE 4 Complete difficulty

Is used when the person can not perform in this life area due of the difficulty in doing so. This scale has a margin of error of 5%. [96-100%]

CODE 8 Not specified

Is used where a person has difficulty with activities in a life area but there is insufficient information to use codes 0-4.

CODE 9 Not applicable

Is used where a life area is not applicable to this person, e.g. domestic life for a child under 5.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.cfm>

Data element attributes

Collection and usage attributes

Guide for use:

This data element, in conjunction with Person – activities and participation life area, code (ICF 2001) AN[NNN], indicates the presence and extent of activity limitation in a given domain of activity.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also [Person – activity and participation life area, code \(ICF 2001\) AN\[NNN\]](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

[Activities and Participation cluster](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Division of General Practice number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Division of general practice – organisation identifier, NNN
<i>METeOR identifier:</i>	270014
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The unique identifier for the Division of general practice number as designated by the Commonwealth Government of Australia. Each separately administered Division of general practice has a unique identifying number.
Data Element Concept:	Division of general practice – organisation identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular Data Working Group
<i>Origin:</i>	The actual Division of General Practice numbers can be obtained by selecting the individual State or Territory from the <i>Divisions Directory</i> found within the Australian Division of General Practice website

Relational attributes

<i>Related metadata references:</i>	Supersedes Division of general practice number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.2 KB)
<i>Implementation in Data Set Specifications:</i>	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

Dyslipidaemia treatment indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – dyslipidaemia treatment with anti-lipid medication indicator (current), code N
<i>METeOR identifier:</i>	302440
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether a person is being currently treated for dyslipidaemia using anti-lipid medication, as represented by a code.
Data Element Concept:	Person – dyslipidaemia treatment with anti-lipid medication indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if a person is being treated for dyslipidaemia using anti-lipid medication. CODE 2 No: Record if a person is not being treated for dyslipidaemia using anti-lipid medication.
<i>Collection methods:</i>	Ask the individual if he/she is currently treated with anti-lipid medication. Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Person – dyslipidaemia treatment status \(anti-lipid medication\), code N](#) Health, Superseded 21/09/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

ECG—Q waves indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person—electrocardiogram Q waves indicator, yes/no code N
<i>METeOR identifier:</i>	347711
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An indicator of whether Q waves are present on a person's follow-up electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Person— electrocardiogram Q waves indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Code 1 Yes Record if Q waves are identified on the follow-up electrocardiogram. Code 2 No Record if no Q waves are identified on the follow-up electrocardiogram.
<i>Collection methods:</i>	Do not record the presence of Q waves for the initial ECG. This data element should only be collected for follow-up ECGs.

Relational attributes

<i>Related metadata references:</i>	See also Electrocardiogram—new Q waves indicator, yes/no code N Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Electrocardiogram cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i>

Record for all follow up electrocardiograms performed after the initial electrocardiogram.

Electrocardiogram—new Q waves indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Electrocardiogram—new Q waves indicator, yes/no code N
<i>Synonymous names:</i>	ECG - new Q waves
<i>METeOR identifier:</i>	343902
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Whether the Q waves identified on a person's follow-up electrocardiogram (ECG) is new, as represented by a code.
Data Element Concept:	Electrocardiogram—new Q waves indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						
<i>Supplementary values:</i>	9 Not stated/inadequately described						

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes (New Q waves) Use this code where the follow-up ECG identifies Q waves ≥ 0.03 seconds in width and ≥ 1 mm (0.1mV) in depth in at least 2 contiguous leads that were <u>not</u> seen on the initial ECG CODE 2 No (Pre-existing Q waves) Use this code where the follow-up ECG identifies Q waves ≥ 0.03 seconds in width and ≥ 1 mm (0.1mV) in depth in at least 2 contiguous leads that were <u>already</u> seen on the initial ECG CODE 9 Not stated/inadequately described Includes unknown
<i>Collection methods:</i>	Do not record whether the Q waves are new or not on the initial ECG. This data element should only be recorded for follow-up ECGs.

Comments:

This data element identifies if new Q waves are present on the follow-up ECG. This information is valuable in coding transmural myocardial infarction.

Relational attributes

Related metadata references:

See also [Person—electrocardiogram Q waves indicator, yes/no code N](#) Health, Standard 01/10/2008

Implementation in Data Set Specifications:

[Electrocardiogram cluster](#) Health, Standard 01/10/2008

Conditional obligation:

Record if Q waves are present on the follow up electrocardiogram.

Electrocardiogram—ST-segment-elevation in lead V4R

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Electrocardiogram – ST-segment-elevation in lead V4R indicator, yes/no code N
<i>Synonymous names:</i>	ECG - ST-segment-elevation lead V4R
<i>METeOR identifier:</i>	343889
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An indicator of whether ST-segment-elevation of greater than or equal to 1mm (0.1mV) in lead V4R of the electrocardiogram (ECG) is present, as represented by a code.
Data Element Concept:	Electrocardiogram – electrocardiogram ST-segment-elevation in lead V4R indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes ST-segment-elevation \geq 1 mm (0.1 mV) in lead V4R CODE 2 No ST-segment-elevation in lead V4R of \leq 1 mm (0.1 mV) or no ST-segment-elevation in lead V4R CODE 9 Not stated/inadequately described Includes unknown
<i>Collection methods:</i>	The presence (or absence) of ST-segment elevation in lead V4R should be recorded when right-sided precordial leads are performed in the ECG.

Comments:

ST-segment elevation in lead V4R represents right ventricular infarction.

Relational attributes

Related metadata references:

See also [Electrocardiogram – lead V4R presence indicator, yes/no code N](#) Health, Standard 01/10/2008

Implementation in Data Set Specifications:

[Electrocardiogram cluster](#) Health, Standard 01/10/2008

Conditional obligation:

Record when lead V4R was performed on the electrocardiogram.

Electrocardiogram—lead V4R presence indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Electrocardiogram—lead V4R presence indicator, yes/no code N
<i>Synonymous names:</i>	ECG - lead V4R indicator
<i>METeOR identifier:</i>	349656
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An indicator of whether lead V4R was performed on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram—lead V4R presence indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Comments:</i>	<p>Lead V4R represents a lead placed on the chest aligned with the right mid-clavicular line, in the 5th intercostal space. The measurements from this lead can identify right ventricular infarction.</p> <p>Lead V4R should be performed in the context of inferior infarction, especially in the presence of haemodynamic compromise.</p>
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Relational attributes

<i>Related metadata references:</i>	See also Electrocardiogram – ST-segment-elevation in lead V4R indicator, yes/no code N Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Electrocardiogram cluster Health, Standard 01/10/2008

Electrocardiogram change location

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Electrocardiogram – change location, code N
<i>METeOR identifier:</i>	356835
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The area in which the change is located on the electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram – change location

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Inferior leads: II, III, aVF</td></tr><tr><td>2</td><td>Anterior leads: V1 to V4</td></tr><tr><td>3</td><td>Lateral leads: I, aVL, V5 to V6</td></tr><tr><td>4</td><td>True posterior: V1 V2</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Inferior leads: II, III, aVF	2	Anterior leads: V1 to V4	3	Lateral leads: I, aVL, V5 to V6	4	True posterior: V1 V2	9	Not stated/inadequately described
Value	Meaning												
1	Inferior leads: II, III, aVF												
2	Anterior leads: V1 to V4												
3	Lateral leads: I, aVL, V5 to V6												
4	True posterior: V1 V2												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Collection and usage attributes

<i>Guide for use:</i>	CODE 4 True posterior: V1 V2 True posterior is relevant only for tall R waves.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	More than one code may be recorded. Report in order of significance. Where a change is located in all leads of the ECG codes 1, 2 and 3 should be recorded. Record all codes that apply (code 9 is excluded from multiple coding).
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Person – electrocardiogram change location, code N](#) Health, Superseded 01/10/2008

[Electrocardiogram cluster](#) Health, Standard 01/10/2008

Electrocardiogram change type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Electrocardiogram – change type, code N
<i>METeOR identifier:</i>	356856
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of change to the heart rhythm seen on a person's electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram – change type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																						
<i>Data type:</i>	Number																						
<i>Format:</i>	NN																						
<i>Maximum character length:</i>	2																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>10</td><td>ST-segment-elevation \geq 1 mm (0.1 mV) in \geq 2 contiguous limb leads</td></tr><tr><td>11</td><td>ST-segment-elevation \geq 2 mm (0.2 mV) in \geq 2 contiguous chest leads</td></tr><tr><td>12</td><td>ST-segment depression \geq 0.5 mm (0.05 mV) in \geq 2 contiguous leads (includes reciprocal changes)</td></tr><tr><td>20</td><td>T-wave inversion \geq 2 mm (0.1 mV)</td></tr><tr><td>30</td><td>Significant Q waves</td></tr><tr><td>40</td><td>Left bundle-branch block (BBB)</td></tr><tr><td>41</td><td>Right bundle-branch block (BBB)</td></tr><tr><td>42</td><td>Indeterminate bundle-branch block (BBB)</td></tr><tr><td>90</td><td>Non specific</td></tr><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	10	ST-segment-elevation \geq 1 mm (0.1 mV) in \geq 2 contiguous limb leads	11	ST-segment-elevation \geq 2 mm (0.2 mV) in \geq 2 contiguous chest leads	12	ST-segment depression \geq 0.5 mm (0.05 mV) in \geq 2 contiguous leads (includes reciprocal changes)	20	T-wave inversion \geq 2 mm (0.1 mV)	30	Significant Q waves	40	Left bundle-branch block (BBB)	41	Right bundle-branch block (BBB)	42	Indeterminate bundle-branch block (BBB)	90	Non specific	99	Not stated/inadequately described
Value	Meaning																						
10	ST-segment-elevation \geq 1 mm (0.1 mV) in \geq 2 contiguous limb leads																						
11	ST-segment-elevation \geq 2 mm (0.2 mV) in \geq 2 contiguous chest leads																						
12	ST-segment depression \geq 0.5 mm (0.05 mV) in \geq 2 contiguous leads (includes reciprocal changes)																						
20	T-wave inversion \geq 2 mm (0.1 mV)																						
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41	Right bundle-branch block (BBB)																						
42	Indeterminate bundle-branch block (BBB)																						
90	Non specific																						
99	Not stated/inadequately described																						
<i>Supplementary values:</i>																							

Collection and usage attributes

<i>Guide for use:</i>	ST-segment changes CODE 10 ST-segment-elevation \geq 1 mm (0.1 mV) in \geq 2 contiguous limb leads ST-segment-elevation indicates greater than or equal to 1 mm (0.1 mV) elevation in 2 or more contiguous limb leads. CODE 11 ST-segment-elevation \geq 2 mm (0.2 mV) in \geq 2 contiguous chest leads ST-segment-elevation indicates greater than or equal to 2 mm (0.2 mV) elevation in 2 or more contiguous chest leads.
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CODE 12 ST-segment depression ≥ 0.5 mm (0.05 mV) in ≥ 2 contiguous leads (includes reciprocal changes)

ST-segment depression of at least 0.5 mm (0.05 mV) in 2 or more contiguous leads (includes reciprocal changes).

T-wave changes

CODE 20 T-wave inversion ≥ 2 mm (0.2 mV)

T-wave inversion of at least 2 mm (0.2 mV) including inverted T waves that are not indicative of acute MI.

Q wave changes

CODE 30 Significant Q waves

Q waves refer to the presence of Q waves that are greater than or equal to 0.03 seconds in width and greater than or equal to 1 mm (0.1 mV) in depth in at least 2 contiguous leads.

Bundle-branch block changes

CODE 40 Left bundle branch block (BBB)

Diffuse left bundle-branch block pattern.

CODE 41 Right bundle-branch block (BBB)

Diffuse right bundle-branch block pattern.

CODE 42 Indeterminate bundle-branch block (BBB)

Bundle-branch block pattern identified, but left or right location is unclear.

CODE 90 Non-specific

Changes not meeting the above criteria.

CODE 99 Not stated/inadequately described

Includes unknown.

Data element attributes

Collection and usage attributes

Guide for use:

More than one code may be recorded.

Record all that apply (codes 90 and 99 are excluded from multiple coding).

Collection methods:

Where codes 40, 41 or 42 are recorded Electrocardiogram - bundle-branch block status, code N must also be recorded.

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Relational attributes

Related metadata references:

Supersedes [Person – electrocardiogram change type, code N](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

[Electrocardiogram cluster](#) Health, Standard 01/10/2008

Electronic communication address (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – electronic communication address, text [X(250)]
<i>Synonymous names:</i>	Electronic communication details
<i>METeOR identifier:</i>	287469
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A unique combination of characters used as input to electronic communication equipment for the purpose of contacting a person, as represented by text.
Data Element Concept:	Person (address) – electronic communication address

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(250)]
<i>Maximum character length:</i>	250

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and usage code assigned.</p> <p>Universal Resource Locator (URL)</p> <p>One form of electronic address used as a locator for an internet-based web site.</p> <p>Example: http://www.aihw.gov.au This is the full address, however, it is not essential to record 'http://www' as the commonly used internet browsers assume these characters are included. Therefore, the URL address could be recorded as 'aihw.gov.au'.</p> <p>Email addresses</p> <p>Email addresses are a combination of a username and an internet domain name (URL) joined by an @ symbol. The use of the full URL is not valid in an email address.</p> <p>Example: myuserid@bigpond.net.au</p> <p>Telephone numbers</p> <ul style="list-style-type: none">Record the prefix plus telephone number. For example, 08 8226 6000 or 0417 123456.
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- Do not record punctuation in telephone numbers. For example, (08) 8226 6000 or 08-8226 6000 would not be correct.

Unknown contact details

Leave the field blank.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

AS 4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

Reference documents:

AS5017 Health Care Client Identification, 2002, Sydney:
Standards Australia

AS4846 Health Care Provider Identification, 2006, Sydney:
Standards Australia

Relational attributes

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Electronic communication address (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – electronic communication address, text [X(250)]
<i>METeOR identifier:</i>	287480
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A unique combination of characters used as input to electronic communication equipment for the purpose of contacting an organisation, as represented by text.
Data Element Concept:	Service provider organisation (address) – electronic communication address

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(250)]
<i>Maximum character length:</i>	250

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and usage code assigned.</p> <p>Universal Resource Locator (URL)</p> <p>One form of electronic address used as a locator for an internet-based web site.</p> <p>Example: http://www.aihw.gov.au This is the full address, however, it is not essential to record 'http://www' as the commonly used internet browsers assume these characters are included. Therefore, the URL address could be recorded as 'aihw.gov.au'.</p> <p>Email addresses</p> <p>Email addresses are a combination of a username and an internet domain name (URL) joined by an @ symbol. The use of the full URL is not valid in an email address.</p> <p>Example: myuserid@bigpond.net.au</p> <p>Telephone numbers</p>
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Record the prefix plus telephone number. For example, 08 8226 6000 or 0417 123456.

Do not record punctuation in telephone numbers. For example, (08) 8226 6000 or 08-8226 6000 would not be correct.

Unknown contact details

Leave the field blank.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

AS 4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

AS5017 Health Care Client Identification, 2002, Sydney:
Standards Australia

In AS5017 this data element is represented by 'Telephone number (client)'. In AS4846 this data element is represented by 'Provider electronic communication details'. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Electronic communication medium (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – electronic communication medium, code N
<i>METeOR identifier:</i>	287519
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A type of communication mechanism used by a person, as represented by a code.
Data Element Concept:	Person (address) – electronic communication medium

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Telephone (excluding mobile telephone)</td></tr><tr><td>2</td><td>Mobile (cellular) telephone</td></tr><tr><td>3</td><td>Facsimile machine</td></tr><tr><td>4</td><td>Pager</td></tr><tr><td>5</td><td>e-mail</td></tr><tr><td>6</td><td>URL</td></tr><tr><td>8</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Telephone (excluding mobile telephone)	2	Mobile (cellular) telephone	3	Facsimile machine	4	Pager	5	e-mail	6	URL	8	Other
Value	Meaning																
1	Telephone (excluding mobile telephone)																
2	Mobile (cellular) telephone																
3	Facsimile machine																
4	Pager																
5	e-mail																
6	URL																
8	Other																

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Electronic communication medium (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – electronic communication medium, code N
<i>METeOR identifier:</i>	287521
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A type of communication mechanism used by an organisation, as represented by a code.
Data Element Concept:	Service provider organisation (address) – electronic communication medium

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Telephone (excluding mobile telephone)</td></tr><tr><td>2</td><td>Mobile (cellular) telephone</td></tr><tr><td>3</td><td>Facsimile machine</td></tr><tr><td>4</td><td>Pager</td></tr><tr><td>5</td><td>e-mail</td></tr><tr><td>6</td><td>URL</td></tr><tr><td>8</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Telephone (excluding mobile telephone)	2	Mobile (cellular) telephone	3	Facsimile machine	4	Pager	5	e-mail	6	URL	8	Other
Value	Meaning																
1	Telephone (excluding mobile telephone)																
2	Mobile (cellular) telephone																
3	Facsimile machine																
4	Pager																
5	e-mail																
6	URL																
8	Other																

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Multiple electronic communication addresses (for example, multiple phone numbers, fax numbers and e-mail) may be recorded as required. Each instance should have an appropriate Electronic communication medium and Electronic communication usage code assigned.
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

In AS4846 alternative alphabetic codes are presented. Refer to the
current standard for more details.

Relational attributes

*Implementation in Data Set
Specifications:*

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Electronic communication usage code (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – electronic communication usage, code N
<i>METeOR identifier:</i>	287579
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The manner of use that a person applies to an electronic communication address, as represented by a code.
Data Element Concept:	Person (address) – electronic communication usage code

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Business use only</td></tr><tr><td>2</td><td>Personal use only</td></tr><tr><td>3</td><td>Both business and personal use</td></tr></tbody></table>	Value	Meaning	1	Business use only	2	Personal use only	3	Both business and personal use
Value	Meaning								
1	Business use only								
2	Personal use only								
3	Both business and personal use								

Data element attributes

Collection and usage attributes

Guide for use: Only applicable to individuals, and not organisations.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	AS 4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia In AS5017 an alternative data element is presented as 'Telephone number type (client)'. In AS4846 this data element is called 'Provider electronic communication type'. In both instances alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Emergency department arrival mode—transport

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – transport mode (arrival), code N
<i>METeOR identifier:</i>	270000
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The mode of transport by which the person arrives at the emergency department, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode – transport mode

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Ambulance, air ambulance or helicopter rescue service</td></tr><tr><td>2</td><td>Police/correctional services vehicle</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Not stated/unknown</td></tr></tbody></table>	Value	Meaning	1	Ambulance, air ambulance or helicopter rescue service	2	Police/correctional services vehicle	8	Other	9	Not stated/unknown
Value	Meaning										
1	Ambulance, air ambulance or helicopter rescue service										
2	Police/correctional services vehicle										
8	Other										
9	Not stated/unknown										
<i>Supplementary values:</i>											

Collection and usage attributes

<i>Guide for use:</i>	CODE 8 Other Includes walking, private transport, public transport, community transport, and taxi.
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Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National reference group for non-admitted patient data development, 2001-02
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Relational attributes

<i>Related metadata references:</i>	Supersedes Emergency department arrival mode - transport, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Non-admitted patient emergency department care NMDS

Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Non-admitted patient emergency department care NMDS](#)

Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#)

Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department date of commencement of service event

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – service commencement date, DDMMYYYY
<i>METeOR identifier:</i>	390398
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	The date on which a non-admitted emergency department service event commences.
<i>Context:</i>	Emergency Department care
<i>Data Element Concept:</i>	Non-admitted patient emergency department service episode – service commencement date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: An Emergency Department service event can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the Emergency Department. Placement of a patient in a cubicle and observations taken to monitor a patient pending a clinical decision regarding commencement of a clinical pathway, do not constitute commencement.

The following examples illustrate the commencement of an Emergency Department service event.

Example 1

- A patient presents at the Emergency Department with mild asthma. At triage, the patient is categorised as category three and returns to the waiting area.
- The patient has a more severe asthma attack in the waiting area, is re-triaged to category two and shown to a cubicle where standard observations are taken.
- A nurse comes to the cubicle and commences treatment based on an acknowledged clinical pathway of the

Emergency Department. At this point : **Emergency Department service event has commenced.**

Example 2

- A patient presents at the Emergency Department in an agitated, delusional state. At triage, the patient is categorised as category two and placed in a cubicle and the mental health practitioner notified.
- Observations are taken and nursing staff continue to observe the patient.
- The mental health practitioner arrives, assesses the patient and develops a management plan. At this point : **Emergency Department service event has commenced.**

Example 3

- A patient presents at the Emergency Department with an ankle injury from football. At triage, the patient is categorised as category four and moved to the 'fast track area'.
- The physiotherapist attends, examines the patient, makes an assessment (including diagnostic imaging requirements) and determines a treatment plan. At this point : **Emergency Department service event has commenced.**

Example 4

- A patient presents at the Emergency Department with a sore arm, following a fall, with limited arm movement possible.
- The patient is categorised as category three at triage and placed in a cubicle.
- A nurse provides analgesia and assesses the patient, including ordering diagnostic imaging. At this point : **Emergency Department service event has commenced.**

Example 5

- A patient presents at the Emergency Department feeling vague and having been generally unwell for a day or two. The patient has a slight cough. At triage, the patient is categorised as category three.
- The patient is placed in a cubicle where standard observations are taken. Respiration is 26 bpm, BP is 90/60 and the patient is hypoxic. The patient is given oxygen, and the treating clinician attends and provides instruction regarding patient care. At this point : **Emergency Department service event has commenced.**

Example 6

- A patient presents at the Emergency Department with chest pain. Triage category two is allocated. The patient is placed in a cubicle and a nurse gives oxygen and Anginine, takes blood samples and conducts an ECG. The ECG is reviewed. At this point : **Emergency Department service event has commenced.**
- A doctor subsequently arrives and the patient is transferred to the catheter lab after examination.

Example 7

- The Emergency Department is notified by ambulance that a patient is being transported having severe behavioural problems.
- The patient is taken to an appropriate cubicle and restrained.
- A clinician administers sedation and requests the attendance of a mental health practitioner. At this point : **Emergency Department service event has commenced.**

Collection methods:

Collected in conjunction with emergency department service commencement time.

Source and reference attributes

Submitting organisation:

Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:

Supersedes [Non-admitted patient emergency department service episode – service commencement date, DDMMYYYY](#) Health, Superseded 22/12/2009

Implementation in Data Set Specifications:

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department departure date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Emergency department stay – physical departure date, DDMMYYYY
<i>METeOR identifier:</i>	322597
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	The date on which a patient departs an emergency department after a stay.
<i>Context:</i>	Emergency department care.
<i>Data Element Concept:</i>	Emergency department stay – physical departure date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Each emergency department stay should include a non-admitted patient emergency department service episode component. The value of the episode end status code should guide the selection of the value to be recorded in this field:</p> <ul style="list-style-type: none">• If the patient is subsequently admitted then record the date the patient leaves the Emergency Department to go to the admitted patient facility. Physically moving the patient to a bed in an emergency department specialist care unit (including EMU, short stay ward, emergency care unit or observation unit) is defined as representing departure from the emergency department.• If the service episode is completed without the patient being admitted, including referral to another hospital, record the date the patient leaves the Emergency Department.• If the patient did not wait record the date the patient leaves the Emergency Department or was first noticed as having left.• If the patient left at their own risk record the date the patient leaves the Emergency Department.• If the patient died in the Emergency Department record the date of death.• If the patient was dead on arrival then record the date of presentation at the Emergency Department.
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Collection methods: Collected in conjunction with emergency department stay physical departure time.

Comments: This data element has been developed for the purpose of State and Territory compliance with the Australian Health Care Agreement and the agreed national access performance indicator.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009
Implementation start date: 01/07/2008
Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009
Implementation start date: 01/07/2010

Emergency department departure time

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Emergency department stay – physical departure time, hhmm
<i>METeOR identifier:</i>	322610
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	The time at which a patient departs an emergency department after a stay.
<i>Context:</i>	Emergency department care.
<i>Data Element Concept:</i>	Emergency department stay – physical departure time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Each emergency department stay should include a non-admitted patient emergency department service episode component. The value of the episode end status code should guide the selection of the value to be recorded in this field:</p> <ul style="list-style-type: none">• If the patient is subsequently admitted then record the time the patient leaves the Emergency Department to go to the admitted patient facility. Physically moving the patient to a bed in an emergency department specialist care unit (including EMU, short stay ward, emergency care unit or observation unit) is defined as representing departure from the emergency department.• If the service episode is completed without the patient being admitted, including referral to another hospital, record the time the patient leaves the Emergency Department.• If the patient did not wait record the time the patient leaves the Emergency Department or was first noticed as having left.• If the patient left at their own risk record the time the patient leaves the Emergency Department.
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- If the patient died in the Emergency Department record the time of death.
- If the patient was dead on arrival then record the time of presentation at the Emergency Department.

Collection methods:

Collected in conjunction with emergency department stay physical departure date.

Comments:

This data element has been developed for the purpose of State and Territory compliance with the Australian Health Care Agreement and the agreed national access performance indicator.

Source and reference attributes

Submitting organisation:

Australian Government Department of Health and Ageing

Relational attributes

Implementation in Data Set Specifications:

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department episode end date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – episode end date, DDMMYYYY
<i>METeOR identifier:</i>	322616
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	The date on which the non-admitted patient emergency department service episode ends.
Data Element Concept:	Non-admitted patient emergency department service episode – episode end date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A non-admitted patient emergency department service episode ends when either the patient is admitted 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.</p> <p>For patients who subsequently undergo a formal admission an admitted patient episode of care should be recorded. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Government Department of Health and Ageing
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	<p>Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006</p> <p><i>Implementation start date:</i> 01/07/2006</p> <p><i>Implementation end date:</i> 30/06/2007</p> <p>Non-admitted patient emergency department care NMDS 2007-2008 Health, Superseded 05/02/2008</p>
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Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department episode end time

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – episode end time, hhmm
<i>METeOR identifier:</i>	322621
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	The time at which the non-admitted patient emergency department service episode ends.
Data Element Concept:	Non-admitted patient emergency department service episode – episode end time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A non-admitted patient emergency department service episode ends when either the patient is admitted 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.</p> <p>For patients who subsequently undergo a formal admission an admitted patient episode of care should be recorded. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Government Department of Health and Ageing
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Non-admitted patient emergency department care NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
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[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department service episode end status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – episode end status, code N
<i>METeOR identifier:</i>	322641
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	The status of the patient at the end of the non-admitted patient emergency department service episode, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode – episode end status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Admitted to this hospital (including to units or beds within the emergency department)</td></tr><tr><td>2</td><td>Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital</td></tr><tr><td>3</td><td>Non-admitted patient emergency department service episode completed - referred to another hospital for admission</td></tr><tr><td>4</td><td>Did not wait to be attended by a health care professional</td></tr><tr><td>5</td><td>Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed</td></tr><tr><td>6</td><td>Died in emergency department as a non-admitted patient</td></tr><tr><td>7</td><td>Dead on arrival, not treated in emergency department</td></tr></tbody></table>	Value	Meaning	1	Admitted to this hospital (including to units or beds within the emergency department)	2	Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital	3	Non-admitted patient emergency department service episode completed - referred to another hospital for admission	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	6	Died in emergency department as a non-admitted patient	7	Dead on arrival, not treated in emergency department
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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																
6	Died in emergency department as a non-admitted patient																
7	Dead on arrival, not treated in emergency department																

Collection and usage attributes

<i>Guide for use:</i>	CODE 2 Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital This code includes patients who departed under their own care, under police custody, under the care of a residential aged care
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facility or other carer. Code 2 excludes those who died in the emergency department, which should be coded to Code 6.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Data element attributes

Collection and usage attributes

Guide for use: A non-admitted patient emergency department service episode ends when either the patient is admitted 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.

Collection methods: Some data systems may refer to this data element as 'Departure status'.

Source and reference attributes

Submitting organisation: Australian Government Department of Health and Ageing

Relational attributes

Related metadata references: Supersedes [Non-admitted patient emergency department service episode – patient departure status, code N](#) Health, Superseded 24/03/2006

Implementation in Data Set Specifications: [Non-admitted patient emergency department care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department time of commencement of service event

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – service commencement time, hhmm
<i>METeOR identifier:</i>	390401
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	The time at which a non-admitted emergency department service event commences.
<i>Context:</i>	Emergency Department care
<i>Data Element Concept:</i>	Non-admitted patient emergency department service episode – service commencement time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

Guide for use: An Emergency Department service event can be commenced by a doctor, nurse, mental health practitioner or other health professional, when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the Emergency Department. Placement of a patient in a cubicle and observations taken to monitor a patient pending a clinical decision regarding commencement of a clinical pathway, do not constitute commencement.

The following examples illustrate the commencement of an Emergency Department service event.

Example 1

- A patient presents at the Emergency Department with mild asthma. At triage, the patient is categorised as category three and returns to the waiting area.
- The patient has a more severe asthma attack in the waiting

area, is re-triaged to category two and shown to a cubicle where standard observations are taken.

- A nurse comes to the cubicle and commences treatment based on an acknowledged clinical pathway of the Emergency Department. At this point : **Emergency Department service event has commenced.**

Example 2

- A patient presents at the Emergency Department in an agitated, delusional state. At triage, the patient is categorised as category two and placed in a cubicle and the mental health practitioner notified.
- Observations are taken and nursing staff continue to observe the patient.
- The mental health practitioner arrives, assesses the patient and develops a management plan. At this point : **Emergency Department service event has commenced.**

Example 3

- A patient presents at the Emergency Department with an ankle injury from football. At triage, the patient is categorised as category four and moved to the 'fast track area'.
- The physiotherapist attends, examines the patient, makes an assessment (including diagnostic imaging requirements) and determines a treatment plan. At this point : **Emergency Department service event has commenced.**

Example 4

- A patient presents at the Emergency Department with a sore arm, following a fall, with limited arm movement possible.
- The patient is categorised as category three at triage and placed in a cubicle.
- A nurse provides analgesia and assesses the patient, including ordering diagnostic imaging. At this point : **Emergency Department service event has commenced.**

Example 5

- A patient presents at the Emergency Department feeling vague and having been generally unwell for a day or two. The patient has a slight cough. At triage, the patient is categorised as category three.
- The patient is placed in a cubicle where standard observations are taken. Respiration is 26 bpm, BP is 90/60 and the patient is hypoxic. The patient is given oxygen, and the treating clinician attends and provides instruction regarding patient care. At this point : **Emergency Department service event has commenced.**

Example 6

- A patient presents at the Emergency Department with chest pain. Triage category two is allocated. The patient is placed in a cubicle and a nurse gives oxygen and Anginine, takes blood samples and conducts an ECG. The ECG is reviewed. At this point : **Emergency Department service event has commenced.**

- A doctor subsequently arrives and the patient is transferred to the catheter lab after examination.

Example 7

- The Emergency Department is notified by ambulance that a patient is being transported having severe behavioural problems.
- The patient is taken to an appropriate cubicle and restrained.
- A clinician administers sedation and requests the attendance of a mental health practitioner. At this point : **Emergency Department service event has commenced.**

Collection methods:

Collected in conjunction with emergency department service episode service commencement date.

Source and reference attributes

Submitting organisation:

Australian Government Department of Health and Ageing

Relational attributes

Related metadata references:

Supersedes [Non-admitted patient emergency department service episode – service commencement time, hhmm](#) Health, Superseded 22/12/2009

Implementation in Data Set Specifications:

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Emergency department waiting time to admission

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – waiting time (to hospital admission), total hours and minutes NNNN
<i>METeOR identifier:</i>	270004
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time elapsed for each patient from presentation to the emergency department to admission to hospital.
Data Element Concept:	Non-admitted patient emergency department service episode – waiting time (to hospital admission)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4
<i>Unit of measure:</i>	Hour and minute

Collection and usage attributes

<i>Guide for use:</i>	HHMM
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Calculated from admission date and time minus date and time patient presents for those emergency department patients who are admitted.
<i>Collection methods:</i>	To be collected on patients presenting to emergency department for unplanned care in public hospitals with emergency department and private hospitals providing contracted services for the public sector.
<i>Comments:</i>	This is a critical waiting times metadata item. It is used to examine the length of waiting time, for performance indicators and benchmarking. Information based on this metadata item will have many uses including to assist in the planning and management of hospitals and in health care research.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

Related metadata references:

Is formed using [Episode of admitted patient care – admission date, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Health service event – presentation time, hhmm](#) Health, Standard 01/03/2005

Is formed using [Non-admitted patient emergency department service episode – patient departure status, code N](#) Health, Superseded 24/03/2006

Is formed using [Episode of admitted patient care – admission time, hhmm](#) Health, Standard 01/03/2005

Is formed using [Health service event – presentation date, DDMMYYYY](#) Health, Standard 01/03/2005

Supersedes [Emergency department waiting time to admission, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.6 KB)

Emergency department waiting time to service delivery

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – waiting time (to service delivery), total minutes NNNNN
<i>METeOR identifier:</i>	390412
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	The time elapsed in minutes for each patient from presentation in the emergency department to the commencement of the Emergency Department service event.
<i>Data Element Concept:</i>	Non-admitted patient emergency department service episode – waiting time

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNNNN
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Minute (m)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Calculated by subtracting date and time the patient presents from Emergency Department date and time of commencement of service event. Although triage category 1 is measured in seconds, it is recognised that the data will not be collected with this precision.
<i>Comments:</i>	It is recognised that at times of extreme urgency or multiple synchronous presentations, or if no medical officer is on duty in the emergency department, this service may be provided by a nurse.

Source and reference attributes

<i>Submitting organisation:</i>	National reference group for non-admitted patient data development, 2001-02
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Relational attributes

<i>Related metadata references:</i>	Supersedes Non-admitted patient emergency department service episode – waiting time (to service delivery), total minutes NNNNN Health, Superseded 22/12/2009
<i>Implementation in Data Set Specifications:</i>	Non-admitted patient emergency department care NMDS 2010-2011 Health, Standard 22/12/2009 <i>Implementation start date:</i> 01/07/2010

Employee expenses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Organisation – employee related expenses, total Australian currency NNNNN.N
<i>METeOR identifier:</i>	359947
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Expenses of an organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, and workers compensation premiums and payouts, in Australian currency.
Data Element Concept:	Organisation – employee related expenses

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Currency
<i>Format:</i>	NNNNN.N
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Australian currency (AU\$)

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.</p> <p>Employee related expenses are to be reported in millions to the nearest 100,000 e.g. \$4,064,000 should be reported as \$4.1 million.</p> <p>When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).</p> <p>Includes:</p> <ul style="list-style-type: none">• Salaries, wages and supplements for all employees of the organisation (including contract staff employed by an agency, provided staffing data is also available). This is to include all paid leave (recreation, sick and long-service) and salary and wage payments relating to workers compensation leave.• Superannuation employer contributions paid or, for an emerging cost scheme, that should be paid (as determined by
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an actuary) on behalf of establishment employees either by the establishment or a central administration such as a state health authority, to a superannuation fund providing retirement and related benefits to establishment employees, for a financial year.

- Workers compensation premiums and payments

Collection methods:

Employee related expenses are to be reported for the *Health industry relevant organisation type* and *Type of health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references:

Is used in the formation of [Organisation – expenses, total Australian currency NNNNN.N](#) Health, Standard 05/12/2007

[Government health expenditure organisation expenditure data cluster](#) Health, Superseded 03/12/2008

[Government health expenditure organisation expenditure data element cluster](#) Health, Standard 01/04/2009

[Government health expenditure organisation expenditure employee related data element cluster](#) Health, Superseded 01/04/2009

[Government health expenditure organisation expenditure employee related data element cluster](#) Health, Standard 01/04/2009

Employment status (admitted patient)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – labour force status, acute hospital and private psychiatric hospital admission code N
<i>METeOR identifier:</i>	269948
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Self-reported employment status of a person, immediately prior to admission to an acute or private psychiatric hospital, as represented by a code.
<i>Context:</i>	The Australian Health Ministers' Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be: employment status, income, occupation and education.
Data Element Concept:	Person – labour force status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Unemployed / pensioner</td></tr><tr><td>2</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Unemployed / pensioner	2	Other
Value	Meaning						
1	Unemployed / pensioner						
2	Other						

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	In practice, this metadata item and current or last occupation could probably be collected with a single question, as is done in Western Australia: Occupation? For example: <ul style="list-style-type: none">• housewife or home duties• pensioner miner• tree feller
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- retired electrician
- unemployed trades assistant
- child
- student
- accountant

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Employment status - acute hospital and private psychiatric hospital admissions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Implementation in Data Set Specifications: [Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Employment status—health professional

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – labour force status, registered health professional code N
<i>METeOR identifier:</i>	383389
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	An indicator of whether a registered health professional is in paid employment, and if so whether the employment is within their registered profession.
Data Element Concept:	Registered health professional – labour force status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Employed in the registered profession</td></tr><tr><td>2</td><td>Employed outside the registered profession</td></tr><tr><td>3</td><td>Not employed</td></tr><tr><td>9</td><td>Unknown/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Employed in the registered profession	2	Employed outside the registered profession	3	Not employed	9	Unknown/inadequately described
Value	Meaning										
1	Employed in the registered profession										
2	Employed outside the registered profession										
3	Not employed										
9	Unknown/inadequately described										
<i>Supplementary values:</i>											

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 EMPLOYED IN THE REGISTERED PROFESSION</p> <p>Health professionals employed in the registered profession may be working in Australia or they may be working overseas.</p> <p>CODE 2 EMPLOYED OUTSIDE OF THE REGISTERED PROFESSION</p> <p>Health professionals who are employed in Australia or overseas, but not in the registered profession.</p> <p>CODE 3 NOT EMPLOYED</p> <p>Health professionals in this category may be unemployed (not employed and seeking work) or not in the labour force (not employed and not seeking work). This is consistent with the ABS Labour Force standard which allows the aggregation of 'Unemployed' and 'Not in the labour force' to form the category 'Not employed'.</p> <p>FURTHER DEFINITIONS</p> <p>The term 'employed' includes employees, employers, own account workers and contributing family workers.</p>
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The definitions of employed and unemployed in this data element differ slightly from Australian Bureau of Statistics (ABS) definitions. The main differences are:

- The labour force collection includes health professionals working in the Defence Forces. ABS does not, with the exception of the population census.
- ABS uses a tightly defined reference period for employment and unemployment; the labour force collection reference period is self-defined by the respondent as his/her usual status during the week before registration.
- The scope of the labour force collection is all health professionals listed by the Australian Health Practitioner Regulation Agency, regardless of their residential status in Australia. The scope of the ABS Labour Force Survey is usual residents of Australia. That is, those persons who will be living in Australia for at least 12 months.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Data is self-reported based on the health professional's status in the registered profession in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: Australian Bureau of Statistics 1996 Standards for Labour Force Statistics Cat.no. 1288.0 Canberra: ABS

Relational attributes

Related metadata references: Supersedes [Health professional – labour force status, code N{.N}](#)

Implementation in Data Set Specifications: [Labour force status cluster](#) Health, Standard 10/12/2009

Employment status—public psychiatric hospital admissions

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – labour force status, public psychiatric hospital admission code N
<i>METeOR identifier:</i>	269955
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Self-reported employment status of a person, immediately prior to admission to a public psychiatric hospital, as represented by a code.
<i>Context:</i>	The Australian Health Ministers’ Advisory Council Health Targets and Implementation Committee (1988) identified socioeconomic status as the most important factor explaining health differentials in the Australian population. The committee recommended that national health statistics routinely identify the various groups of concern. This requires routine recording in all collections of indicators of socioeconomic status. In order of priority, these would be: employment status, income, occupation and education.
Data Element Concept:	Person – labour force status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Child not at school</td></tr><tr><td>2</td><td>Student</td></tr><tr><td>3</td><td>Employed</td></tr><tr><td>4</td><td>Unemployed</td></tr><tr><td>5</td><td>Home duties</td></tr><tr><td>6</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Child not at school	2	Student	3	Employed	4	Unemployed	5	Home duties	6	Other
Value	Meaning														
1	Child not at school														
2	Student														
3	Employed														
4	Unemployed														
5	Home duties														
6	Other														

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	In practice, this data item and current or last occupation could probably be collected with a single question, as is done in Western Australia:
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Occupation?

For example:

- housewife or home duties
- pensioner miner
- tree feller
- retired electrician
- unemployed trades assistant
- child
- student
- accountant

However, for national reporting purposes it is preferable to distinguish these two data items logically.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Employment status - public psychiatric hospital admissions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.6 KB)

Implementation in Data Set Specifications:

[Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Environmental factor

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person—environmental factor, code (ICF 2001) AN[NNN]
<i>METeOR identifier:</i>	320207
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The physical, social and attitudinal environment in which people live and conduct their lives, as represented by a code.
<i>Context:</i>	The environment in which a person functions or experiences disability.
Data Element Concept:	Person—environmental factor

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	AN[NNN]
<i>Maximum character length:</i>	5

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.</p> <p>Environmental factors represent the circumstances in which the individual lives. These factors are conceived as immediate (e.g. physical features of the environment, social environment) and societal (formal and informal social structures, services and systems). Different environments may have a very different impact on the same individual with a given health condition.</p> <p>Facilitators are features of the environment that have a positive effect on disability. Barriers are features of the environment that have a negative effect on disability.</p> <p>Data can be collected at the three digit level in one chapter and at the chapter level in another. However it is only possible to collect data at a single level of the hierarchy in a single chapter to maintain mutual exclusivity. For example, it is not permitted to collect both 'Attitudes' (chapter level) and 'Social, norms, practices and ideology' (3 digit level) as the former includes the latter.</p> <p>The value domain below refers to the highest hierarchical level (ICF chapter level). Data collected at this level, in association with <i>Extent of environmental factor influence code [X]N</i> will use the codes as indicated. The full range of the permissible values together</p>
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with definitions can be found in the *Environmental Factors* component of the ICF.

CODE e1 Products and technology

CODE e2 Natural environment and human-made changes to environment

CODE e3 Support and relationships

CODE e4 Attitudes

CODE e5 Services, systems and policies

Data collected at this level will provide a general description of the environmental factors and can only be compared with data collected at the same level.

An example of a value domain at the 3 digit level from the Environmental factors component may include:

CODE e225 Climate

CODE e240 Light

CODE e250 Sound

CODE e255 Vibration

CODE e260 Air quality

An example of a value domain at the 4 digit level from the environmental factors component may include:

CODE e1151 Assistive products and technology for personal use in daily life

CODE e1201 Assistive products and technology for personal indoor and outdoor mobility and transportation

CODE e2151 Assistive products and technology for communication

CODE e1301 Assistive products and technology for education

CODE e1351 Assistive products and technology for employment

CODE e1401 Assistive products and technology for culture, recreation and sport

CODE e1451 Assistive products and technology for the practice of religion and spirituality

The prefix *e* denotes the domains within the component of *Environmental Factors*.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.cfm>

Data element attributes

Collection and usage attributes

Guide for use:

This data element is a neutral list of environmental factors. It may be used, in conjunction with Person—extent of environmental factor influence, code (ICF 2001) [X]N, in health, community services and other disability-related data collections to record the environmental factors that facilitate or inhibit optimum functioning at the body, person or societal level. Identification of environmental factors may assist in determining appropriate interventions to support the person to achieve optimum functioning.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also [Person—extent of environmental factor influence, code \(ICF 2001\) \[X\]N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

[Environmental factors cluster](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Episode of residential care end date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of residential care—episode end date, DDMMYYYY
<i>METeOR identifier:</i>	270062
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date on which a resident formally or statistically ends an episode of residential care .
Data Element Concept:	Episode of residential care—episode end date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

<i>Related metadata references:</i>	Supersedes Episode of residential care end date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)
<i>Implementation in Data Set Specifications:</i>	Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006
	Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
	Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008
	Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009 <i>Implementation start date:</i> 01/07/2008 <i>Implementation end date:</i> 30/06/2009
	Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010 <i>Implementation start date:</i> 01/07/2009 <i>Implementation end date:</i> 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Episode of residential care end mode

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of residential care – episode end mode, code N
<i>METeOR identifier:</i>	270063
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The reason for ending an episode of residential care , as represented by a code.
Data Element Concept:	Episode of residential care – episode end mode

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Died</td></tr><tr><td>2</td><td>Left against clinical advice / at own risk</td></tr><tr><td>3</td><td>Commenced leave where there is no intention that the resident returns to overnight residential care within seven days</td></tr><tr><td>4</td><td>Other end of residential care at this establishment</td></tr><tr><td>5</td><td>End of reference period</td></tr></tbody></table>	Value	Meaning	1	Died	2	Left against clinical advice / at own risk	3	Commenced leave where there is no intention that the resident returns to overnight residential care within seven days	4	Other end of residential care at this establishment	5	End of reference period
Value	Meaning												
1	Died												
2	Left against clinical advice / at own risk												
3	Commenced leave where there is no intention that the resident returns to overnight residential care within seven days												
4	Other end of residential care at this establishment												
5	End of reference period												
<i>Supplementary values:</i>	9 Unknown/not stated/inadequately described												

Collection and usage attributes

<i>Guide for use:</i>	<p>CODES 1 - 4 These codes refer to the formal episode of residential care end.</p> <p>CODE 1 Died</p> <p>CODE 2 Left against clinical advice / at own risk</p> <p>CODE 3 Commenced leave where there is no intention that the resident returns to overnight residential care within seven days</p> <p>CODE 5 End of reference period</p> <p>This code refers to the statistical episode of residential care end.</p> <p>CODE 9 Unknown/not stated/inadequately described</p> <p>This code refers to other.</p>
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Data element attributes

Relational attributes

Related metadata references:

Supersedes [Episode of residential care end mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.3 KB)

Implementation in Data Set Specifications:

[Residential mental health care NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Episode of residential care start date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of residential care—episode start date, DDMMYYYY
<i>METeOR identifier:</i>	270064
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which the resident formally or statistically starts an episode of residential care .
Data Element Concept:	Episode of residential care—episode start date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

<i>Related metadata references:</i>	Supersedes Episode of residential care start date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
<i>Implementation in Data Set Specifications:</i>	Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008 Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009 <i>Implementation start date:</i> 01/07/2008 <i>Implementation end date:</i> 30/06/2009 Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010 <i>Implementation start date:</i> 01/07/2009 <i>Implementation end date:</i> 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Episode of residential care start mode

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of residential care—episode start mode, code N
<i>METeOR identifier:</i>	270075
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The reason for starting an episode of residential care , as represented by a code.
Data Element Concept:	Episode of residential care—episode start mode

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days</td></tr><tr><td>2</td><td>Other (i.e. start of a new residential stay)</td></tr><tr><td>3</td><td>Start of a new reference period</td></tr></tbody></table>	Value	Meaning	1	Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days	2	Other (i.e. start of a new residential stay)	3	Start of a new reference period
Value	Meaning								
1	Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days								
2	Other (i.e. start of a new residential stay)								
3	Start of a new reference period								
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Unknown/not stated/inadequately described</td></tr></tbody></table>	9	Unknown/not stated/inadequately described						
9	Unknown/not stated/inadequately described								

Collection and usage attributes

<i>Guide for use:</i>	<p>CODES 1-2 These codes refer to the formal episode of residential care start.</p> <p>CODE 1 Unplanned return from leave where there had been no intention that the resident would return to overnight residential care at the establishment within seven days</p> <p>CODE 2 Other (i.e. start of a new residential stay)</p> <p>CODE 3 Start of a new reference period</p> <p>This code refers to the statistical episode of residential care start.</p> <p>CODE 9 Unknown/not stated/inadequately described</p> <p>This code refers to other.</p>
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Data element attributes

Relational attributes

<i>Related metadata references:</i>	Supersedes Episode of residential care start mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
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Implementation in Data Set Specifications:

[Residential mental health care NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Erectile dysfunction

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (male) – erectile dysfunction, code N
<i>METeOR identifier:</i>	270132
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether a male individual has a history of erection failure or has received treatment to achieve erection sufficient for penetration in the last 12 months and prior, as represented by a code.
Data Element Concept:	Person (male) – erectile dysfunction

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Erectile dysfunction- developed in the last 12 months</td></tr><tr><td>2</td><td>Erectile dysfunction- developed prior to the last 12 months</td></tr><tr><td>3</td><td>No erectile dysfunction</td></tr></tbody></table>	Value	Meaning	1	Erectile dysfunction- developed in the last 12 months	2	Erectile dysfunction- developed prior to the last 12 months	3	No erectile dysfunction
Value	Meaning								
1	Erectile dysfunction- developed in the last 12 months								
2	Erectile dysfunction- developed prior to the last 12 months								
3	No erectile dysfunction								
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	9	Not stated/inadequately described						
9	Not stated/inadequately described								

Collection and usage attributes

<i>Guide for use:</i>	Determine whether this developed within or prior to the last 12 months.
<i>Collection methods:</i>	Ask the individual if he has a history of treatment or failure to achieve or maintain erection sufficient for penetration.

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record for male patients only.
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Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes [Erectile dysfunction, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS Health](#), Superseded 21/09/2005

[Diabetes \(clinical\) DSS Health](#), Standard 21/09/2005

Establishment identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – organisation identifier (Australian), NNX[X]NNNNN
<i>METeOR identifier:</i>	269973
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The identifier for the establishment in which episode or event occurred. Each separately administered health care establishment to have a unique identifier at the national level.
Data Element Concept:	Establishment – organisation identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	NNX[X]NNNNN
<i>Maximum character length:</i>	9

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Concatenation of: Australian state/territory identifier (character position 1); Sector (character position 2); Region identifier (character positions 3-4); and Organisation identifier (state/territory), (character positions 5-9).
<i>Comments:</i>	Establishment identifier should be able to distinguish between all health care establishments nationally.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Establishment identifier, version 4, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.0 KB) Is formed using Establishment – Australian state/territory identifier, code N Health, Standard 01/03/2005 Is formed using Establishment – organisation identifier (state/territory), NNNNN Health, Standard 01/03/2005 Is formed using Establishment – sector, code N Health, Standard 01/03/2005
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Implementation in Data Set Specifications:

Is formed using [Establishment – region identifier, X\[X\]](#) Health, Standard 01/03/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

[Alcohol and other drug treatment services NMDS](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#)
Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#)
Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#)
Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Community mental health care 2004-2005](#) Health, Superseded
08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

[Community mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Community mental health establishments NMDS 2004-2005](#)
Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

[Elective surgery waiting times \(census data\) NMDS](#) Health,
Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(census data\) NMDS 2006-2009](#)
Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

[Elective surgery waiting times \(census data\) NMDS 2009-](#) Health,
Standard 03/12/2008

Implementation start date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(removals data\) NMDS 2006-2009](#)
Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2009-](#)
Health, Standard 03/12/2008

Implementation start date: 01/07/2009

[Health care client identification](#) Health, Superseded 04/05/2005

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-
2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-
2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-
2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Outpatient care NMDS](#) Health, Superseded 04/07/2007

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Outpatient care NMDS](#) Health, Standard 04/07/2007

Implementation start date: 01/07/2007

[Perinatal NMDS](#) Health, Superseded 06/09/2006

Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Perinatal NMDS](#) Health, Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009
Implementation start date: 01/07/2008
Implementation end date: 30/06/2010
[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009
Implementation start date: 01/07/2010
[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009
[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010
Implementation start date: 01/07/2009
[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010
Implementation start date: 01/07/2010
[Residential mental health care NMDS 2005-2006](#) Health, Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Residential mental health care NMDS 2006-2007](#) Health, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Establishment number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – organisation identifier (state/territory), NNNNN
<i>METeOR identifier:</i>	269975
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An identifier for an establishment, unique within the state or territory.
Data Element Concept:	Establishment – organisation identifier (state/territory)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	NNNNN
<i>Maximum character length:</i>	5

Data element attributes

Collection and usage attributes

<i>Comments:</i>	Identifier should be a unique code for the health care establishment used in that state/territory.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Establishment number, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.6 KB) Is used in the formation of Establishment – organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005 Admitted patient care NMDS Health, Superseded 07/12/2005
<i>Implementation in Data Set Specifications:</i>	<i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008 Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009 <i>Implementation start date:</i> 01/07/2008 <i>Implementation end date:</i> 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded
22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

[Community mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Health care client identification](#) Health, Superseded 04/05/2005

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009
[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009
Implementation start date: 01/07/2009
Implementation end date: 30/06/2010
[Residential mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Residential mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009
[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010
Implementation start date: 01/07/2009
Implementation end date: 30/06/2010
[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010
Implementation start date: 01/07/2010

Establishment sector

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – sector, code N
<i>METeOR identifier:</i>	269977
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A section of the health care industry with which a health care establishment can identify, as represented by a code.
Data Element Concept:	Establishment – sector

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Public</td></tr><tr><td>2</td><td>Private</td></tr></tbody></table>	Value	Meaning	1	Public	2	Private
Value	Meaning						
1	Public						
2	Private						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This data element is used to differentiate between establishments run by the government sector (code 1) and establishments that receive some government funding but are run by the non-government sector (code 2).</p> <p>CODE 1 is to be used when the establishment:</p> <ul style="list-style-type: none">operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,is part of the general government sector or is controlled by some part of the general government sector,provides government services free of charge or at nominal prices, andis financed mainly from taxation. <p>CODE 2 is to be used only when the establishment:</p> <ul style="list-style-type: none">is not controlled by government,is directed by a group of officers, an executive committee or a similar bodyelected by a majority of members, andmay be an income tax exempt charity.
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Relational attributes

Related metadata references:

Supersedes [Establishment sector, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.8 KB)

Is used in the formation of [Establishment – organisation identifier \(Australian\), NNX\[X\]NNNNN](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Community mental health care NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Health care client identification](#) Health, Superseded 04/05/2005

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Residential mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Establishment type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – establishment type, sector and services provided code AN.N{.N}
<i>METeOR identifier:</i>	269971
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Type of establishment (defined in terms of legislative approval, service provided and patients treated) for each separately administered establishment, as represented by a code.
Data Element Concept:	Establishment – establishment type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																										
<i>Data type:</i>	String																																										
<i>Format:</i>	AN.N{.N}																																										
<i>Maximum character length:</i>	6																																										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>R1.1</td><td>Public acute care hospital</td></tr><tr><td>R1.2</td><td>Private acute care hospital</td></tr><tr><td>R1.3.1</td><td>Veterans Affairs hospital</td></tr><tr><td>R1.3.2</td><td>Defence force hospital</td></tr><tr><td>R1.3.3</td><td>Other Commonwealth hospital</td></tr><tr><td>R2.1</td><td>Public psychiatric hospital</td></tr><tr><td>R2.2</td><td>Private psychiatric hospital</td></tr><tr><td>R3.1</td><td>Private charitable nursing home for the aged</td></tr><tr><td>R3.2</td><td>Private profit nursing home for the aged</td></tr><tr><td>R3.3</td><td>Government nursing home for the aged</td></tr><tr><td>R3.4</td><td>Private charitable nursing home for young disabled</td></tr><tr><td>R3.5</td><td>Private profit nursing home for young disabled</td></tr><tr><td>R3.6</td><td>Government nursing home for young disabled</td></tr><tr><td>R5.2</td><td>State government hostel for the aged</td></tr><tr><td>R4.1</td><td>Public alcohol and drug treatment centre</td></tr><tr><td>R4.2</td><td>Private alcohol and drug treatment centre</td></tr><tr><td>R5.1</td><td>Charitable hostels for the aged</td></tr><tr><td>R5.3</td><td>Local government hostel for the aged</td></tr><tr><td>R5.4</td><td>Other charitable hostel</td></tr><tr><td>R5.5</td><td>Other State government hostel</td></tr></tbody></table>	Value	Meaning	R1.1	Public acute care hospital	R1.2	Private acute care hospital	R1.3.1	Veterans Affairs hospital	R1.3.2	Defence force hospital	R1.3.3	Other Commonwealth hospital	R2.1	Public psychiatric hospital	R2.2	Private psychiatric hospital	R3.1	Private charitable nursing home for the aged	R3.2	Private profit nursing home for the aged	R3.3	Government nursing home for the aged	R3.4	Private charitable nursing home for young disabled	R3.5	Private profit nursing home for young disabled	R3.6	Government nursing home for young disabled	R5.2	State government hostel for the aged	R4.1	Public alcohol and drug treatment centre	R4.2	Private alcohol and drug treatment centre	R5.1	Charitable hostels for the aged	R5.3	Local government hostel for the aged	R5.4	Other charitable hostel	R5.5	Other State government hostel
Value	Meaning																																										
R1.1	Public acute care hospital																																										
R1.2	Private acute care hospital																																										
R1.3.1	Veterans Affairs hospital																																										
R1.3.2	Defence force hospital																																										
R1.3.3	Other Commonwealth hospital																																										
R2.1	Public psychiatric hospital																																										
R2.2	Private psychiatric hospital																																										
R3.1	Private charitable nursing home for the aged																																										
R3.2	Private profit nursing home for the aged																																										
R3.3	Government nursing home for the aged																																										
R3.4	Private charitable nursing home for young disabled																																										
R3.5	Private profit nursing home for young disabled																																										
R3.6	Government nursing home for young disabled																																										
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R5.3	Local government hostel for the aged																																										
R5.4	Other charitable hostel																																										
R5.5	Other State government hostel																																										

R5.6	Other Local government hostel
R6.1	Public hospice
R6.2	Private hospice
N7.1	Public day centre/hospital
N7.2	Public freestanding day surgery centre
N7.3	Private day centre/hospital
N7.4	Private freestanding day surgery centre
N8.1.1	Public community health centre
N8.1.2	Private (non-profit) community health centre
N8.2.1	Public domiciliary nursing service
N8.2.2	Private (non-profit) domiciliary nursing service
N8.2.3	Private (profit) domiciliary nursing service

Collection and usage attributes

Guide for use:

Establishments are classified into 10 major types subdivided into major groups:

- residential establishments (R)
- non-residential establishments (N)

CODE R1 Acute care hospitals

Establishments which provide at least minimal medical, surgical or obstetric services for inpatient treatment and/or care, and which provide round-the-clock comprehensive qualified nursing service as well as other necessary professional services. They must be licensed by the state health department, or controlled by government departments. Most of the patients have acute conditions or temporary ailments and the average stay per admission is relatively short.

Hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical care are included in this category. Hospices (establishments providing palliative care to terminally ill patients) that are freestanding and do not provide any other form of acute care are classified to R6.

CODE R2 Psychiatric hospitals

Establishments devoted primarily to the treatment and care of inpatients with psychiatric, mental, or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Cwlth) (now licensed/approved by each state health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Centres for the non-acute treatment of drug dependence, developmental and intellectual disability are not included here (see below). This code also excludes institutions mainly providing living quarters or day care.

CODE R3 Nursing homes

Establishments which provide long-term care involving regular basic nursing care to chronically ill, frail, disabled or convalescent

persons or senile inpatients. They must be approved by the Commonwealth Department of Health and Family Services and/or licensed by the State, or controlled by Government departments.

Private profit nursing homes are operated by private profit-making individuals or bodies.

Private charitable nursing homes are participating nursing homes operated by religious and charitable organisations.

Government nursing homes are nursing homes either operated by or on behalf of a state or territory Government.

CODE R4 Alcohol and drug treatment centres

Freestanding centres for the treatment of drug dependence on an inpatient basis.

CODE R5 Hostels and residential services

Establishments run by public authorities or registered non-profit organisation to provide board, lodging or accommodation for the aged, distressed or disabled who cannot live independently but do not need nursing care in a hospital or nursing home. Only hostels subsidised by the Commonwealth are included. Separate dwellings are not included, even if subject to an individual rental rebate arrangement. Residents are generally responsible for their own provisions, but may be provided in some establishments with domestic assistance (meals, laundry, personal care). Night shelters providing only casual accommodation are excluded.

CODE R6 Hospices

Establishments providing palliative care to terminally ill patients. Only freestanding hospices which do not provide any other form of acute care are included in this category.

CODE N7 Same-day establishments

This code includes both the traditional day centre/hospital and also freestanding day surgery centres.

Day centres/hospitals are establishments providing a course of acute treatment on a full-day or part-day non-residential attendance basis at specified intervals over a period of time. Sheltered workshops providing occupational or industrial training are excluded.

Freestanding day surgery centres are hospital facilities providing investigation and treatment for acute conditions on a day-only basis and are approved by the Commonwealth for the purposes of basic table health insurance benefits.

CODE N8 Non-residential health services

Services administered by public authorities or registered non-profit organisations which employ full-time equivalent medical or paramedical staff (nurses, nursing aides, physiotherapists, occupational therapists and psychologists, but not trade instructors or teachers). This definition distinguishes health services from welfare services (not within the scope of the National Minimum Data Project) and thereby excludes such services as sheltered workshops, special schools for the

intellectually disabled, meals on wheels and baby clinics offering advisory services but no actual treatment. Non-residential health services should be enumerated in terms of services or organisations rather than in terms of the number of sites at which care is delivered.

Non-residential health services provided by a residential establishment (for example, domiciliary nursing service which is part of a public hospital) should not be separately enumerated.

CODE N8.1 Community health centres

Public or registered non-profit establishments in which a range of non-residential health services is provided in an integrated and coordinated manner, or which provides for the coordination of health services elsewhere in the community.

CODE N8.2 Domiciliary nursing service

Public or registered non-profit or profit-making establishments providing nursing or other professional paramedical care or treatment to patients in their own homes or in (non-health) residential institutions. Establishments providing domestic or housekeeping assistance are excluded by the general definition above.

Comments: Note that national minimum data sets currently include only community health centres and domiciliary nursing services.

Data element attributes

Collection and usage attributes

Comments: In the current data element, the term establishment is used in a very broad sense to mean bases, whether institutions, organisations or the community from which health services are provided. Thus, the term covers conventional health establishments and also organisations which may provide services in the community.

This metadata item is currently under review by the Establishments Framework Working Group of the Health Data Standards Committee. Recommendations will provide a comprehensive coverage of the health service delivery sector.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Establishment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (31.2 KB)

Is used in the formation of [Episode of care – number of psychiatric care days, total N\[NNNN\]](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Extended leave status in registered profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – extended leave status in registered profession, code N
<i>METeOR identifier:</i>	383415
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	Whether a registered health professional is on extended leave (3 months or more) from their registered profession, as represented by a code.
Data Element Concept:	Registered health professional – extended leave status in registered profession

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>On extended leave (3 months or more)</td></tr><tr><td>2</td><td>Not on extended leave</td></tr><tr><td>9</td><td>Unknown/inadequately described</td></tr></tbody></table>	Value	Meaning	1	On extended leave (3 months or more)	2	Not on extended leave	9	Unknown/inadequately described
Value	Meaning								
1	On extended leave (3 months or more)								
2	Not on extended leave								
9	Unknown/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 ON EXTENDED LEAVE (3 MONTHS OR MORE)</p> <p>The person is on a period of leave from their place of employment for three months or more. The person may be starting their extended leave or they may be part-way through their extended leave.</p> <p>CODE 2 NOT ON EXTENDED LEAVE</p> <p>The person is not on a period of leave for three months or more. They may be working or they may be on short-term leave of less than three months.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This data element is applicable to registered health professionals who are employed in the registered profession.
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Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Labour force status cluster](#) Health, Standard 10/12/2009

Extended wait patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – extended wait patient indicator, code N
<i>METeOR identifier:</i>	269964
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether a patient is an extended wait patient, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode – extended wait patient indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Extended wait patient</td></tr><tr><td>2</td><td>Other patient</td></tr></tbody></table>	Value	Meaning	1	Extended wait patient	2	Other patient
Value	Meaning						
1	Extended wait patient						
2	Other patient						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	A patient is classified as an extended wait patient if the patient is in clinical urgency category 3 at the time of admission or at a census time and has been waiting for the elective surgery for more than one year.
<i>Comments:</i>	This metadata item is used to identify clinical urgency category 3 patients who had waited longer than one year at admission or have waited longer than one year at the time of a census. An extended wait patient is not an overdue patient as there is no maximum desirable waiting time specified for patients in clinical urgency category 3 as they have been assessed as not having a clinically urgent need for the awaited procedure.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Extended wait patient, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.8 KB) Is formed using Elective surgery waiting list episode – waiting
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Implementation in Data Set Specifications:

[time \(at a census date\), total days N\[NNN\]](#) Health, Standard
01/03/2005

Is formed using [Elective surgery waiting list episode – waiting time \(at removal\), total days N\[NNN\]](#) Health, Standard
01/03/2005

[Elective surgery waiting times \(census data\) NMDS](#) Health,
Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(census data\) NMDS 2006-2009](#)
Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

[Elective surgery waiting times \(census data\) NMDS 2009-](#) Health,
Standard 03/12/2008

Implementation start date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(removals data\) NMDS 2006-2009](#)
Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2009-](#)
Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Extent of participation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – extent of participation in a life area, code (ICF 2001) N
<i>METeOR identifier:</i>	320219
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The degree of participation by an individual in a specified life area, as represented by a code.
<i>Context:</i>	Human functioning and disability
<i>Data Element Concept:</i>	Person – extent of participation in a life area

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001	
<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	0	Full participation
	1	Mild participation restriction
	2	Moderate participation restriction
	3	Severe participation restriction
	4	Complete participation restriction
<i>Supplementary values:</i>	8	Not specified
	9	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.</p> <p>In the context of health, participation is involvement in a life situation. Participation restrictions are problems an individual may experience in involvement of life situations.</p> <p>This metadata item may be used to describe the extent of participation in life situations for an individual with a health condition. The standard or norm to which an individual's participation is compared is that of an individual without a similar health condition in that particular society. The participation restriction records the discordance between the experienced participation and the expected participation of an</p>
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individual without a health condition. The definition of 'particular society' is not specified and will inevitably give rise to different interpretations. If limiting the interpretation, it will be necessary to state the factors which are taken into account, for example, age, gender, ethnicity, religion, education, locality (town, state, rural, remote, urban).

The user will select the code that most closely summarises, in terms of duration, frequency, manner or outcome, the level of participation of the person for whom the data is recorded.

CODE 0 Full participation

Used when the person participates in this life area in the same way in terms of duration, frequency, manner or outcome as other individuals without a similar health condition in that particular society

CODE 1 Mild participation restriction

Used for example, when the person is restricted in their participation less than 25% of the time, and/or with a low alteration in functioning which may happen occasionally over the last 30 days

CODE 2 Moderate participation restriction

Used for example, when the person is restricted in their participation between 26% and 50% of the time with a significant, and/or with a moderate effect on functioning (Up to half the total scale of performance) which may happen regularly over the last 30 days

CODE 3 Severe participation restriction

Used for example, when participation in this life area can be achieved, but only rarely and/or with an extreme effect on functioning which may happen often over the last 30 days

CODE 4 Complete participation restriction

Used when the person can not participate in this life area. This scale has a margin of error of 5%

CODE 8 Not specified

Used when a person's participation in a life area is restricted but there is insufficient information to use codes 0-4

CODE 9 Not applicable

Used when participation in a life area is not relevant, such as employment for an infant.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.cfm>

Data element attributes

Collection and usage attributes

Guide for use:

Extent of participation is always associated with a health condition. For example, a restriction in participation in 'community, social and civic life' may be recorded when the person has had a stroke, but not when the restriction is associated only with personal preferences, without a related health condition. A value is attached to restriction of participation (i.e. a participation restriction is a disadvantage). The value is dependent on cultural norms, so that an individual may be disadvantaged in one group or location and not in another place.

This data element is used in conjunction with a specified Activities and participation life area (ICF 2001) AN[NNN]. For example, a 'mild restriction in participation in exchange of information'.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also [Person—activity and participation life area, code \(ICF 2001\) AN\[NNN\]](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

[Activities and Participation cluster](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

External cause

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Injury event – external cause, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	391330
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	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

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>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.</p> <p>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.</p> <p>External cause codes V00 to Y34 must be accompanied by an activity code.</p>
<i>Comments:</i>	<p>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.</p> <p>An extended activity code is being developed in consultation with the National Injury Surveillance Unit, Flinders University, Adelaide.</p>

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 \(ICD-10-AM 6th edn\) ANN{.N\[N\]}](#) Health, Superseded 22/12/2009

Implementation in Data Set Specifications: [Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Injury surveillance DSS](#) Health, Standard 14/12/2009

External cause (non-admitted patient)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Injury event – external cause, non-admitted patient code NN
<i>METeOR identifier:</i>	269988
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Environmental event, circumstance or condition as the cause of injury, poisoning or other adverse effect to a non-admitted patient.
<i>Context:</i>	Injury surveillance: 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.
Data Element Concept:	Injury event – external cause

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																												
<i>Data type:</i>	String																												
<i>Format:</i>	NN																												
<i>Maximum character length:</i>	2																												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Motor vehicle - driver</td></tr><tr><td>02</td><td>Motor vehicle - passenger or unspecified occupant</td></tr><tr><td>03</td><td>Motorcycle - driver</td></tr><tr><td>04</td><td>Motorcycle - passenger or unspecified</td></tr><tr><td>05</td><td>Pedal cyclist or pedal cycle passenger</td></tr><tr><td>06</td><td>Pedestrian</td></tr><tr><td>07</td><td>Other or unspecified transport-related circumstance</td></tr><tr><td>08</td><td>Horse-related (includes fall from, struck or bitten by)</td></tr><tr><td>09</td><td>Fall - low (on same level or</td></tr><tr><td>10</td><td>Fall - high (drop of 1 metre or more)</td></tr><tr><td>11</td><td>Drowning, submersion - swimming pool</td></tr><tr><td>12</td><td>Drowning, submersion - other than swimming pool (excludes drowning associated with water craft)</td></tr><tr><td>13</td><td>Other threat to breathing (including strangling and asphyxiation)</td></tr></tbody></table>	Value	Meaning	01	Motor vehicle - driver	02	Motor vehicle - passenger or unspecified occupant	03	Motorcycle - driver	04	Motorcycle - passenger or unspecified	05	Pedal cyclist or pedal cycle passenger	06	Pedestrian	07	Other or unspecified transport-related circumstance	08	Horse-related (includes fall from, struck or bitten by)	09	Fall - low (on same level or	10	Fall - high (drop of 1 metre or more)	11	Drowning, submersion - swimming pool	12	Drowning, submersion - other than swimming pool (excludes drowning associated with water craft)	13	Other threat to breathing (including strangling and asphyxiation)
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14	Fire, flames, smoke
15	Hot drink, food, water, other fluid, steam, gas or vapour
16	Hot object or substance, not otherwise specified
17	Poisoning - drugs or medicinal substance
18	Poisoning - other substance
19	Firearm
20	Cutting, piercing object
21	Dog-related
22	Animal-related (excluding Horse and Dog)
23	(deleted)
24	Machinery in operation
25	Electricity
26	Hot conditions (natural origin) sunlight
27	Cold conditions (natural origins)
28	Other specified external cause
29	Unspecified external cause
30	Struck by or collision with person
31	Struck by or collision with object

Collection and usage attributes

Comments: This code list has been derived from the ICD-10-AM external cause classification.

Source and reference attributes

Reference documents: International Classification of Diseases - Tenth Revision - Australian Modification (3rd edition 2002)

Data element attributes

Collection and usage attributes

Guide for use: This metadata item is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. Non-admitted patients in emergency departments). Select the item which best characterises the circumstances of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate select the one that comes first in the code list. The external cause - non-admitted patient group must always be accompanied by an external cause - human intent code (see metadata item Injury event – external cause, non-admitted patient human intent code NN).

Comments: This metadata item has been developed to cater for the information requirements of the wide range of settings where injury surveillance is undertaken and do not have the capability of recording the complete ICD-10-AM external cause codes.

Further information on the national injury surveillance program can be obtained from 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
National Health Data Committee

Reference documents: International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2002) National Centre for Classification in Health, Sydney

Relational attributes

Related metadata references: Supersedes [External cause - non-admitted patient, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (21.0 KB)

External cause—human intent

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Injury event—human intent of injury, code NN
<i>METeOR identifier:</i>	268944
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The clinician’s assessment identifying the most likely role of human intent in the occurrence of the injury or poisoning, as represented by a code.
Data Element Concept:	Injury event—human intent of injury

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																								
<i>Data type:</i>	String																								
<i>Format:</i>	NN																								
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Collection and usage attributes

Guide for use: Select the code which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. This metadata item must always be accompanied by an Injury event—external cause, non-admitted patient human intent code NN code.

This Value domain is for use in injury surveillance purposes only, when it is not possible to use a complete ICD-10-AM code (e.g. non-admitted patients in emergency departments).

Data element attributes

Collection and usage attributes

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.

Source and reference attributes

Submitting organisation: National Data Standards for Injury Surveillance Advisory Group

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [External cause - human intent, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.4 KB)

Implementation in Data Set Specifications: [Injury surveillance DSS](#) Health, Superseded 05/02/2008

[Injury surveillance DSS](#) Health, Superseded 14/12/2009

[Injury surveillance DSS](#) Health, Standard 14/12/2009

[Injury surveillance NMDS](#) Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Injury surveillance NMDS](#) Health, Superseded 07/12/2005

Family name

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (name) – family name, text X[X(39)]
<i>Synonymous names:</i>	Surname; Last name
<i>METeOR identifier:</i>	286953
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
<i>Definition:</i>	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.
Data Element Concept:	Person (name) – family name

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The agency or establishment should record the person's full family name on their information systems.</p> <p>National Community Services Data Dictionary specific:</p> <p>In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. Or, where proof of identity is required, as the name that is recorded on a majority of the higher point scoring documents that are produced as proof of identity.</p>
<i>Collection methods:</i>	<p>This metadata item should be recorded for all persons who receive services from or are of interest to an organisation. For the purposes of positive identification, it may also be recorded for providers of those services who are individuals.</p> <p>Mixed case should be used.</p> <p>Family name should be recorded in the format preferred by the person. The format should be the same as that written by the person on a (pre) registration form or in the same format as that printed on an identification card, such as a Medicare card, to ensure consistent collection of name data.</p>

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

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

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be the name on their Medicare card. The Person name type metadata item can be used to distinguish between the different types of names that may be used by the person. The following format may assist with data collection:

What is your family name?

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

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

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

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

Hyphenated family names:

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

Punctuation:

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

Examples:

- hyphen, e.g. Wilson-Phillips

Do not leave a space before or after a hyphen, i.e. between the

last letter of 'Wilson' and the hyphen, nor a space between the hyphen and the first letter of 'Phillips'.

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

Do not leave a space before or after the apostrophe, i.e. between the 'O' and the apostrophe, or a space between the apostrophe and 'Brien'.

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

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

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

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

Registered unnamed newborn babies:

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

Persons with only one name:

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

Registering an unidentified person:

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

Registering health care clients from disaster sites:

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

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

If the family name needs to be shortened:

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

Use of incomplete names or fictitious names:

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

Baby for **adoption**:

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

Prefixes:

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

Ethnic Names:

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

Misspelled family name:

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

Comments:

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

National Community Services Data Dictionary specific:

Selected letters of the family name in combination with selected

letters of the given name, date of birth and sex, may be used for record linkage for statistical purposes only.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare Standards Australia
<i>Origin:</i>	National Health Data Committee National Community Services Data Committee Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

<i>Related metadata references:</i>	See also Person (name) – given name, text [X(40)] Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005 Supersedes Person (name) – family name, text X[X(39)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005 Is used in the formation of Person (name) – letters of name, text XXXXX Community services, Standard 14/09/2009 Is used in the formation of Person – letters of given name, text XX Community services, Standard 27/03/2007 Is used in the formation of Person – letters of family name, text XXX Community services, Standard 27/03/2007
<i>Implementation in Data Set Specifications:</i>	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009 Cancer (clinical) DSS Health, Superseded 22/12/2009 Cancer (clinical) DSS Health, Standard 22/12/2009 Health care client identification DSS Health, Superseded 03/12/2008 Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Fasting status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Health service event – fasting indicator, code N
<i>METeOR identifier:</i>	302941
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether the patient was fasting at the time of an examination, test, investigation or procedure, as represented by a code.
Data Element Concept:	Health service event – fasting indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if the patient is fasting at the time of an examination, test, investigation or procedure. CODE 2 No: Record if the patient is not fasting at the time of an examination, test, investigation or procedure.
<i>Comments:</i>	In settings where the monitoring of a person's health is ongoing and where management can change over time (such as general practice), the service contact date should be recorded.

Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group Cardiovascular Data Working Group
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Relational attributes

Related metadata references:

Supersedes [Health service event – fasting status, code N](#) Health, Superseded 21/09/2005

Is used in the formation of [Person – low-density lipoprotein cholesterol level \(calculated\), total millimoles per litre N\[N\].N](#) Health, Standard 01/10/2008

Is used in the formation of [Person – low-density lipoprotein cholesterol level \(calculated\), total millimoles per litre N\[N\].N](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Feedback collection indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – feedback collection indicator, yes/no code N
<i>METeOR identifier:</i>	290438
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Whether feedback relating to services and service delivery is actively and routinely collected from clients and staff within a service provider organisation, as represented by a code.
Data Element Concept:	Service provider organisation – feedback collection indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Boolean	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Yes
	2	No

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The active and routine collection of feedback from clients and/or staff means that, as a matter of routine, the agency initiates and implements feedback mechanisms and does not rely on mechanisms such as ad hoc comments, ad hoc questionnaires, informal debriefing sessions, or similar casual arrangements.</p> <p>Active mechanisms include the use of periodic questionnaires that are implemented through either face-to-face interviews, by telephone or by mail, focus groups aimed at collecting feedback from the participants, established debriefing sessions, or other routine procedures the agency has in place to collect feedback.</p> <p>CODE 1 Yes</p> <p>The service provider organisation actively and routinely collects feedback relating to services and service delivery from clients <u>and</u> staff within the service provider organisation. If feedback is actively and routinely collected from clients only or staff only, this should be recorded as 'No' (Code 2).</p> <p>CODE 2 No</p> <p>The service provider organisation does not actively and routinely</p>
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collect feedback relating to services and service delivery from clients and staff within the service provider organisation.

Collection methods:

Record only one code.

Source and reference attributes

Submitting organisation:

Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

[Palliative care performance indicators DSS](#) Health, Standard 05/12/2007

Feedback collection method

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – feedback collection method, code N
<i>METeOR identifier:</i>	290476
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The method the service provider organisation employs to actively and routinely collect feedback on services and service delivery, as represented by a code.
Data Element Concept:	Service provider organisation – feedback collection method

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	N																		
<i>Maximum character length:</i>	1																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Questionnaire - periodic face-to-face interview</td></tr><tr><td>2</td><td>Questionnaire - face-to-face interview on exit</td></tr><tr><td>3</td><td>Questionnaire - periodic telephone interview</td></tr><tr><td>4</td><td>Questionnaire - telephone interview on exit</td></tr><tr><td>5</td><td>Questionnaire - periodic written survey</td></tr><tr><td>6</td><td>Questionnaire - written survey on exit</td></tr><tr><td>7</td><td>Feedback focus group</td></tr><tr><td>8</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Questionnaire - periodic face-to-face interview	2	Questionnaire - face-to-face interview on exit	3	Questionnaire - periodic telephone interview	4	Questionnaire - telephone interview on exit	5	Questionnaire - periodic written survey	6	Questionnaire - written survey on exit	7	Feedback focus group	8	Other
Value	Meaning																		
1	Questionnaire - periodic face-to-face interview																		
2	Questionnaire - face-to-face interview on exit																		
3	Questionnaire - periodic telephone interview																		
4	Questionnaire - telephone interview on exit																		
5	Questionnaire - periodic written survey																		
6	Questionnaire - written survey on exit																		
7	Feedback focus group																		
8	Other																		

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The active and routine collection of feedback means that, as a matter of routine, the agency initiates and implements feedback methods and does not rely on mechanisms such as ad hoc comments, ad hoc questionnaires, informal debriefing sessions, or similar casual arrangements.</p> <p>Active methods include the use of periodic questionnaires that are implemented through either face-to-face interviews, by telephone or by mail, focus groups aimed at collecting feedback from the participants, established debriefing sessions, or other routine procedures the agency has in place to collect feedback.</p> <p>The aim of the method used must be to collect feedback on services and service delivery.</p>
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'Periodic' may mean at set intervals or at (a) specified points in time during the service episode.

'On exit' refers to the closure of the service episode (for clients or related people), or (for staff) the time at which the staff member ceases to be employed by the agency.

CODE 7 Feedback focus group

An in-depth qualitative interview with a small number of persons, held specifically to collect feedback from the participants.

Collection methods:

More than one code can be recorded.

Source and reference attributes

Submitting organisation:

Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

[Palliative care performance indicators DSS](#) Health, Standard 05/12/2007

Conditional obligation:

Recorded when the data element *Service provider organisation – feedback collection indicator, yes/no code N* value is 'yes' (code 1).

Fibrinolytic drug used

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – fibrinolytic drug administered, code N
<i>METeOR identifier:</i>	356870
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of fibrinolytic drug administered to a person, as represented by a code.
Data Element Concept:	Person – fibrinolytic drug administered

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Streptokinase</td></tr><tr><td>2</td><td>t-PA (Tissue Plasminogen Activator) (Alteplase)</td></tr><tr><td>3</td><td>r-PA (Retepase)</td></tr><tr><td>4</td><td>TNK t-PA (Tenecteplase)</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Streptokinase	2	t-PA (Tissue Plasminogen Activator) (Alteplase)	3	r-PA (Retepase)	4	TNK t-PA (Tenecteplase)	9	Not stated/inadequately described
Value	Meaning												
1	Streptokinase												
2	t-PA (Tissue Plasminogen Activator) (Alteplase)												
3	r-PA (Retepase)												
4	TNK t-PA (Tenecteplase)												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Relational attributes

Related metadata references: Supersedes [Person – fibrinolytic drug administered, code N](#)
Health, Superseded 01/10/2008

Implementation in Data Set Specifications: [Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Conditional obligation:
If prescribed, provide the fibrinolytic drug administered.

Fibrinolytic therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – fibrinolytic therapy status, code NN
<i>METeOR identifier:</i>	285087
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The person's fibrinolytic therapy status, as represented by a code.
Data Element Concept:	Person – fibrinolytic therapy status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																												
<i>Data type:</i>	Number																												
<i>Format:</i>	NN																												
<i>Maximum character length:</i>	2																												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>10</td><td>Given</td></tr><tr><td>21</td><td>Not given - therapy not indicated</td></tr><tr><td>22</td><td>Not given - patient refusal</td></tr><tr><td>23</td><td>Not given - previous haemorrhagic stroke at any time; other strokes or cerebrovascular events within 1 year</td></tr><tr><td>24</td><td>Not given - known intracranial neoplasm</td></tr><tr><td>25</td><td>Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses)</td></tr><tr><td>26</td><td>Not given - suspected aortic dissection</td></tr><tr><td>27</td><td>Not given - severe uncontrolled hypertension on presentation (blood pressure >180 mmHg systolic and/or 110 mmHg diastolic). Note: This could be an absolute contraindication in low-risk patients with MI.</td></tr><tr><td>28</td><td>Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in 2.3 & 2.4 contraindications</td></tr><tr><td>29</td><td>Not given - current use of anticoagulants in therapeutic doses (INR greater than or equal to 2); known bleeding diathesis</td></tr><tr><td>30</td><td>Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)</td></tr><tr><td>31</td><td>Not given - pregnancy</td></tr><tr><td>32</td><td>Not given - other</td></tr></tbody></table>	Value	Meaning	10	Given	21	Not given - therapy not indicated	22	Not given - patient refusal	23	Not given - previous haemorrhagic stroke at any time; other strokes or cerebrovascular events within 1 year	24	Not given - known intracranial neoplasm	25	Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses)	26	Not given - suspected aortic dissection	27	Not given - severe uncontrolled hypertension on presentation (blood pressure >180 mmHg systolic and/or 110 mmHg diastolic). Note: This could be an absolute contraindication in low-risk patients with MI.	28	Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in 2.3 & 2.4 contraindications	29	Not given - current use of anticoagulants in therapeutic doses (INR greater than or equal to 2); known bleeding diathesis	30	Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)	31	Not given - pregnancy	32	Not given - other
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32	Not given - other																												

Supplementary values: 90 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: CODES 23, 24, 25, 26, 27, 28, 29, 30 and 31
More than one code may be recorded for the following codes: 23, 24, 25, 26, 27, 28, 29, 30 and 31.

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group
Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes [Fibrinolytic therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.0 KB)

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

Field of medicine—medical practitioner

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – principal field of medicine, medical practitioner code N
<i>METeOR identifier:</i>	377809
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The field of medicine in which a medical practitioner spent the most hours in the week before registration, as represented by a code.
Data Element Concept:	Registered health professional – principal field of medicine

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>General practitioner (GP)</td></tr><tr><td>2</td><td>Hospital non-specialist (salaried)</td></tr><tr><td>3</td><td>Specialist</td></tr><tr><td>4</td><td>Specialist-in-training</td></tr><tr><td>5</td><td>Other clinician</td></tr><tr><td>6</td><td>Non-clinician</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	General practitioner (GP)	2	Hospital non-specialist (salaried)	3	Specialist	4	Specialist-in-training	5	Other clinician	6	Non-clinician	9	Not stated/inadequately described
Value	Meaning																
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2	Hospital non-specialist (salaried)																
3	Specialist																
4	Specialist-in-training																
5	Other clinician																
6	Non-clinician																
9	Not stated/inadequately described																
<i>Supplementary values:</i>																	

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 GENERAL PRACTITIONER</p> <p>A medical practitioner who works in general practice and has membership with the Royal Australian College of General Practice (RACGP) or who holds a training position supervised by a member of the college. It includes medical practitioners who are currently:</p> <ul style="list-style-type: none">• Vocationally registered• a RACGP fellow• a RACGP fellowship trainee• a GP registrar <p>CODE 2 HOSPITAL NON-SPECIALIST (SALARIED)</p> <p>A medical practitioner mainly employed in a salaried position in a hospital who is not in training to gain a recognised specialist qualification. They include interns, Resident Medical Officers</p>
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(RMOs), and Hospital Medical Officers (HMOs).

CODE 3 SPECIALIST

A medical practitioner with a qualification awarded by, or which equates to that awarded by, the relevant specialist professional college in Australia and works in that speciality area.

CODE 4 SPECIALIST-IN-TRAINING

A medical practitioner who has been accepted by a specialist medical college into a training position supervised by a member of the college and is working in that position.

CODE 5 OTHER CLINICIAN

A medical practitioner that has mainly undertaken clinical work in the week before registration, but who does not fall into any of the above categories.

CODE 6 NON-CLINICIAN

Includes all medical practitioners that have not mainly undertaken clinical work in the week prior to registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Registered medical professional labour force DSS Health, Standard 10/12/2009](#)

First day of the last menstrual period

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Pregnancy – first day of the last menstrual period, date DDMMYYYY
<i>METeOR identifier:</i>	270038
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date of the first day of the mother's last menstrual period (LMP).
<i>Data Element Concept:</i>	Pregnancy – first day of the last menstrual period

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	If the first day is unknown, it is unnecessary to record the month and year (i.e. record 99999999).
<i>Comments:</i>	The first day of the LMP is required to estimate gestational age, which is a key outcome of pregnancy and an important risk factor for neonatal outcomes. Although the date of the LMP may not be known, or may sometimes be erroneous, estimation of gestational age based on clinical assessment may also be inaccurate. Both methods of assessing gestational age are required for analysis of outcomes.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes First day of the last menstrual period, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB) Is used in the formation of Female (pregnant) – estimated gestational age, total weeks NN Health, Superseded 02/12/2009
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Floor/level number (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – floor/level identifier, [NNNA]
<i>Synonymous names:</i>	Australian level number
<i>METeOR identifier:</i>	270029
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The unique identifier for the floor/level where a person can be located.
Data Element Concept:	Person (address) – floor/level identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	[NNNA]
<i>Maximum character length:</i>	4

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Floor/level number and suffix are both optional. The Floor/level number must be recorded with its corresponding Floor/level type. Some Floor/level numbers may be followed by an alphabetic suffix. Examples of Floor/level identification: FL 1A L 3 LG A
<i>Collection methods:</i>	Do not leave a space between the number and alpha suffix. To be collected in conjunction with Floor/level type.

Source and reference attributes

<i>Origin:</i>	Health Data Standards Committee Australia Post Address Presentation Standard
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes [Floor/level number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (13.9 KB)

Is used in the formation of [Person \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of [Person \(address\) – health address line, text \[X\(180\)\]](#) Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Floor/level number (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – floor/level identifier, [NNNA]
<i>METeOR identifier:</i>	290264
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The unique identifier for floor/level, where an organisation can be located.
Data Element Concept:	Service provider organisation (address) – floor/level identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	[NNNA]
<i>Maximum character length:</i>	4

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Floor/level number and suffix are both optional. The Floor/level number must be recorded with its corresponding Floor/level type. Some Floor/level numbers may be followed by an alphabetic suffix. Examples of Floor/level identification: FL 1A L 3 LG A
<i>Collection methods:</i>	Do not leave a space between the number and alpha suffix. To be collected in conjunction with Floor/level type.

Source and reference attributes

<i>Origin:</i>	Health Data Standards Committee Australia Post Address Presentation Standard
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Relational attributes

<i>Related metadata references:</i>	Is used in the formation of Service provider organisation (address) – address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
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Implementation in Data Set Specifications:

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Floor/level type (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – floor/level type, code A[A]
<i>Synonymous names:</i>	Australian level type
<i>METeOR identifier:</i>	270024
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The type of floor/level where a person can be located, as represented by a code.
Data Element Concept:	Person (address) – floor/level type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	String																
<i>Format:</i>	A[A]																
<i>Maximum character length:</i>	2																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>B</td><td>Basement</td></tr><tr><td>FL</td><td>Floor</td></tr><tr><td>G</td><td>Ground</td></tr><tr><td>L</td><td>Level</td></tr><tr><td>LG</td><td>Lower Ground</td></tr><tr><td>M</td><td>Mezzanine</td></tr><tr><td>UG</td><td>Upper Ground</td></tr></tbody></table>	Value	Meaning	B	Basement	FL	Floor	G	Ground	L	Level	LG	Lower Ground	M	Mezzanine	UG	Upper Ground
Value	Meaning																
B	Basement																
FL	Floor																
G	Ground																
L	Level																
LG	Lower Ground																
M	Mezzanine																
UG	Upper Ground																

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Some floor/level identification may require the Floor/level type plus a Floor/level number to be recorded.
<i>Collection methods:</i>	To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.

Source and reference attributes

<i>Origin:</i>	Health Data Standards Committee Australia Post Address Presentation Standard
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes [Floor/level type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.5 KB)

Is used in the formation of [Person \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of [Person \(address\) – health address line, text \[X\(180\)\]](#) Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Floor/level type (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – floor/level type, code A[A]
<i>METeOR identifier:</i>	290245
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The type of floor/level where an organisation can be located, as represented by a code.
Data Element Concept:	Service provider organisation (address) – floor/level type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	String																
<i>Format:</i>	A[A]																
<i>Maximum character length:</i>	2																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>B</td><td>Basement</td></tr><tr><td>FL</td><td>Floor</td></tr><tr><td>G</td><td>Ground</td></tr><tr><td>L</td><td>Level</td></tr><tr><td>LG</td><td>Lower Ground</td></tr><tr><td>M</td><td>Mezzanine</td></tr><tr><td>UG</td><td>Upper Ground</td></tr></tbody></table>	Value	Meaning	B	Basement	FL	Floor	G	Ground	L	Level	LG	Lower Ground	M	Mezzanine	UG	Upper Ground
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B	Basement																
FL	Floor																
G	Ground																
L	Level																
LG	Lower Ground																
M	Mezzanine																
UG	Upper Ground																

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	To be collected in conjunction with Floor/level number where applicable. Some Floor/level type entries will often have no corresponding number e.g. Basement, Ground, Lower ground, Mezzanine and Upper ground.
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Source and reference attributes

<i>Origin:</i>	Health Data Standards Committee Australia Post Address Presentation Standard
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Relational attributes

<i>Related metadata references:</i>	Is used in the formation of Service provider organisation (address) – address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
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Implementation in Data Set Specifications:

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Foot deformity

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – foot deformity indicator, code N
<i>METeOR identifier:</i>	302449
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether a deformity is present on either foot, as represented by a code.
Data Element Concept:	Person – foot deformity indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if a foot deformity is present on either foot. CODE 2 No: Record if no foot deformity is present on either foot. Common deformities include claw toes, pes cavus, hallux valgus, hallux rigidus, hammer toe, Charcot foot and nail deformity.
<i>Collection methods:</i>	Both feet to be examined for the presence of foot deformity.
<i>Comments:</i>	Foot deformities are associated with high mechanical pressure on the overlying skin that lead to ulceration in the absence of protective pain sensation and when shoes are unsuitable. Limited joint mobility is often present, with displaced plantar fat pad and more prominent metatarsal heads.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
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Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents:

Lesley V Campbell, Antony R Graham, Rosalind M Kidd, Hugh F Molloy, Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society.

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27 - 42.

Reiber GE. Epidemiology of the diabetic foot. In: Levin ME, O'Neal LW, Bowker JH, editors. The diabetic foot. 5th ed. St Louis: Mosby Year Book, 1993; 1 - 5.

Most RS, Sinnock P. The epidemiology of lower limb extremity amputations in diabetic individuals. Diabetes Care 1983; 6: 87 - 91.

Therapeutic Guidelines Limited (05.04.2002) Management plan for diabetes.

Relational attributes

Related metadata references:

Supersedes [Person – foot deformity status, code N](#) Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Foot lesion (active)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – foot lesion indicator (active), code N
<i>METeOR identifier:</i>	302437
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether an individual has an active foot lesion, other than an ulcer, on either foot, as represented by a code.
Data Element Concept:	Person – foot lesion indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if current active foot lesion other than ulceration is present on either foot. CODE 2 No: Record if no current active foot lesion other than ulceration is present on either foot. The following entities would be included: fissures, infections, inter-digital maceration, corns, calluses and nail dystrophy.
<i>Collection methods:</i>	Assess whether the individual has an active foot lesion on either foot.

Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes [Person – foot lesion status \(active\), code N](#) Health,
Superseded 21/09/2005

*Implementation in Data Set
Specifications:*

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Foot ulcer (history)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – foot ulcer indicator (history), code N
<i>METeOR identifier:</i>	302819
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether person has a previous history of ulceration on either foot, as represented by a code.
Data Element Concept:	Person – foot ulcer indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if person has a previous history of ulceration on either foot. CODE 2 No: Record if person has no previous history of ulceration on either foot.
<i>Collection methods:</i>	Ask the individual if he/she a previous history of foot ulceration. Alternatively obtain this information from appropriate documentation.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:

Supersedes [Person – foot ulcer history status, code N](#) Health,
Superseded 21/09/2005

*Implementation in Data Set
Specifications:*

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Foot ulcer (current)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – foot ulcer indicator (current), code N
<i>METeOR identifier:</i>	302445
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether an individual has a current foot ulcer on either foot, as represented by a code.
Data Element Concept:	Person – foot ulcer indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if a foot ulcer is currently present on either foot. CODE 2 No: Record if a foot ulcer is not currently present on either foot.
<i>Collection methods:</i>	Access whether the individual has a current foot ulcer on either foot. Assessment <ul style="list-style-type: none">ask the patient about previous or current foot problems, neuropathic symptoms, rest pain and intermittent claudication;inspect the feet (whole foot, nails, between the toes) to identify active foot problems and the 'high-risk foot';assess footwear;

- check peripheral pulses;
- examine for neuropathy by testing reflexes and sensation preferably using tuning fork, 10 g monofilament and/or biothesiometer.

Comments:

Foot ulcer is usually situated on the edge of the foot or toes because blood supply is the poorest at these sites. In a purely vascular ulcer, nerve function is normal and sensation is intact, hence vascular ulcers are usually painful.

Foot ulcers require urgent care from an interdisciplinary team, which may include a general practitioner, podiatrist, endocrinologist physician, nurse or surgeon.

Source and reference attributes

Submitting organisation:

National diabetes data working group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents:

The Diabetic Foot Vol 3 No 4. Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus.

Relational attributes

Related metadata references:

Supersedes [Person – foot ulcer status \(current\), code N](#) Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Formal community support access status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – formal community support access indicator (current), code N
<i>METeOR identifier:</i>	270169
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether a person is currently accessing a formal community support service or services, as represented by a code.
Data Element Concept:	Person – formal community support access indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Currently accessing</td></tr><tr><td>2</td><td>Currently not accessing</td></tr><tr><td>9</td><td>Not known/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Currently accessing	2	Currently not accessing	9	Not known/inadequately described
Value	Meaning								
1	Currently accessing								
2	Currently not accessing								
9	Not known/inadequately described								
<i>Supplementary values:</i>									

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1: The person is currently accessing at least one paid community support service (i.e. meals on wheels, home help, in-home respite, service packages, district nursing services, etc).</p> <p>CODE 2: The person is not currently accessing any paid community support service or services.</p> <p>CODE 9: The person's current status with regards to accessing community support services is not known or inadequately described for more specific coding.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular Data Working Group
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Relational attributes

Related metadata references:

Supersedes [Formal community support access status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.5 KB)

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Full-time equivalent staff (mental health)—all staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment (mental health) – full-time equivalent staff (paid), total N[NNN{.N}]
<i>METeOR identifier:</i>	296553
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The aggregate full-time equivalent staff units paid for all staffing categories within a mental health establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff
<i>Unit of measure precision:</i>	1

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The total is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.</p> <p>Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.</p>
<i>Collection methods:</i>	<p>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.</p> <p>Where staff provide services to more than one hospital (for Public</p>

hospitals NMDS) or service unit (for Mental health establishments NMDS), 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

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Is formed using [Establishment – full-time equivalent staff \(paid\) \(other personal care staff\), average N\[NNN{.N}\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – full-time equivalent staff \(paid\) \(domestic and other staff\), average N\[NNN{.N}\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – full-time equivalent staff \(paid\) \(administrative and clerical staff\), average N\[NNN{.N}\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – full-time equivalent staff \(paid\) \(enrolled nurses\), average N\[NNN{.N}\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – full-time equivalent staff \(paid\) \(registered nurses\), average N\[NNN{.N}\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – full-time equivalent staff \(paid\) \(consumer consultants\), average N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Is formed using [Establishment – full-time equivalent staff \(paid\) \(carer consultants\), average N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Is formed using [Establishment – full-time equivalent staff \(paid\) \(salaried medical officers\), average N\[NNN{.N}\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – full-time equivalent staff \(paid\) \(diagnostic and health professionals\), average N\[NNN{.N}\]](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Full-time equivalent staff—administrative and clerical staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}]
<i>METeOR identifier:</i>	270496
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all administrative and clerical staff within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (administrative and clerical staff)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this metadata item.</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee 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.</p> <p>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.</p> <p>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).</p>
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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

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)

Is used in the formation of [Establishment \(mental health\) – full-time equivalent staff \(paid\), total N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—average

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid), average N[NNN{.N}]
<i>METeOR identifier:</i>	270543
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all staffing categories within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Calculated by adding the full-time equivalents for each staffing category listed below:</p> <ul style="list-style-type: none">C1.1 Salaried medical officersC1.2 Registered nursesC1.3 Enrolled nursesC1.4 Student nursesC1.5 Trainee/pupil nursesC1.6 Other personal care staffC1.7 Diagnostic and health professionalsC1.8 Administrative and clerical staffC1.9 Domestic and other staff <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>Data on full-time equivalent staffing numbers by category should</p>
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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).

Full-time equivalent staff units are the on-job hours paid for (including overtime) and hours of paid leave of any type for a staff member (or contract employee where applicable) divided by the number of ordinary-time hours normally paid for a full-time staff member when on the job (or contract employee where applicable) under the relevant award or agreement for the staff member (or contract employee occupation where applicable). Hours of unpaid leave are to be excluded.

Contract staff employed through an agency are included where the contract is for the supply of labour (e.g. nursing) rather than of products (e.g. photocopier maintenance). In the former case, the contract would normally specify the amount of labour supplied and could be reported as full-time equivalent units.

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

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)

Implementation in Data Set Specifications:

[Community mental health establishments NMDS 2004-2005 Health, Superseded 08/12/2004](#)

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Full-time equivalent staff—carer consultants

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}]
<i>METeOR identifier:</i>	296498
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all carer consultants within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (carer consultants)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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).</p>
<i>Comments:</i>	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

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is used in the formation of [Establishment \(mental health\) – full-time equivalent staff \(paid\), total N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—consultant psychiatrists and psychiatrists

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists), average N[NNN{.N}]
<i>METeOR identifier:</i>	287509
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all consultant psychiatrists and psychiatrists within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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 metadata items.</p> <p>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).</p>
<i>Comments:</i>	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

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—consumer consultants

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}]
<i>METeOR identifier:</i>	296496
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all consumer consultants within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (consumer consultants)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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).</p>
<i>Comments:</i>	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

Origin: National Health Data Committee

Relational attributes

Related metadata references: Is used in the formation of [Establishment \(mental health\) – full-time equivalent staff \(paid\), total N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications: [Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005
Implementation start date: 01/07/2005
[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009
[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009
Implementation start date: 01/07/2009
Implementation end date: 30/06/2010
[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009
Implementation start date: 01/07/2010

Conditional obligation:
If specialised mental health service organisation-consumer participation arrangements status (consumer consultants employed) METeOR 288866 = 1, this data element must be completed.

Full-time equivalent staff—diagnostic and health professionals

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}]
<i>METeOR identifier:</i>	270495
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all diagnostic and health professionals within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (diagnostic and health professionals)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This metadata item includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff). This metadata item includes full-time equivalent staff units of occupational therapists, social workers, psychologists, and other diagnostic and health professionals.</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee 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.</p> <p>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</p>
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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

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)

Is used in the formation of [Establishment \(mental health\) – full-time equivalent staff \(paid\), total N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—domestic and other staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}]
<i>METeOR identifier:</i>	270498
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all domestic and other staff within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (domestic and other staff)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded.</p> <p>This metadata item also includes all staff not elsewhere included (primarily maintenance staff, trades people and gardening staff).</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee 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.</p> <p>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.</p> <p>Where staff provide services to more than one establishment, full-time equivalent staff members should be apportioned between all</p>
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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

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)

Is used in the formation of [Establishment \(mental health\) – full-time equivalent staff \(paid\), total N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—enrolled nurses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}]
<i>METeOR identifier:</i>	270497
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all enrolled nurses within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (enrolled nurses)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Enrolled nurses are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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.</p> <p>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).</p>
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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

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)
Is used in the formation of [Establishment \(mental health\) – full-time equivalent staff \(paid\), total N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications: [Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005
Implementation start date: 01/07/2005
[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009
[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009
Implementation start date: 01/07/2009
Implementation end date: 30/06/2010
[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009
Implementation start date: 01/07/2010
[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—occupational therapists

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (occupational therapists), average N[NNN{.N}]
<i>METeOR identifier:</i>	287603
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all occupational therapists within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (occupational therapists)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Occupational Therapists.</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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).</p>
<i>Comments:</i>	<p>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.</p>

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—other diagnostic and health professionals

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (other diagnostic and health professionals), average N[NNN{.N}]
<i>METeOR identifier:</i>	287611
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all other diagnostic and health professionals within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (other diagnostic and health professionals)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature. This metadata item covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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).</p>
<i>Comments:</i>	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

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—other medical officers

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (other medical officers), average N[NNN{.N}]
<i>METeOR identifier:</i>	287531
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all other medical officers within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (other medical officers)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Medical officers employed or engaged by the organisation who are neither registered as psychiatrists within the state or territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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 metadata items.</p> <p>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).</p>
<i>Comments:</i>	<p>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.</p>

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—other personal care staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}]
<i>METeOR identifier:</i>	270171
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all other personal care staff within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (other personal care staff)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item includes attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee 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.</p> <p>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).</p> <p>Data on full-time equivalent staffing numbers by category should be consistent with data on salaries and wages by staffing</p>
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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

Steward:

Australian Bureau of Statistics (ABS)

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)

Is used in the formation of [Establishment \(mental health\) – full-time equivalent staff \(paid\), total N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—psychiatry registrars and trainees

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (psychiatry registrars and trainees), average N[NNN{.N}]
<i>METeOR identifier:</i>	287529
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all psychiatry registrars and trainees within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (psychiatry registrars and trainees)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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).</p>
<i>Comments:</i>	<p>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</p>

establishment outputs and for assessments and comparisons of labour costs.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—psychologists

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (psychologists), average N[NNN{.N}]
<i>METeOR identifier:</i>	287609
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all psychologists within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (psychologists)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Persons who are registered as psychologists with the relevant state and territory registration board.</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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).</p>
<i>Comments:</i>	<p>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.</p>

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—registered nurses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}]
<i>METeOR identifier:</i>	270500
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all registered nurses within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (registered nurses)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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.</p> <p>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).</p>
<i>Comments:</i>	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

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)

Is used in the formation of [Establishment \(mental health\) – full-time equivalent staff \(paid\), total N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—salaried medical officers

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}]
<i>METeOR identifier:</i>	270494
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all salaried medical officers within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (salaried medical officers)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Medical officers employed by the hospital on a full time or part time salaried basis. This excludes visiting medical officers engaged on an honorary, sessional or fee for service basis.</p> <p>This metadata item includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent).</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>If under the relevant award of agreement a full-time employee is paid for an 80 (ordinary time) hour fortnight, the full-time equivalent for a part-time employee who works 64 hours is 0.8. If a full-time employee 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.</p> <p>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.</p>
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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).

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.

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.

Relational attributes

Related metadata references:

Supersedes [Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)

Is used in the formation of [Establishment \(mental health\) – full-time equivalent staff \(paid\), total N\[NNN{.N}\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—social workers

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (social workers), average N[NNN{.N}]
<i>METeOR identifier:</i>	287607
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all social workers within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (social workers)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.</p> <p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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).</p>
<i>Comments:</i>	<p>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.</p>

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Full-time equivalent staff—student nurses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (student nurses), average N[NNN{.N}]
<i>METeOR identifier:</i>	270499
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all student nurses within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (student nurses)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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.</p> <p>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).</p>
<i>Comments:</i>	<p>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</p>

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

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Full-time equivalent staff—trainee/pupil nurses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – full-time equivalent staff (paid) (trainee/pupil nurses), average N[NNN{.N}]
<i>METeOR identifier:</i>	270493
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The average number of full-time equivalent staff units paid for all trainee/pupil nurses within an establishment.
Data Element Concept:	Establishment – full-time equivalent staff (paid) (trainee/pupil nurses)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN{.N}]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Full-time equivalent (FTE) staff

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The average is to be calculated from pay period figures. The length of the pay period is assumed to be a fortnight.</p> <p>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.</p> <p>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.</p> <p>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).</p>
<i>Comments:</i>	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

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Full-time equivalent staff, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Functional stress ischaemic and perfusion outcome result

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Functional stress test – ischaemic and perfusion outcome result, code N
<i>Synonymous names:</i>	Functional stress test result
<i>METeOR identifier:</i>	349703
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The result of the person's functional stress test in terms of ischaemic and perfusion outcomes, as represented by a code.
Data Element Concept:	Functional stress test – ischaemic and perfusion outcome result

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>No abnormal outcome</td></tr><tr><td>2</td><td>Ischaemic discomfort and/or ST shift</td></tr><tr><td>3</td><td>Fixed perfusion or wall motion defects only</td></tr><tr><td>4</td><td>Reversible perfusion or wall motion defects only</td></tr><tr><td>5</td><td>Fixed and reversible perfusion and wall motion defects</td></tr><tr><td>6</td><td>Equivocal</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	No abnormal outcome	2	Ischaemic discomfort and/or ST shift	3	Fixed perfusion or wall motion defects only	4	Reversible perfusion or wall motion defects only	5	Fixed and reversible perfusion and wall motion defects	6	Equivocal	9	Not stated/inadequately described
Value	Meaning																
1	No abnormal outcome																
2	Ischaemic discomfort and/or ST shift																
3	Fixed perfusion or wall motion defects only																
4	Reversible perfusion or wall motion defects only																
5	Fixed and reversible perfusion and wall motion defects																
6	Equivocal																
9	Not stated/inadequately described																
<i>Supplementary values:</i>																	

Collection and usage attributes

<i>Guide for use:</i>	<p>Depending on the method used for the stress test, and therefore the way the results are viewed, some of these codes will not be applicable. For example where an ECG was used for the stress test codes 3, 4 and 5 will not be applicable.</p> <p>CODE 1 No abnormal outcome</p> <p>Use this code when the stress test result identifies no evidence of ischaemia (i.e. no typical angina pain and no ST shifts).</p> <p>CODE 2 Ischaemic discomfort and/or ST shift</p> <p>Use this code when the stress test result identifies either:</p> <ul style="list-style-type: none">• Both ischaemic discomfort and ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping); or• new ST shift greater than or equal to 2 mm (0.2 mV) (horizontal or down-sloping) believed to represent ischaemia even in the absence of ischaemic discomfort.
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This code only applies to stress tests where no imaging component was performed.

CODE 3 Fixed perfusion or wall motion defects only

Use this code when the stress test result identifies fixed perfusion defects only. This means the presence of non-viable myocardium with no areas of inducible ischaemia during functional stress testing.

This code only applies to stress tests where an imaging component was performed.

CODE 4 Reversible perfusion or wall motion defects only

Use this code when the stress test result identifies reversible perfusion defects only. This means the presence of inducible defects in myocardial perfusion with underlying viable myocardium in all areas.

This code only applies to stress tests where an imaging component was performed.

CODE 5 Fixed and reversible perfusion or wall motion defects

Use this code when the stress test result identifies reversible and fixed perfusion defects. This means the presence of non-viable myocardial areas, together with areas of inducible defects in reperfusion.

This code only applies to stress tests where an imaging component was performed.

CODE 6 Equivocal

Use this code when the stress test result identifies either:

- Typical ischaemic pain but no ST shift greater than or equal to 1 mm (0.1 mV) (horizontal or downsloping); OR ST shift of 1 mm (0.1 mV) (horizontal or downsloping) but no ischaemic discomfort.
- Defect on myocardial imaging of uncertain nature or significance.

Data element attributes

Relational attributes

Related metadata references:

Supersedes [Person – functional stress test ischaemic result, code N](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

[Functional stress test cluster](#) Health, Standard 01/10/2008

Conditional obligation:

To be provided when a functional stress test is performed.

Functional stress test assessment of cardiac perfusion

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Functional stress test – assessment of cardiac perfusion, code N[N]
<i>Synonymous names:</i>	Functional stress test method
<i>METeOR identifier:</i>	344432
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The method of functional assessment of cardiac perfusion undertaken in a person's stress test, as represented by a code.
Data Element Concept:	Functional stress test – assessment of cardiac perfusion

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Exercise tolerance</td></tr><tr><td>2</td><td>Pharmacological</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Exercise tolerance	2	Pharmacological	9	Not stated/inadequately described
Value	Meaning								
1	Exercise tolerance								
2	Pharmacological								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Exercise tolerance Use this code when a treadmill, bicycle or arm-exercise was used to increase the cardiac work. CODE 2 Pharmacological Use this code when any form of pharmacologic augmentation was used to increase cardiac work. For example, dobutamine, atropine or persantin. CODE 9 Not stated/inadequately described Not for use in primary data collections.
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Data element attributes

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Functional stress test cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> To be provided when a functional stress test is performed.
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Functional stress test element

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Functional stress test – stress test element, code N
<i>METeOR identifier:</i>	356883
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The element included in a person's functional stress test, as represented by a code.
Data Element Concept:	Functional stress test – functional stress test element

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>ECG monitoring</td></tr><tr><td>2</td><td>Echocardiography</td></tr><tr><td>3</td><td>Radionuclide (perfusion) imaging (e.g. Thallium, Sestamibi)</td></tr><tr><td>4</td><td>Positron Emission Tomography (PET)</td></tr><tr><td>5</td><td>Magnetic Resonance Imaging (MRI)</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	ECG monitoring	2	Echocardiography	3	Radionuclide (perfusion) imaging (e.g. Thallium, Sestamibi)	4	Positron Emission Tomography (PET)	5	Magnetic Resonance Imaging (MRI)	9	Not stated/inadequately described
Value	Meaning														
1	ECG monitoring														
2	Echocardiography														
3	Radionuclide (perfusion) imaging (e.g. Thallium, Sestamibi)														
4	Positron Emission Tomography (PET)														
5	Magnetic Resonance Imaging (MRI)														
9	Not stated/inadequately described														
<i>Supplementary values:</i>															

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	More than one code may be recorded (code 9 is excluded from multiple coding).
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Person – functional stress test element, code N Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Functional stress test cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> To be provided when a functional stress test is performed.

Functional stress test intensity

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Functional stress test – stress test intensity, code N
<i>METeOR identifier:</i>	344443
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The intensity of the functional stress test performed on a person, as represented by a code.
Data Element Concept:	Functional stress test – stress test intensity

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Maximal (symptom limited)</td></tr><tr><td>2</td><td>Submaximal</td></tr><tr><td>3</td><td>Rest / distribution study</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Maximal (symptom limited)	2	Submaximal	3	Rest / distribution study	9	Not stated/inadequately described
Value	Meaning										
1	Maximal (symptom limited)										
2	Submaximal										
3	Rest / distribution study										
9	Not stated/inadequately described										
<i>Supplementary values:</i>											

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Maximal (symptom limited)</p> <p>Use this code when the intensity of the stress test is to increase the person's heart rate with the exercise to 85-90% of their predicted maximum heart rate.</p> <p>CODE 2 Submaximal</p> <p>Use this code when the intensity of the stress test is limited to increasing the person's heart rate with the exercise to 120 beats per minute or 70% of their predicted maximum heart rate.</p> <p>CODE 3 Rest/distribution study</p> <p>Use this code when a Thallium (nuclear) study has been undertaken for the assessment of viability, where no exercise or pharmacologic stress component has been undertaken</p> <p>CODE 9 Not stated/inadequately described</p> <p>Not for use in primary data collections.</p>
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Data element attributes

Collection and usage attributes

Collection methods:

The intensity is determined and recorded by the clinicians performing the test.

Comments:

The stress test intensity has implications for the interpretation of the test results.

Relational attributes

Implementation in Data Set Specifications:

[Functional stress test cluster](#) Health, Standard 01/10/2008

Conditional obligation:

To be provided when a functional stress test is performed.

Functional stress test performed indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – functional stress test performed indicator, yes/no code N
<i>METeOR identifier:</i>	347697
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An indicator of whether a functional stress test was performed on a person, as represented by a code.
Data Element Concept:	Person – functional stress test performed indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Code 1 Yes Record if a functional stress test was performed. Code 2 No Record if no functional stress test was performed.
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Functional stress test cluster Health, Standard 01/10/2008
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Funding source for hospital patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – principal source of funding, hospital code NN
<i>METeOR identifier:</i>	339080
<i>Registration status:</i>	Health, Standard 29/11/2006
<i>Definition:</i>	The principal source of funds for an admitted patient episode or non-admitted patient service event, as represented by a code.
<i>Context:</i>	Admitted patient care. Hospital non-admitted patient care.
Data Element Concept:	Episode of care – principal source of funding

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																														
<i>Data type:</i>	String																														
<i>Format:</i>	NN																														
<i>Maximum character length:</i>	2																														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Australian Health Care Agreements</td></tr><tr><td>02</td><td>Private health insurance</td></tr><tr><td>03</td><td>Self-funded</td></tr><tr><td>04</td><td>Worker's compensation</td></tr><tr><td>05</td><td>Motor vehicle third party personal claim</td></tr><tr><td>06</td><td>Other compensation (e.g. public liability, common law, medical negligence)</td></tr><tr><td>07</td><td>Department of Veterans' Affairs</td></tr><tr><td>08</td><td>Department of Defence</td></tr><tr><td>09</td><td>Correctional facility</td></tr><tr><td>10</td><td>Other hospital or public authority (contracted care)</td></tr><tr><td>11</td><td>Reciprocal health care agreements (with other countries)</td></tr><tr><td>12</td><td>Other</td></tr><tr><td>13</td><td>No charge raised</td></tr><tr><td>Supplementary values:</td><td>99 Not known</td></tr></tbody></table>	Value	Meaning	01	Australian Health Care Agreements	02	Private health insurance	03	Self-funded	04	Worker's compensation	05	Motor vehicle third party personal claim	06	Other compensation (e.g. public liability, common law, medical negligence)	07	Department of Veterans' Affairs	08	Department of Defence	09	Correctional facility	10	Other hospital or public authority (contracted care)	11	Reciprocal health care agreements (with other countries)	12	Other	13	No charge raised	Supplementary values:	99 Not known
Value	Meaning																														
01	Australian Health Care Agreements																														
02	Private health insurance																														
03	Self-funded																														
04	Worker's compensation																														
05	Motor vehicle third party personal claim																														
06	Other compensation (e.g. public liability, common law, medical negligence)																														
07	Department of Veterans' Affairs																														
08	Department of Defence																														
09	Correctional facility																														
10	Other hospital or public authority (contracted care)																														
11	Reciprocal health care agreements (with other countries)																														
12	Other																														
13	No charge raised																														
Supplementary values:	99 Not known																														

Collection and usage attributes

<i>Guide for use:</i>	CODE 01 Australian Health Care Agreements Australian Health Care Agreements should be recorded as the funding source for Medicare eligible admitted patients who elect
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to be treated as public patients and Medicare eligible emergency department patients and Medicare eligible patients presenting at a public hospital outpatient department for whom there is not a third party arrangement.

Includes: Public admitted patients in private hospitals funded by state or territory health authorities (at the state or regional level).

Excludes: Inter-hospital contracted patients and overseas visitors who are covered by Reciprocal health care agreements and elect to be treated as public admitted patients.

CODE 02 Private health insurance

Excludes: overseas visitors for whom travel insurance is the major funding source.

CODE 03 Self-funded

This code includes funded by the patient, by the patient's family or friends, or by other benefactors.

CODE 10 Other hospital or public authority

Includes: Patients receiving treatment under contracted care arrangements (Inter-hospital contracted patient).

CODE 11 Reciprocal health care agreements (with other countries)

Australia has Reciprocal Health Care Agreements with the United Kingdom, the Netherlands, Italy, Malta, Sweden, Finland, Norway, New Zealand and Ireland. 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.

Excludes: Overseas visitors who elect to be treated as private patients.

CODE 12 Other funding source

Includes: Overseas visitors for whom travel insurance is the major funding source.

CODE 13 No charge

Includes: Admitted patients who are Medicare ineligible and receive public hospital services free of charge at the discretion of the hospital or the state/territory. Also includes patients who receive private hospital services for whom no accommodation or facility charge is raised (for example, when the only charges are

for medical services bulk-billed to Medicare), and patients for whom a charge is raised but is subsequently waived.

Excludes: Admitted public patients (Medicare eligible) whose funding source should be recorded as Australian Health Care Agreements or Reciprocal Health Care Agreements. Also excludes Medicare eligible non-admitted patients, presenting to a public hospital emergency department and Medicare eligible patients (for whom there is not a third party payment arrangement) presenting at a public hospital outpatient department, whose funding source should be recorded as Australian Health Care Agreements.

Also excludes patients presenting to an outpatient department who have chosen to be treated as a private patient and have been referred to a named medical specialist who is exercising a right of private practice. These patients are not considered to be patients of the hospital (see Guide for use).

Data element attributes

Collection and usage attributes

Guide for use:

If there is an expected funding source followed by a finalised actual funding source (for example, in relation to compensation claims), then the actual funding source known at the end of the reporting period should be recorded.

The expected funding source should be reported if the fee has not been paid but is not to be waived.

If a charge is raised for accommodation or facility fees for the episode/service event, the intent of this data element is to collect information on who is expected to pay, provided that the charge would cover most of the expenditure that would be estimated for the episode/service event. If the charge raised would cover less than half of the expenditure, then the funding source that represents the majority of the expenditure should be reported.

The major source of funding should be reported for nursing-home type patients.

Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Episode of care – expected principal source of funding, hospital code NN](#) Health, Superseded 29/11/2006

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded
22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Geographical location of establishment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – geographical location, code (ASGC 2009) NNNNN
<i>METeOR identifier:</i>	386781
<i>Registration status:</i>	Health, Standard 02/10/2009
<i>Definition:</i>	The geographical location of the main administrative centre of an establishment, as represented by a code.
Data Element Concept:	Establishment – geographic location

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Australian Standard Geographical Classification 2009
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNNN
<i>Maximum character length:</i>	5

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The geographical location is reported using a five-digit numerical code to indicate the Statistical Local Area (SLA) within the reporting state or territory, as defined in the Australian Standard Geographical Classification (ASGC) (Australian Bureau of Statistics (ABS), catalogue number 1216.0). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA).</p> <p>The Australian Standard Geographical Classification (ASGC) is updated on an annual basis with a date of effect of 1 July each year.</p> <p>The Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including SLA) from the main structure of the ASGC. For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign an SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or state can be used with the locality name to assign the SLA.</p> <p>In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the establishment is used with the Streets Sub-index of the NLI to assign the SLA.</p>
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Source and reference attributes

Origin: Australian Standard Geographical Classification (Australian Bureau of Statistics Catalogue No. 1216.0)

Relational attributes

Related metadata references: Supersedes [Establishment – geographical location, code \(ASGC 2008\) NNNNN](#) Health, Superseded 02/10/2009

Is formed using [Establishment – Australian state/territory identifier, code N](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications: [Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Geographical location of service delivery outlet

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service delivery outlet – geographic location, code (ASGC 2009) NNNNN
<i>METeOR identifier:</i>	386787
<i>Registration status:</i>	Health, Standard 02/10/2009
<i>Definition:</i>	Geographical location of a site from which a health/community service is delivered, as represented by a code.
Data Element Concept:	Service delivery outlet – geographic location

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Australian Standard Geographical Classification 2009
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNNN
<i>Maximum character length:</i>	5

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The geographical location is reported using a five digit numerical code to indicate the Statistical Local Area (SLA) within the reporting state or territory, as defined in the Australian Standard Geographical Classification (ASGC). It is a composite of State identifier and SLA (first digit = State identifier, next four digits = SLA).</p> <p>The Australian Bureau of Statistics' National Localities Index (NLI) can be used to assign each locality or address in Australia to an SLA. The NLI is a comprehensive list of localities in Australia with their full code (including SLA) from the main structure of the ASGC. For the majority of localities, the locality name (suburb or town, for example) is sufficient to assign an SLA. However, some localities have the same name. For most of these, limited additional information such as the postcode or State can be used with the locality name to assign the SLA.</p> <p>In addition, other localities cross one or more SLA boundaries and are referred to as split localities. For these, the more detailed information of the number and street of the establishment is used with the Streets Sub- index of the NLI to assign the SLA.</p>
<i>Comments:</i>	To enable the analysis of the accessibility of service provision in relation to demographic and other characteristics of the population of a geographic area.

Source and reference attributes

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

Origin: Australian Standard Geographical Classification (ABS Cat. No. 1216.0)

Relational attributes

Related metadata references: Supersedes [Service delivery outlet – geographic location, code \(ASGC 2008\) NNNNN](#) Health, Superseded 02/10/2009

Is formed using [Establishment – Australian state/territory identifier, code N](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications: [Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Gestational age

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Product of conception – gestational age, completed weeks N[N]
<i>METeOR identifier:</i>	298105
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	The age of a product of conception in completed weeks.
Data Element Concept:	Product of conception – gestational age

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N]				
<i>Maximum character length:</i>	2				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99</td><td>Not stated/unknown</td></tr></tbody></table>	Value	Meaning	99	Not stated/unknown
Value	Meaning				
99	Not stated/unknown				
<i>Unit of measure:</i>	Completed weeks				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Gestational age is the best clinical estimate of the duration of pregnancy at a specific point in time, based on the first day of the last menstrual period, ultrasound or physical examination of the baby.</p> <p>Gestational age is conventionally expressed in completed weeks. When gestational age is calculated using the first day of the last normal menstrual period, the first day is counted as day zero and not day one. Therefore, a 25 week, 5 day fetus is considered a 25 week fetus (25+0, 25+1, 25+2, 25+3, 25+4, 25+5, 25+6).</p> <p>When ultrasound is used to date a pregnancy, the earliest ultrasound examination should be used and should preferably be between 6 and 10 weeks gestation. Scans performed beyond 24 weeks gestation are unlikely to be reliable in estimating gestational age and should not be used for this purpose.</p> <p>The duration of gestation can be determined from the first day of the last normal menstrual period, from ultrasound or clinical assessment. For the purpose of the national collection, gestational age is expressed in completed weeks.</p> <p>The World Health Organisation identifies the following categories:</p> <ul style="list-style-type: none">• pre-term: less than 37 completed weeks (less than 259 days) of gestation;
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- term: from 37 completed weeks to less than 42 completed weeks (259 to 293 days) of gestation; and
- post-term: 42 completed weeks or more (294 days or more) of gestation.

Comments: Gestational age is a key marker in pregnancy and an important risk factor for neonatal outcomes.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

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

Reference documents: American Academy of Pediatrics (2004) 'Policy statement - Age terminology during the perinatal period'.

Relational attributes

Related metadata references: See also [Pregnancy – estimated duration \(at the first visit for antenatal care\), completed weeks N\[N\]](#) Health, Standard 02/12/2009

Supersedes [Female \(pregnant\) – estimated gestational age, total weeks NN](#) Health, Superseded 02/12/2009

Implementation in Data Set Specifications: [Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009
Implementation start date: 01/07/2010

Given name sequence number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (name) – given name sequence number, code N
<i>METeOR identifier:</i>	287595
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The numerical order of the given names or initials of a person, as represented by a code.
Data Element Concept:	Person (name) – given name sequence number

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	2																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>First given name</td></tr><tr><td>2</td><td>Second given name</td></tr><tr><td>3</td><td>Third given name</td></tr><tr><td>4</td><td>Fourth given name</td></tr><tr><td>5</td><td>Fifth given name</td></tr><tr><td>6</td><td>Sixth given name</td></tr><tr><td>7</td><td>Seventh given name</td></tr><tr><td>8</td><td>Eighth given name</td></tr><tr><td>9</td><td>Ninth and subsequent given name</td></tr></tbody></table>	Value	Meaning	1	First given name	2	Second given name	3	Third given name	4	Fourth given name	5	Fifth given name	6	Sixth given name	7	Seventh given name	8	Eighth given name	9	Ninth and subsequent given name
Value	Meaning																				
1	First given name																				
2	Second given name																				
3	Third given name																				
4	Fourth given name																				
5	Fifth given name																				
6	Sixth given name																				
7	Seventh given name																				
8	Eighth given name																				
9	Ninth and subsequent given name																				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To be used in conjunction with Given name. Example: Mary Georgina Smith In the example above 'Mary' would have a given name sequence number of 1 and 'Georgina' would have a given name sequence number of 2. Example: Jean Claude Marcel Moreaux If the person has recorded a single given name as more than one word, displaying spaces in between the words (e.g. Jean Claude), their given names are recorded in data collection systems in the same way (i.e. Jean Claude is one given name and Marcel is another given name). 'Jean Claude' would have a Given name
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sequence number of '1' and 'Marcel' would have a Given name sequence number of '2'.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

Relational attributes

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Given name(s)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (name) – given name, text [X(40)]
<i>METeOR identifier:</i>	287035
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
<i>Definition:</i>	The person's identifying name within the family group or by which the person is socially identified, as represented by text.
Data Element Concept:	Person (name) – given name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(40)]
<i>Maximum character length:</i>	40

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A person may have more than one Given name. All given names should be recorded.</p> <p>The agency or establishment should record the person's full given name(s) on their information systems.</p> <p>National Community Services Data Dictionary specific:</p> <p>In instances where there is uncertainty about which name to record for a person living in a remote Aboriginal or Torres Strait Islander community, Centrelink follows the practice of recording the Indigenous person's name as it is first provided to Centrelink. In situations where proof of identity is required, the name is that recorded on a majority of the higher point scoring documents that are produced as proof of identity.</p> <p>National Health Data Dictionary specific:</p> <p>Each individual Given name should have a Given name sequence number associated with it.</p> <p>Health care establishments may record given names (first and other given names) in one field or several fields. This metadata item definition applies regardless of the format of data recording.</p> <p>A full history of names is to be retained.</p>
<i>Collection methods:</i>	<p>This metadata item should be recorded for all clients.</p> <p>Given name(s) should be recorded in the format preferred by the</p>

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

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

A person should generally be registered using their preferred name as it is more likely to be used in common usage and on subsequent visits to the agency or establishment. The person's preferred name may in fact be their legal (or Medicare card) name. The Person name type metadata item (see Comments) can be used to distinguish between the different types of names that may be used by the person.

The following format may assist with data collection:

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

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

If so, what are they

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

- (a) Medicare card name (if different to preferred name).
- (b) Alias (any other name that you are known by).

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

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

Registering an unidentified health care client:

If the person is a health care client and her/his given name is not known record unknown in the 'Given name' field and use alias Name type. When the person's name becomes known, add the actual name as preferred Name type (or other as appropriate). Do not delete or overwrite the alias name of unknown.

Use of first initial:

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

Persons with only one name:

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

Record complete information:

All of the person's given names should be recorded.

Shortened or alternate first given name:

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

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

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

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

Punctuation:

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

- Hyphen, for example Anne-Maree, Mary-Jane

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

- spaces, for example Jean Claude Marcel Moreaux

If the person has recorded their given name as more than one word, displaying spaces in between the words, record their given names in data collection systems in the same way (that is Jean Claude is one given name and Marcel is another given name).

Names not for continued use:

For cultural reasons, a person such as an Aboriginal or Torres Strait Islander may advise that they are no longer using the given name they previously used and are now using an alternative current name. Record their current name as their preferred given name and record their previously used name as an alias name (with a Name conditional use flag of 'not for continued use').

Composite name:

If a person identifies their first name as being a composite word, both parts should be recorded under the first Given Name (rather than the first and second Given Name).

If 'Anne Marie Walker' notes her preferred Given Name to be 'Anne Marie', then 'Anne Marie' is recoded as (first) Given Name, and (second) Given Name is left blank.

Registering an unnamed newborn baby:

An unnamed (newborn) baby is to be registered using the mother's given name in conjunction with the prefix 'Baby of'. For example, if

the baby's mother's given name is Fiona, then record 'Baby of Fiona' in the preferred 'Given name' field for the baby. This name is recorded under the newborn Name type. If a name is subsequently given, record the new name as the preferred given name and retain the newborn name.

Registering unnamed multiple births:

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

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

- Twin:
use Twin, that is Twin 1 of Fiona
- Triplet:
use Trip, that is Trip 1 of Fiona
- Quadruplet:
use Quad, that is Quad 1 of Fiona
- Quintuplet:
use Quin, that is Quin 1 of Fiona
- Sextuplet:
use Sext, that is Sext 1 of Fiona
- Septuplet:
use Sept, that is Sept 1 of Fiona.

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

Ethnic Names:

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

Misspelled given names:

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

Comments:

Often people use a variety of names, including legal names, married/maiden names, nicknames, assumed names, traditional names, etc. Even small differences in recording - such as the difference between Thomas and Tom - can make Record linkage impossible. To minimise discrepancies in the recording and reporting of name information, agencies or establishments should

ask the person for their full (formal) Given name and Family name. These may be different from the name that the person may prefer the agency or establishment workers to use in personal dealings. Agencies or establishments may choose to separately record the preferred name that the person wishes to be used by agency or establishment workers. In some cultures it is traditional to state the family name first. To overcome discrepancies in recording/reporting that may arise as a result of this practice, agencies or establishments should always ask the person to specify their first given name and their family or surname separately. These should then be recorded as Given name and Family name as appropriate, regardless of the order in which they may be traditionally given.

National Community Services Data Dictionary specific:

Selected letters of the given name in combination with selected letters of the family name, date of birth and sex may be used for **record linkage** for statistical purposes only.

National Health Data Dictionary specific:

Health care provider identification DSS and Health care client identification DSS

For the purpose of positive identification or contact, agencies or establishments that collect Given name should also collect Given name sequence number. Given name sequence number is also a metadata item in Australian Standard AS4846-2004 Health care provider identification and is proposed for inclusion in the review of Australian Standard AS5017-2002 Health care client identification. AS5017 and AS4846 use alternative alphabetic codes for Given name sequence number. Refer to the current standards for more details.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare Standards Australia
<i>Origin:</i>	National Health Data Committee National Community Services Data Committee Commonwealth Department of Health and Family Services 1998. Home and Community Care Data Dictionary Version 1.0. Canberra: DHFS Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

<i>Related metadata references:</i>	Supersedes Person (name) – given name, text [X(40)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005 See also Person (name) – family name, text X[X(39)] Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005 Is used in the formation of Person (name) – letters of name, text
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Implementation in Data Set Specifications:

[XXXXX](#) Community services, Standard 14/09/2009

Is used in the formation of [Person – letters of given name, text XX](#)
Community services, Standard 27/03/2007

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Glycoprotein IIb/IIIa receptor antagonist (status)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – glycoprotein IIb/IIIa receptor antagonist status, code NN
<i>METeOR identifier:</i>	285115
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The person's glycoprotein IIb/IIIa receptor antagonist therapy status, as represented by a code.
Data Element Concept:	Person – glycoprotein IIb/IIIa receptor antagonist status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																						
<i>Data type:</i>	Number																						
<i>Format:</i>	NN																						
<i>Maximum character length:</i>	2																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>10</td><td>Given</td></tr><tr><td>21</td><td>Not given - therapy not indicated</td></tr><tr><td>22</td><td>Not given - patient refusal</td></tr><tr><td>23</td><td>Not given - known intracranial neoplasm</td></tr><tr><td>24</td><td>Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses). Suspected aortic dissection</td></tr><tr><td>25</td><td>Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in contraindications</td></tr><tr><td>26</td><td>Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)</td></tr><tr><td>27</td><td>Not given - pregnancy</td></tr><tr><td>28</td><td>Not given - other</td></tr><tr><td>90</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	10	Given	21	Not given - therapy not indicated	22	Not given - patient refusal	23	Not given - known intracranial neoplasm	24	Not given - active or recent (within 2 to 4 weeks) internal bleeding (does not include menses). Suspected aortic dissection	25	Not given - history of prior cerebrovascular accident or known intracerebral pathology not covered in contraindications	26	Not given - recent trauma (within 2 to 4 weeks), including head trauma, traumatic or prolonged (greater than 10 minutes) CPR, or major surgery (less than 3 weeks)	27	Not given - pregnancy	28	Not given - other	90	Not stated/inadequately described
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90	Not stated/inadequately described																						
<i>Supplementary values:</i>																							

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

Guide for use: This metadata item pertains to the administering of Glycoprotein IIb/IIIa receptor antagonist drugs at any time point during this current event.

CODES 21 - 28 Not given

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

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group

Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes [Glycoprotein IIb/IIIa receptor antagonist status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

Glycosylated Haemoglobin—upper limit of normal range (percentage)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range of glycosylated haemoglobin, percentage N[N].N
<i>METeOR identifier:</i>	270333
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Laboratory standard for the value of glycosylated haemoglobin (HbA1c) measured as a percentage that is the upper boundary of the normal range.
Data Element Concept:	Laboratory standard – upper limit of normal range of glycosylated haemoglobin

Value domain attributes

Representational attributes

<i>Representation class:</i>	Percentage				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N].N				
<i>Maximum character length:</i>	3				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99.9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	99.9	Not stated/inadequately described
Value	Meaning				
99.9	Not stated/inadequately described				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the HbA1c normal reference range from the laboratory result.
<i>Collection methods:</i>	This value is usually notified in patient laboratory results and may vary for different laboratories.
<i>Comments:</i>	HbA1c results vary between laboratories; use the same laboratory for repeated testing.

Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

<i>Related metadata references:</i>	See also Person – glycosylated haemoglobin level (measured), percentage N[N].N Health, Standard 01/03/2005 Supersedes Glycosylated Haemoglobin (HbA1c) - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.9 KB)
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Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Glycosylated haemoglobin level (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – glycosylated haemoglobin level (measured), percentage N[N].N
<i>METeOR identifier:</i>	270325
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's glycosylated haemoglobin (HbA1c) level, measured as percentage.
Data Element Concept:	Person – glycosylated haemoglobin level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Percentage				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N].N				
<i>Maximum character length:</i>	3				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99.9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	99.9	Not stated/inadequately described
Value	Meaning				
99.9	Not stated/inadequately described				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	HbA1c results vary between laboratories; use the same laboratory for repeated testing. When reporting, record absolute result of the most recent HbA1c level in the last 12 months. Record the absolute result of the test (%).
<i>Collection methods:</i>	Test is performed in accredited laboratories: <ul style="list-style-type: none">• A single blood sample is sufficient and no preparation of the patient is required.• Measure HbA1c ideally using High Performance Liquid Chromatography (HPLC).

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
<i>Reference documents:</i>	Koenig, R. J. Peterson, CM and Kilo, C et al. Hemoglobin A1c as an indicator of the degree of glucose intolerance in diabetes. Diabetes 259 (1976): 230-232. Nathan, D.M., Singer, D.E, Hurxthal, K, and Goodson, J.D. The clinical information value of the glycosylated hemoglobin assay. N. Eng. J. Med. 310 (1984): 341-346.

Relational attributes

Related metadata references:

See also [Laboratory standard – upper limit of normal range of glycosylated haemoglobin, percentage N\[N\].N](#) Health, Standard 01/03/2005

Supersedes [Glycosylated Haemoglobin \(HbA1c\) - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (18.0 KB)

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Goal of care

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Community nursing service episode – goal of care, code NN
<i>METeOR identifier:</i>	270225
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The goal or expected outcome of a plan of care, negotiated by the service provider and recipient, as represented by a code.
Data Element Concept:	Community nursing service episode – goal of care

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	String																
<i>Format:</i>	NN																
<i>Maximum character length:</i>	2																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Well person for preventative/maintenance/health promotion program</td></tr><tr><td>02</td><td>Person will make a complete recovery</td></tr><tr><td>03</td><td>Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required</td></tr><tr><td>04</td><td>Person has a long-term care need and the goal is aimed at on-going support to maintain at home</td></tr><tr><td>05</td><td>Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die</td></tr><tr><td>06</td><td>Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time</td></tr><tr><td>07</td><td>For assessment only/not applicable</td></tr></tbody></table>	Value	Meaning	01	Well person for preventative/maintenance/health promotion program	02	Person will make a complete recovery	03	Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required	04	Person has a long-term care need and the goal is aimed at on-going support to maintain at home	05	Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die	06	Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time	07	For assessment only/not applicable
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06	Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time																
07	For assessment only/not applicable																

Collection and usage attributes

<i>Guide for use:</i>	CODE 01 Well person for preventative/maintenance/health promotion program Service recipients are those making contact with the health service primarily as a part of a preventative/maintenance health promotion program. This means they are well and do not require care for established health problems. They include well antenatal persons attending or being seen by the service for screening or health education purposes.
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CODE 02 Person will make a complete recovery

Describes those persons whose condition is self-limiting and from which complete recovery is anticipated, or those with established or long-term health problems who are normally independent in their management.

Goal 2 service recipient includes:

- post-surgical or acute medical service recipients whose care at home is to facilitate convalescence. Such admissions to home care occur as a result of early discharge from hospital; post-surgical complication such as wound infection; or because the person is at risk during the recovery phase and requires surveillance for a limited period;
- persons recovering from an acute illness and referred from the general practitioner or other community-based facility;
- persons with **disability** or established health problem normally independent of health services, and currently recovering from an acute condition or illness as above.

CODE 03 Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required

Refers to those service recipients whose care plan is aimed at returning them to independent functioning at home either through self-care or with informal assistance, such that formal services will be discontinued. The distinguishing characteristic of this group is that complete recovery is not expected but some functional gain may be possible. Further, the condition is not expected to deteriorate rapidly or otherwise cause the client to be at risk without contact or surveillance from the community service.

CODE 04 Person has a long-term care need and the goal is aimed at on-going support to maintain at home

Refers to those service recipients whose health problem/condition is not expected to resolve and who will require ongoing maintenance care from the nursing service. Such clients are distinguished from those in Goal 3 in that their condition is of an unknown or long-term nature and not expected to cause death in the foreseeable future. They may require therapy for restoration of function initially and intermittently, and may also have intermittent admissions for respite. However, the major part of their care is planned to be at home.

CODE 05 Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die

Refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.

CODE 06 Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time

Includes persons who have a limited ability to remain at home because of their intensive care requirements and the inability of formal and informal services to meet these needs. Admission to institutional care is therefore a part of the care planning process and the timing dependent upon the capacity and/or wish to remain at home. The distinguishing feature of this group is that the admission is not planned to be an intermittent event to boost the capacity for home care but is expected to be of a more permanent (or indeterminate) nature.

- Excluded from this group are persons with established health problems or permanent disability, if the contact is related to the condition. For example, persons with diabetes and in a diabetes program would be included in Goal 3; however, such persons would be included in Goal 6 if the contact with the service is not related to an established health problem but is primarily for preventative/maintenance care as described above.

CODE 07 For assessment only/not applicable

Service recipients are those for whom the reason for the visit is to undertake an assessment. This may include clients in receipt of a Domiciliary Nursing Care Benefit (DNCB) for whom the purpose of the visit is to determine ongoing DNCB eligibility and requirements for care. Implicit in this visit is review of the person's health status and circumstances, to ensure that their ongoing support does not place them or their carer at avoidable risk.

Data element attributes

Collection and usage attributes

Guide for use:

Only one option is permissible and where Code 07 is selected, Code 9 must be used in the metadata item Community nursing service episode – nursing interventions, code N.

Collection methods:

At time of formal review of the client, the original goal of care should be retained and not over-written by the system. The goal of care relates to the episode bounded by the date of first contact with community nursing service and date of last contact and in this format provides a focussing effect at the time of planning for care.

Comments:

Agencies who had previously implemented this metadata item should note changes to the code set in the Value domain.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Relational attributes

Related metadata references:

Supersedes [Goal of care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (23.1 KB)

Grants to non-government organisations—accommodation services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation—accommodation services grants to non-government organisations, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	296547
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of accommodation services, defined as housing services that are linked to support services for people affected by a mental health issue.
Data Element Concept:	Specialised mental health service organisation—accommodation services grants to non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

Guide for use: Where the exact dollar amount, for accommodations services as a whole, is unable to be provided an estimate should be derived from available local information.

Note: Only subtypes 3 and 5 are included as 'Accommodation services' for the Mental Health Establishments NMDS. Subtypes 1, 2 and 4 are not included as 'Accommodation services' for this NMDS. Categories 3 and 5 listed below are to be reported in aggregate. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under the other and unspecified services grants to non-government organisations data element.

Accommodation services are subcategorised into 5 subtypes:

1. *Crisis/interim accommodation* - Short-term accommodation which may be staffed up to 24 hours a day, seven days a week for people affected by a mental health issue. Accommodation is facility based/residential with an

average of 4-8 beds. Length of stay is generally limited to a maximum of three months.

2. *Transitional supported accommodation* - Short to medium accommodation (3-12 months) that is provided in a residential/facility based setting.
3. *Headleasing* - Provides a supportive landlord service that assists tenants to access and maintain suitable accommodation and maintains their tenancies and which is linked to support.
4. *Residential rehabilitation* - Short to long-term residential facility based accommodation provided to people with high needs. Staff support is provided.
5. *Long term supported accommodation* - Secure/tenured long-term accommodation with staff support as necessary or desired.

Collection methods:

Grants for accommodation services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also [Specialised mental health service organisation – other and unspecified services grants to non-government organisations, total Australian currency N\[N\(8\)\]](#) Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

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Implementation start date: 01/07/2009

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[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—advocacy services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation—advocacy services grants to non-government organisations, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	286911
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of advocacy services, defined as services that provide assistance to people affected by a mental health issue to access their human and legal rights and promote reform.
Data Element Concept:	Specialised mental health service organisation—advocacy services grants to non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Where the exact dollar amount for advocacy services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.</p> <p>Advocacy services are subcategorised into 2 subtypes, however data are not expected to be reported at this level:</p> <ol style="list-style-type: none">1. <i>Systemic</i> - The representation and promotion of the rights, views and responsibilities of people affected by mental health issues in the community, public and private sectors at both domestic and international levels.2. <i>Individual</i> - The representation and promotion of the rights and views of the individual affected by a mental health issue.
<i>Collection methods:</i>	Grants for advocacy services are to be reported at the lowest statistical unit level which the expenditure occurred

(state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also [Specialised mental health service organisation – other and unspecified services grants to non-government organisations, total Australian currency N\[N\(8\)\]](#) Health, Superseded 07/12/2005

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Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—community awareness/health promotion services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	287011
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for community awareness/health promotion services, defined as services aimed at raising awareness about mental health/illness and those affected by mental health issues through the provision of information and/or education to the community, in order to enhance the community's capacity to support people affected by a mental health issue.
Data Element Concept:	Specialised mental health service organisation—community awareness/health promotion services grants to non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the exact dollar amount for community awareness/health promotion services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
<i>Collection methods:</i>	Grants for community awareness/health promotion services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

Related metadata references:

See also [Specialised mental health service organisation – other and unspecified services grants to non-government organisations, total Australian currency N\[N\(8\)\]](#) Health, Superseded 07/12/2005

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

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Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—counselling services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation – counselling services grants to non-government organisations, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	287021
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for counselling services provided by professionals and non-professionals that provide emotional support, psychological support, assistance with achieving goals and the strengthening of community and social networks for people affected by a mental health issue.
Data Element Concept:	Specialised mental health service organisation – counselling services grants to non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the exact dollar amount for counselling services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
<i>Collection methods:</i>	Grants for counselling services are to be reported only at the level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation – other and unspecified services grants to non-government
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Implementation in Data Set Specifications:

[organisations, total Australian currency N\[N\(8\)\]](#) Health, Superseded 07/12/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

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Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

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[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

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[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

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[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations— independent living skills support services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation— independent living skills support services grants to non-government organisations, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	296480
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for services that provide encouragement and support of people living with a mental health issue to participate actively in their day to day living in a community.
Data Element Concept:	Specialised mental health service organisation— independent living skills support services grants to non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the exact dollar amount for independent living skills support services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
<i>Collection methods:</i>	Grants for independent living skills support services are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation— other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
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Grants to non-government organisations—other and unspecified mental health services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation— other and unspecified mental health services grants to non-government organisations, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	306250
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	Grants made to non-government organisations for provision of mental health services not elsewhere classified and grants not allocatable to specific service types.
Data Element Concept:	Specialised mental health service organisation— other and unspecified mental health services grants to non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the exact dollar amount for other and unspecified mental health services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific mental health service types, the value of grants not allocatable to specific mental health service types should be included. Grants for mental health services classified elsewhere are listed below under Relational metadata attributes.
<i>Collection methods:</i>	Grants to non-government organisations for mental health services not elsewhere classified are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

<i>Related metadata references:</i>	Supersedes Specialised mental health service organisation— other and unspecified services grants to non-government
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[organisations, total Australian currency N\[N\(8\)\] Health](#),
Superseded 07/12/2005

See also [Specialised mental health service organisation – self-help support groups services grants for non-government organisations, total Australian currency N\[N\(8\)\] Health](#), Standard 08/12/2004

See also [Specialised mental health service organisation – respite services grants to non-government organisations, total Australian currency N\[N\(8\)\] Health](#), Standard 08/12/2004

See also [Specialised mental health service organisation – recreation services grants to non-government organisations, total Australian currency N\[N\(8\)\] Health](#), Standard 08/12/2004

See also [Specialised mental health service organisation – psychosocial support services grants for non-government organisations, total Australian currency N\[N\(8\)\] Health](#), Standard 08/12/2004

See also [Specialised mental health service organisation – pre-vocational training services grants for non-government organisations, total Australian currency N\[N\(8\)\] Health](#), Standard 08/12/2004

See also [Specialised mental health service organisation – independent living skills support services grants to non-government organisations, total Australian currency N\[N\(8\)\] Health](#), Standard 08/12/2004

See also [Specialised mental health service organisation – counselling services grants to non-government organisations, total Australian currency N\[N\(8\)\] Health](#), Standard 08/12/2004

See also [Specialised mental health service organisation – community awareness/health promotion services grants to non-government organisations \(financial year\), total Australian currency N\[N\(8\)\] Health](#), Standard 08/12/2004

See also [Specialised mental health service organisation – advocacy services grants to non-government organisations, total Australian currency N\[N\(8\)\] Health](#), Standard 08/12/2004

See also [Specialised mental health service organisation – accommodation services grants to non-government organisations, total Australian currency N\[N\(8\)\] Health](#), Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 21/03/2006

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Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

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[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

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Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

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02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—pre-vocational training services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation – pre-vocational training services grants for non-government organisations, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	296484
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for pre-vocational training services, defined as the provision of training and skill development to individuals affected by a mental health issue to facilitate their progress into employment of their choice.
Data Element Concept:	Specialised mental health service organisation – pre-vocational training services grants for non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the exact dollar amount for pre-vocational training services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
<i>Collection methods:</i>	Grants for pre-vocational training expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation – other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
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Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

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Implementation start date: 01/07/2006

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[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

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Implementation start date: 01/07/2009

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[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—psychosocial support services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation— psychosocial support services grants for non-government organisations, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	296486
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for psychosocial support services, defined as services that work in partnership with the individual affected by a mental health issue and their carers to provide a range of support and skill development options addressing key issues in attainment of mental health and social competence goals.
Data Element Concept:	Specialised mental health service organisation— psychosocial support services grants for non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the exact dollar amount for recreation services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
<i>Collection methods:</i>	Grants for recreation expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation— other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
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[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Grants to non-government organisations—recreation services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation – recreation services grants to non-government organisations, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	296488
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for recreation services, defined as services that provide and/or facilitate a range of leisure and social opportunities to people affected by a mental health issue to enhance their social competence.
Data Element Concept:	Specialised mental health service organisation – recreation services grants to non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the exact dollar amount for recreation services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
<i>Collection methods:</i>	Grants for recreation expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation – other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
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Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

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Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

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Implementation start date: 01/07/2010

Grants to non-government organisations—respite services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation—respite services grants to non-government organisations, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	296490
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for respite services, defined as the provision of services that allow a planned break from the usual caring environment.
Data Element Concept:	Specialised mental health service organisation—respite services grants to non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the exact dollar amount for respite services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
<i>Collection methods:</i>	Grants for respite expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation—other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005

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02/12/2009

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Grants to non-government organisations—self-help support group services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service organisation – self-help support groups services grants for non-government organisations, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	296492
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for self-help groups support services, defined as the provision of opportunities for people affected by a mental health issue to learn from and support each other.
Data Element Concept:	Specialised mental health service organisation – self-help support groups services grants for non-government organisations

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the exact dollar amount for self-help support groups services is unable to be provided an estimate should be derived from available local information. Where data are unavailable on grant amounts for specific service types, the value of grants not allocatable to specific service types should be reported under other and unspecified services grants to non-government organisations.
<i>Collection methods:</i>	Grants for self-help support group expenditure are to be reported at the lowest statistical unit level at which the expenditure occurred (state/territory or region), and should not be counted at more than one level.

Relational attributes

<i>Related metadata references:</i>	See also Specialised mental health service organisation – other and unspecified services grants to non-government organisations, total Australian currency N[N(8)] Health, Superseded 07/12/2005
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Gross capital expenditure (accrual accounting)—buildings and building services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (accrual accounting) (buildings and building services) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270521
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of buildings and building services (including plant).
<i>Data Element Concept:</i>	Establishment – gross capital expenditure (accrual accounting) (buildings and building services)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

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Gross capital expenditure (accrual accounting)— constructions

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (accrual accounting) (constructions) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270526
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of constructions (other than buildings).
Data Element Concept:	Establishment – gross capital expenditure (accrual accounting) (constructions)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

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Gross capital expenditure (accrual accounting)— equipment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (accrual accounting) (equipment) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270525
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of equipment.
Data Element Concept:	Establishment – gross capital expenditure (accrual accounting) (equipment)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

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Gross capital expenditure (accrual accounting)— information technology

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (accrual accounting) (information technology) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270527
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of information technology.
Data Element Concept:	Establishment – gross capital expenditure (accrual accounting) (information technology)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

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Gross capital expenditure (accrual accounting)—intangible assets

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (accrual accounting) (intangible assets) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270522
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of intangible assets.
Data Element Concept:	Establishment – gross capital expenditure (accrual accounting) (intangible assets)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
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Gross capital expenditure (accrual accounting)—land

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (accrual accounting) (land) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270528
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of land.
Data Element Concept:	Establishment – gross capital expenditure (accrual accounting) (land)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
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Gross capital expenditure (accrual accounting)—major medical equipment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (accrual accounting) (major medical equipment) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	269968
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of major medical equipment.
Data Element Concept:	Establishment – gross capital expenditure (accrual accounting) (major medical equipment)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
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Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—other equipment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (accrual accounting) (other equipment) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270523
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of other equipment, such as furniture, art objects, professional instruments and containers.
Data Element Concept:	Establishment – gross capital expenditure (accrual accounting) (other equipment)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure (accrual accounting)—transport

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (accrual accounting) (transport) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270524
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure, measured in Australian dollars, in a period on the acquisition or enhancement of transport.
Data Element Concept:	Establishment – gross capital expenditure (accrual accounting) (transport)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - gross (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—computer equipment/installations

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (computer equipment/installations) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270520
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Gross capital expenditure, measured in Australian dollars, on computer equipment/installations.
Data Element Concept:	Establishment – gross capital expenditure (computer equipment/installations)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—intangible assets

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (intangible assets) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270517
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Gross capital expenditure, measured in Australian dollars, in relation to intangible assets.
Data Element Concept:	Establishment – gross capital expenditure (intangible assets)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—land and buildings

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (land and buildings) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270519
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Gross capital expenditure, measured in Australian dollars, on land and buildings.
Data Element Concept:	Establishment – gross capital expenditure (land and buildings)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—major medical equipment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (major medical equipment) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	269966
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Gross capital expenditure, measured in Australian dollars, on major medical equipment.
Data Element Concept:	Establishment – gross capital expenditure (major medical equipment)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

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Superseded 05/01/2010

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Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—other

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (other capital expenditure) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270516
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Other gross capital expenditure, measured in Australian dollars, which are not included elsewhere.
Data Element Concept:	Establishment – gross capital expenditure (other capital expenditure)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Gross capital expenditure—plant and other equipment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – gross capital expenditure (plant and other equipment) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270518
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Gross capital expenditure, measured in Australian dollars, on plant and other equipment.
Data Element Concept:	Establishment – gross capital expenditure (plant and other equipment)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to the nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (18.4 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment (public psychiatric or alcohol and drug hospital) – number of group session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care (public psychiatric, alcohol & drug) - emergency and outpatient group sessions
<i>METeOR identifier:</i>	270217
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the emergency and outpatient functional unit of a public psychiatric hospital or an alcohol and drug hospital.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Emergency patients and outpatients are persons who receive non-admitted care. Group session non-admitted care is care provided to persons who receive direct care within the emergency department or other designated clinics within the hospital and who are not formally admitted at the time when the care is provided. A person who first contacts the hospital and receives non-admitted care, for example through the emergency department, and is subsequently admitted should have both components of care enumerated separately.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

Related metadata references:

Supersedes [Type of non-admitted patient care \(public psychiatric, alcohol & drug\), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (21.1 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions (public psychiatric, alcohol and drug hospital)—outreach and community

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment (public psychiatric or alcohol and drug hospital) – number of group session occasions of service for non-admitted patients (outreach and community), total N[NNNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care (public psychiatric, alcohol & drug) - outreach and community group sessions
<i>METeOR identifier:</i>	270219
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the outreach and community functional unit of a public psychiatric hospital or an alcohol and drug hospital.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	For outreach/community patients, care is delivered by hospital employees to the patient in the home, place of work or other non-hospital site.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Type of non-admitted patient care (public psychiatric, alcohol & drug), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (21.1 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDs Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—alcohol and other drug

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - alcohol and other drug group sessions
<i>METeOR identifier:</i>	270479
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group session to non-admitted patients in the alcohol and drug functional unit of an establishment.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Comments:</i>	<p>This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p>

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS Health, Superseded 21/03/2006](#)

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS Health, Superseded 23/10/2006](#)

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008](#)

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008](#)

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010](#)

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010](#)

Implementation start date: 01/07/2010

Group sessions—allied health services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (allied health services), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - allied health services group sessions
<i>METeOR identifier:</i>	270480
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in allied health services functional units or clinics of an establishment.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Allied health services include units primarily concerned with physiotherapy, family planning, dietary advice, optometry, occupational therapy, and so on.</p> <p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	<p>At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.</p>

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—community health services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (community health services), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - community health services group sessions
<i>METeOR identifier:</i>	270491
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the community health services functional unit of an establishment.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Community health services include units primarily concerned with baby clinics, immunisation clinics, aged care assessment teams, and so on.</p> <p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	<p>At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.</p>

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—dental

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (dental), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - dental group sessions
<i>METeOR identifier:</i>	270488
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group session to non-admitted patients in the dental unit of an establishment
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
<i>Comments:</i>	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS Health, Superseded 21/03/2006](#)

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS Health, Superseded 23/10/2006](#)

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008](#)

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008](#)

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010](#)

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010](#)

Implementation start date: 01/07/2010

Group sessions—dialysis

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (dialysis), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - dialysis group sessions
<i>METeOR identifier:</i>	270368
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the dialysis unit of an establishment.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Where patients receive treatment in a ward or clinic classified elsewhere (for example Emergency Department), they are to be counted as dialysis patients and are to be excluded from other categories. All forms of dialysis that are undertaken as a treatment necessary for renal failure are to be included.</p> <p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	<p>At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.</p>
<i>Comments:</i>	<p>This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in</p>

various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS Health, Superseded 21/03/2006](#)
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006

[Public hospital establishments NMDS Health, Superseded 23/10/2006](#)
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008](#)
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008](#)
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010](#)
Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010](#)
Implementation start date: 01/07/2010

Group sessions—district nursing services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (district nursing services), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - district nursing services group sessions
<i>METeOR identifier:</i>	270482
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients by the district nursing service of an establishment.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>District nursing services:</p> <ul style="list-style-type: none">• are for medical/nursing/psychiatric care• are provided by a nurse, paramedic or medical officer• involve travel by the service provider• exclude care provided by staff from a unit classified in the community health category. <p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
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Collection methods:

At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients. This distinction creates difficulties for community health centres.

These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary.

For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

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[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—emergency services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (emergency services), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - emergency services group sessions
<i>METeOR identifier:</i>	270485
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the designated emergency department of an establishment.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
<i>Comments:</i>	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS Health, Superseded 21/03/2006](#)

Implementation start date: 01/07/2005

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Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008](#)

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008](#)

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010](#)

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010](#)

Implementation start date: 01/07/2010

Group sessions—endoscopy and related procedures

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - endoscopy and related procedures group sessions
<i>METeOR identifier:</i>	270484
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the endoscopy and related procedures functional unit of an establishment.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For all occasions of endoscopy and related procedures provided as group sessions to non-admitted patients.</p> <p>Endoscopy and related procedures include:</p> <ul style="list-style-type: none">• cystoscopy• gastroscopy• oesophagoscopy• duodenoscopy• colonoscopy• bronchoscopy• laryngoscopy. <p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and</p>
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is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

Collection methods:

At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.

Comments:

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDS Health, Superseded 21/03/2006](#)

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS Health, Superseded 23/10/2006](#)

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008](#)

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—mental health

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment—number of group session occasions of service for non-admitted patients (mental health), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - mental health group sessions
<i>METeOR identifier:</i>	270490
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in designated psychiatric or mental health units of an establishment.

Data Element Concept:	Establishment—number of group session occasions of service for non-admitted patients
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Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
<i>Comments:</i>	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)
Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS Health, Superseded 21/03/2006](#)
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Public hospital establishments NMDS Health, Superseded 23/10/2006](#)
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008](#)
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
[Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008](#)
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009
[Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010](#)
Implementation start date: 01/07/2009
[Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010](#)
Implementation start date: 01/07/2010

Group sessions—other medical/surgical/diagnostic

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - other medical/surgical/diagnostic group sessions
<i>METeOR identifier:</i>	270487
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the medical/surgical/diagnostic functional unit of an establishment not defined elsewhere.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Includes ECG, obstetrics, nuclear medicine, general surgery, fertility, and so on.</p> <p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
<i>Comments:</i>	This metadata item is derived from metadata items that are not

currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

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Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—other outreach services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (other outreach services), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - other outreach services group sessions
<i>METeOR identifier:</i>	270489
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients as outreach services not classified in allied health or community health services.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Includes units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy, and so on.</p> <p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	<p>At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.</p>

Comments:

This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

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[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

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Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Group sessions—pathology

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (pathology), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - pathology group sessions
<i>METeOR identifier:</i>	270481
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in designated pathology laboratories of an establishment.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Occasions of pathology services to all patients from other establishments should be counted separately.</p> <p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
<i>Comments:</i>	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples

include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)
Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

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Implementation start date: 01/07/2010

Group sessions—pharmacy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (pharmacy), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - pharmacy group sessions
<i>METeOR identifier:</i>	270486
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as group sessions to non-admitted patients in the pharmacy unit of an establishment.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Those drugs dispensed/administered in other departments such as the emergency or outpatient are to be counted by the respective department.</p> <p>department Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
<i>Comments:</i>	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in various ways by hospitals/outpatient departments. Examples

include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

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Implementation start date: 01/07/2010

Group sessions—radiology and organ imaging

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group session occasions of service for non-admitted patients (radiology and organ imaging), total N[NNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - radiology and organ imaging group sessions
<i>METeOR identifier:</i>	270483
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of groups of patients/clients receiving radiology and organ imaging services in a health service establishment.
Data Element Concept:	Establishment – number of group session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Includes x-ray department as well as specialised organ imaging clinics carrying out ultrasound, computerised tomography and magnetic resonance imaging.</p> <p>Each group is to be counted once, irrespective of size or the number of staff providing services.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
<i>Collection methods:</i>	At present, occasions of service to groups are counted in an inconsistent manner. The numbers of occasions of service should be collected for both individual and group sessions for public psychiatric hospitals and alcohol and drug hospitals.
<i>Comments:</i>	This metadata item is derived from metadata items that are not currently specified in METeOR, but which are recorded in

various ways by hospitals/outpatient departments. Examples include identifiers of individual consultations/visits, and diagnostic tests.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Group sessions, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.1 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

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Health industry relevant organisation type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Health industry relevant organisation – main activity type, code NNN
<i>METeOR identifier:</i>	372264
<i>Registration status:</i>	Health, Standard 01/04/2009
<i>Definition:</i>	Describes a health industry relevant organisation based on its main activity, as represented by a code.
Data Element Concept:	Health industry relevant organisation – main activity type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																						
<i>Data type:</i>	Number																																						
<i>Format:</i>	NNN																																						
<i>Maximum character length:</i>	3																																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td></td><td>Main Health Care Services organisation</td></tr><tr><td>101</td><td>Hospital – public</td></tr><tr><td>102</td><td>Hospital – private (excluding private free-standing day hospital facility)</td></tr><tr><td>103</td><td>Hospital – private free-standing day hospital facility (excluding private non free-standing day hospital facility)</td></tr><tr><td>104</td><td>Residential facility – mental health care</td></tr><tr><td>105</td><td>Residential facility – other</td></tr><tr><td>106</td><td>Provider of ambulance service</td></tr><tr><td>107</td><td>Medical and diagnostic laboratory</td></tr><tr><td>108</td><td>Clinical practices – medical – general</td></tr><tr><td>109</td><td>Clinical practices – medical – specialist</td></tr><tr><td>110</td><td>Clinical practices – medical – other</td></tr><tr><td>111</td><td>Clinical practices – dental</td></tr><tr><td>112</td><td>Clinical practices – other</td></tr><tr><td>113</td><td>Community health facility – substance abuse</td></tr><tr><td>114</td><td>Community health facility – mental</td></tr><tr><td>115</td><td>Community health facility – other</td></tr><tr><td>116</td><td>Blood and organ bank</td></tr><tr><td>117</td><td>Retail sale/supplier of medical goods – optical glasses and other vision products</td></tr></tbody></table>	Value	Meaning		Main Health Care Services organisation	101	Hospital – public	102	Hospital – private (excluding private free-standing day hospital facility)	103	Hospital – private free-standing day hospital facility (excluding private non free-standing day hospital facility)	104	Residential facility – mental health care	105	Residential facility – other	106	Provider of ambulance service	107	Medical and diagnostic laboratory	108	Clinical practices – medical – general	109	Clinical practices – medical – specialist	110	Clinical practices – medical – other	111	Clinical practices – dental	112	Clinical practices – other	113	Community health facility – substance abuse	114	Community health facility – mental	115	Community health facility – other	116	Blood and organ bank	117	Retail sale/supplier of medical goods – optical glasses and other vision products
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118	Retail sale/supplier of medical goods – hearing aids
119	Retail sale/supplier of medical goods – dispensing community pharmacist
120	Retail sale/supplier of medical goods – other
121	Public health program service provider
122	General health administration service provider
123	Private health insurance
188	Other Main Health Care Service providers
198	Regional health service not further defined
199	State/territory health authority not further defined
	Secondary/non-Health Care Services organisation
201	Pharmaceutical industry
202	University
203	Non-health related insurance
204	Residential aged care facility
288	Other Secondary/non-Health Care Services organisation

Collection and usage attributes

Guide for use:

Main Health Care Service organisation

CODE 101 Hospital – public

An organisation comprised of a health care facility or group of health care facilities established under Commonwealth, state or territory legislation as a hospital or free-standing day hospital facility and authorised to provide treatment and/or care to patients. Comprises all health care facilities that are reported as public hospitals to the Public Hospital Establishments National Minimum Data Set (PHE NMDS). This includes organisations such as rehabilitation hospitals; psychiatric hospitals; mothercraft hospitals; and hospices and multi-purpose services defined as hospitals. The list of public hospitals reported to the PHE NMDS is available at www.aihw.gov.au/publications/index.cfm in the Australian Hospital Statistics annual report.

NOTE 1: Excludes providers of services where those services are not captured in the hospital financial statements. For example, the provider of a pathology or pharmacy service may be co-located within the hospital, but as a private service, and will pay the hospital for use of the site. The provider of this pathology or pharmacy service would be recorded under codes 106 to 112.

CODE 102 Hospital – private (excluding private free-standing day hospital facilities)

An organisation comprised of a health care facility or a group of health care facilities established under Commonwealth, state or territory legislation as a hospital and authorised to provide treatment and/or care to patients.

Comprises hospitals that are NOT reporting to the PHE NMDS.

NOTE: State and territory data providers are to refer to the GHE NMDS Collection Guidelines for instructions on how to report expenditure for this category.

Excludes private free-standing day hospital facilities reported under code 103.

CODE 103 Hospital - private free-standing day facility
(excluding private non free-standing day hospital facilities)

An organisation comprised of one or more private free-standing day hospital facilities which provide investigation and treatment for acute conditions on a day-only basis and is approved by the Commonwealth as a hospital for the purposes of private health insurance benefits. The four main types of private free-standing day hospitals are specialist endoscopy, ophthalmic, plastic/cosmetic and general. Excludes private non free-standing day hospital facilities reported under code 102.

CODE 104 Residential facility – mental health care

An organisation comprised of one or more specialised mental health facilities primarily engaged in providing residential care to persons requiring mental health diagnosis and treatment combined with either nursing, supervisory or other types of care as required (including medical) by the residents.

Excludes residential care facilities primarily providing aged care or care for persons requiring treatment for alcohol or other substance abuse or persons with a disability.

CODE 105 Residential facility – other

Includes all government-funded facilities primarily engaged in providing residential care to persons requiring diagnosis and treatment for alcohol and other substance abuse combined with either nursing, supervisory or other types of care as required (including medical) by the residents. Includes hospices that are not defined as hospitals and respite and transitional care services.

Excludes facilities primarily providing services to aged persons or persons requiring mental health diagnosis and treatment.

Also excludes residential care facilities that report under the Commonwealth, State and Territory Disability Agreement where the primary purpose is care for persons with a disability.

CODE 106 Provider of ambulance service

Organisations primarily engaged in providing transportation of patients by ground or air, along with health (or medical) care. These services are often provided during a medical emergency but are not restricted to emergencies. The vehicles are equipped with lifesaving equipment operated by medically trained personnel. Includes organisations providing public ambulance services or flying doctor services such as Royal Flying Doctor Service and Care Flight, and support programs to assist isolated patients with travel to obtain specialised health care.

NOTE 2: Excludes providers of services where those services are captured in public or private hospital financial statements. For example, the provider of an ambulance, medical or diagnostic

laboratory, general practice, specialist medical, dental or other health practitioner service may be located within a hospital set of accounts and its expenditure recorded on the hospital financial statement. The provider of the ambulance or other service would then be recorded under code 101.

CODE 107 Medical and diagnostic laboratory

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in providing analytic or diagnostic services, including body fluid analysis and diagnostic imaging, generally to the medical profession or the patient on referral from a health practitioner. Includes diagnostic imaging centres; dental or medical X-ray laboratories ultrasound services; medical testing laboratories; medical pathology laboratories; medical forensic laboratories; and X-ray clinic services. Includes public and private medical and diagnostic laboratories.

See NOTE 2 under code 106.

CODE 108 Clinical practices – medical – general

Organisations of registered medical practitioners holding the degree of a Doctor of medicine or a qualification at a corresponding level primarily engaged in the independent practice of general medicine. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or medical centres.

See NOTE 2 under code 106.

This item is not currently required to be reported by state and territory health authorities.

CODE 109 Clinical practices – medical – specialist

This item is not currently required to be reported by state and territory health authorities.

Organisations of health practitioners holding the degree of a Doctor of medicine or a qualification at a corresponding level primarily engaged in the independent practice of specialist medicine or surgery, other than pathology and diagnostic imaging services. These practitioners operate a wide range of specialities in private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or health maintenance type medical centres. Includes for example:

- Anaesthetist service
- Dermatology service
- Ear, nose and throat specialist service
- Gynaecology service
- Neurology service
- Obstetrics service
- Paediatric service
- Psychiatry service
- Specialist medical clinic service

- Specialist surgical service
See NOTE 2 under code 106.

CODE 110 Clinical practices – medical – other

This item is not currently required to be reported by state and territory health authorities.

Includes organisations of physicians not able to be allocated to Codes 108 or 109

CODE 111 Clinical practices – dental

Organisations of registered health practitioners holding the degree of Doctor of dental medicine or a qualification at a corresponding level primarily engaged in the independent practice of general or specialised dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals, medical centres or community health facilities. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialise in a single field of dentistry. Also included are dental hospitals providing ambulatory services only. Includes for example:

- Cleft lip and palate services
- Community dental service
- Dental assessment and treatment
- Dental hospital (out-patient)
- Dental practice service
- Dental practitioner service
- Dental surgery service
- Endodontic service
- Oral and maxillofacial services
- Oral pathology service
- Oral surgery service
- Orthodontic service
- Pedodontic service
- Periodontic service

See NOTE 2 under code 106.

CODE 112 Clinical practices – other

This item is not currently required to be reported by state and territory health authorities.

Organisations of independent health practitioners (other than physicians and dentists), such as chiropractors, optometrists, mental health specialists, physical, occupational, and speech therapists and audiologists organisations primarily engaged in providing **ambulatory** health care. These practitioners operate private or group practices in their own offices (e.g., centres, clinics) or in the facilities of others, such as hospitals or medical centres. Includes for example:

- Acupuncture service

- Aromatherapy service
- Audiology service
- Chiropractic service
- Clinical psychology service
- Dental hygiene service
- Dietician service
- Hearing aid dispensing
- Homoeopathic service
- Midwifery service
- Naturopathic service
- Nursing service
- Occupational therapy service
- Optometrist
- Osteopathic service
- Podiatry service
- Speech pathology service
- Therapeutic massage service

See NOTE 2 under code 106.

CODE 113 Community health facility – substance abuse

Organisations with health staff primarily engaged in providing ambulatory services related to the diagnosis and treatment of alcohol and other substance abuse. These are community-based organisations that treat patients who do not require admitted patient treatment. They may provide counselling staff and information regarding a wide range of substance abuse issues and/or refer patients to more extensive treatment programmes, if necessary. Includes for example:

- Community based alcoholism treatment centres and clinics (other than hospitals or residential care facilities);
- Community based detoxification centre and clinics (other than hospitals or residential care facilities);
- Community based drug addiction treatment centres and clinics (other than hospitals or residential care facilities);
- Community based substance abuse treatment centres and clinics (other than hospitals or residential care facilities).

CODE 114 Community health facility – mental

An organisation comprised of one or more specialised mental health services or facilities with health staff primarily engaged in providing ambulatory services related to the diagnosis and treatment of mental health disorders. These specialised mental health services generally treat patients who do not require admitted patient treatment. However, these services do include consultation/liaison services provided to admitted patients by community mental health services. They may provide counselling staff and information regarding a wide range of

mental health issues and/or refer patients to more extensive treatment programmes, if necessary. They may also provide treatment both on and off site, for example through mobile units. Includes only government-funded specialised mental health services, such as community mental health centres and clinics.

Includes expenditure on government-managed community specialised mental health services, plus the cost of the grants to non-government organisations that provide community specialised mental health services, not the total expenditure by these non-government organisations.

Excludes mental health clinics in hospitals and residential mental health care facilities.

CODE 115 Community health facility – other

Organisations with health staff primarily engaged in providing general or specialised ambulatory care. Centres or clinics of health practitioners with the same degree or with different degrees from more than one speciality practising within the same establishment i.e., physician and dentist) are included in this item. Includes only government-funded community health facilities such as:

- Community centres and clinics;
- General practitioner plus centres;
- Multi-speciality community clinics.

Excludes clinical practices that provide exclusively medical services or exclusively health services, ambulatory mental health and substance abuse centres, and free-standing ambulatory surgical centres (reported under codes 108 to 114) and kidney dialysis centres and clinics (reported under codes 101 to 103 if part of a hospital or code 109 if they are free-standing ambulatory centres).

CODE 116 Blood and organ bank

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in collecting, storing and distributing blood and blood products and storing and distributing body organs.

CODE 117 Retail sale/supplier of medical goods – optical glasses and other vision products

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the retail sale of optical glasses and other vision products to the general public for personal or household consumption or utilisation. This includes the fitting and repair provided in combination with sales of optical glasses and other vision products.

Excludes organisations primarily engaged in providing optometric services.

CODE 118 Retail sale/supplier of medical goods – hearing aids

This item is not currently required to be reported by state and

territory health authorities.

Organisations primarily engaged in the sale of hearing aids to the general public for personal or household consumption or utilisation. This includes the fitting and repair provided in combination with the sale of hearing aids.

Excludes organisations primarily engaged in hearing testing where that also includes a component of hearing aid dispensing and fitting.

CODE 119 Retail sale/supplier of medical goods – dispensing community pharmacist

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the retail sale of pharmaceuticals to the general public for personal or household consumption or utilisation. Instances when the processing of medicine may be involved should be only incidental to selling. This includes both medicines with and without prescription.

Excludes organisations listed under code 201.

CODE 120 Retail sale/supplier of medical goods – other

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in the sale of medical appliances other than optical goods and hearing aids to the general public with or without prescription for personal or household consumption or utilisation. Included are:

- Organisations primarily engaged in the manufacture of medical appliances but where the fitting and repair is usually done in combination with manufacture of medical appliances.
- Organisations engaged in the retail sale of other miscellaneous medical goods to the general public for personal or household consumption or utilisation (included are sales other than by shops, such as electronic shopping and mail-order houses).

Illustrative examples

- sale of fluids (e.g. for home dialysis);
- all other miscellaneous health and personal care stores;
- all other sale of pharmaceuticals and medical goods;
- electronic shopping and mail-order houses specialised in medical goods.

CODE 121 Provision and administration of public health program

Organisations engaged in government or private administration and provision of public health programs such as health promotion, organised screening, immunisation and health protection programs.

CODE 122 General health administration

Organisations primarily engaged in the regulation of activities of

agencies that provide health care, overall administration of health policy, and health insurance. This item comprises government administration (excluding social security) primarily engaged in the formulation and administration of government policy in health and in the setting and enforcement of standards for medical and paramedical personnel and for hospitals, clinics, etc., including the regulation and licensing of providers of health services. For example:

- Department of Health;
- Agencies for the regulation of safety in the workplace.

Excludes organisations primarily engaged in the provision and administration of public health programs which is reported under code 121.

CODE 123 Private health insurance provider

This item is not currently required to be reported by state and territory health authorities.

- Organisations engaged in insurance of health (other than social security funds and other social insurance funds) that provide insurance cover for hospital, medical, dental, pharmaceutical or funeral expenses. This includes organisations primarily engaged in activities involved in or closely related to the management of private health insurance (activities of insurance agents, average and loss adjusters and actuaries).

CODE 188 Main Health Care Service organisation - other

Organisations mainly engaged in providing health care services that are not reported under codes 101 to 123. Includes health or health-related call centres or e-health sites such as Poisons Information Centre and centres that provide information on alcohol and other drugs, mental health or other health issues.

CODE 198 Regional health service (not further defined)

Organisations at an area health service or regional level could be a combination of categories 101 to 188 but which could not be further disaggregated.

CODE 199 State/territory health authority (not further defined)

Organisations at the state or territory health authority level that could be a combination of categories 101 to 188 but which could not be further disaggregated.

Secondary/non-Health Care Service organisation

This item is not currently required to be reported by state and territory health authorities.

CODE 201 Pharmaceutical industry

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in wholesaling human pharmaceuticals, medicines, cosmetics, perfumes and toiletries. Also included are units mainly engaged in wholesaling veterinary drugs or medicines

Excludes organisations listed under code 119.

CODE 202 University

This item is not currently required to be reported by state and territory health authorities.

Organisations primarily engaged in providing undergraduate or postgraduate teaching but which also undertake health research activities. Also includes organisations primarily engaged in undertaking research in the agricultural, biological, physical or social sciences. Units may undertake the research for themselves or others.

Includes:

- Postgraduate school, university operation
- Research school, university operation
- Specialist institute or college
- Undergraduate school, university operation
- University operation

For reporting purposes includes only the health or health related research component or other health services component of these organisations' activities.

CODE 203 Non-health related insurance

This item is not currently required to be reported by state and territory health authorities.

Units mainly engaged in providing general insurance cover (except life and health insurance).

Includes:

- Motor vehicle third party insurance provision
- Worker's compensation insurance provision

CODE 204 Residential aged care facility

This item is not currently required to be reported by state and territory health authorities.

An organisation comprised of one or more government-funded facilities primarily engaged in providing residential care to aged persons and in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements (i.e. report to the System for the payment of Aged Residential Care (SPARC) collection.

Excludes facilities primarily providing services to persons requiring mental health diagnosis and treatment. Also excludes residential care facilities that report under the Commonwealth, State and Territory Disability Agreement where the primary purpose is care for persons with a disability.

CODE 288 Secondary/non-Health Care Service organisation – other

This item is not currently required to be reported by state and territory health authorities.

This item comprises organisations that are not reported under codes 201 to 203 which provide health care as secondary providers or other providers. Included are providers of

occupational health care and home care provided by private households.

Includes:

Occupational health care services not provided in separate health care organisations (all industries);

- Military health services not provided in separate health care organisations
- Prison health services not provided in separate health care organisations
- School health services
- Other providers n.e.c.

Other providers of services which support the health care industry such as laundry or catering services.

Other providers of services unrelated to the health care industry such as the building or automotive industry.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Reference documents:

Organisation for Economic Cooperation and Development 2000. A System of Health Accounts. Version 1.0. Paris: OECD.

Australian Bureau of Statistics 2006. Australian and New Zealand Standard Industry Classification. Cat. no. 1292.0. Canberra: ABS.

RACGP 6 September 2005

<www.racgp.org.au/whatisgeneralpractice>

Data element attributes

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Relational attributes

Related metadata references:

Supersedes [Health industry relevant organisation – main activity type, code NNN](#) Health, Superseded 01/04/2009

Implementation in Data Set Specifications:

[Government health expenditure organisation expenditure capital consumption data element cluster](#) Health, Standard 01/04/2009

[Government health expenditure organisation expenditure data element cluster](#) Health, Standard 01/04/2009

[Government health expenditure organisation expenditure employee related data element cluster](#) Health, Standard 01/04/2009

[Government health expenditure organisation expenditure purchase of goods and services data element cluster](#) Health, Standard 01/04/2009

[Government health expenditure organisation revenue data element cluster](#) Health, Standard 01/04/2009

Health professionals attended (diabetes mellitus)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – health professionals attended for diabetes mellitus (last 12 months), code N
<i>METeOR identifier:</i>	270287
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The health professionals that a person has attended in the last 12 months in relation to issues arising from diabetes mellitus, as represented by a code.
Data Element Concept:	Person – health professionals attended for diabetes mellitus

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Diabetes educator</td></tr><tr><td>2</td><td>Dietician</td></tr><tr><td>3</td><td>Ophthalmologist</td></tr><tr><td>4</td><td>Optometrist</td></tr><tr><td>5</td><td>Podiatrist</td></tr><tr><td>8</td><td>None of the above</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Diabetes educator	2	Dietician	3	Ophthalmologist	4	Optometrist	5	Podiatrist	8	None of the above	9	Not stated/inadequately described
Value	Meaning																
1	Diabetes educator																
2	Dietician																
3	Ophthalmologist																
4	Optometrist																
5	Podiatrist																
8	None of the above																
9	Not stated/inadequately described																
<i>Supplementary values:</i>																	

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Record a code sequentially for each health professional attended.</p> <p>A person may have attended several health professionals in the last 12 months; therefore more than one code can be recorded sequentially.</p> <p>Example 1: If a person has attended a diabetes educator and a podiatrist in the last twelve months, the code recorded would be 15.</p> <p>Example 2: If all have been seen, the code recorded would be 12345.</p> <p>If the person answers 'NO' to all the health professionals specified, code 8 should be applied.</p> <p>CODE 9 should only be used in situations where it is not practicable to ask the questions.</p>
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Collection methods:

The person should be asked about each type of health professional in successive questions, as follows:

Have you attended any of the following health professionals in relation to diabetes mellitus in the last 12 months?

Diabetes educator Yes No

Dietician Yes No

Ophthalmologist Yes No

Optometrist Yes No

Podiatrist Yes No

The appropriate code should be recorded for each health professional attended.

Comments:

The health professional occupations are assigned the following codes at the occupation level of the Australian Standard Classification of Occupations, Second Edition, Australian Bureau of Statistics, 1997, Catalogue No. 1220.0

Diabetes educator 2512-13

Dietician 2393-11

Ophthalmologist 2312-19

Optometrist 2384-11

Podiatrist 2388-11

Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes [Health professionals attended - diabetes mellitus, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.8 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Heart rate

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – heart rate, total beats per minute N[NN]
<i>METeOR identifier:</i>	285123
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The person's heart rate measured in beats per minute.
<i>Data Element Concept:</i>	Person – heart rate

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total								
<i>Data type:</i>	Number								
<i>Format:</i>	N[NN]								
<i>Maximum character length:</i>	3								
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>997</td><td>Cardiac arrest</td></tr><tr><td>998</td><td>Not recorded</td></tr><tr><td>999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	997	Cardiac arrest	998	Not recorded	999	Not stated/inadequately described
Value	Meaning								
997	Cardiac arrest								
998	Not recorded								
999	Not stated/inadequately described								
<i>Unit of measure:</i>	Heart beats per minute								

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Heart rate, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005

Heart rhythm type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Electrocardiogram – heart rhythm type, code N[N]
<i>METeOR identifier:</i>	361626
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of rhythm associated with the beating of the heart as determined from the electrocardiogram (ECG), as represented by a code.
Data Element Concept:	Electrocardiogram – heart rhythm type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																								
<i>Data type:</i>	String																								
<i>Format:</i>	N[N]																								
<i>Maximum character length:</i>	2																								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Sinus rhythm</td></tr><tr><td>2</td><td>Atrial fibrillation</td></tr><tr><td>3</td><td>Atrial flutter</td></tr><tr><td>4</td><td>Second degree heart block</td></tr><tr><td>5</td><td>Complete heart block</td></tr><tr><td>6</td><td>Supraventricular tachycardia</td></tr><tr><td>7</td><td>Idioventricular rhythm</td></tr><tr><td>8</td><td>Ventricular tachycardia</td></tr><tr><td>9</td><td>Ventricular fibrillation</td></tr><tr><td>10</td><td>Paced</td></tr><tr><td>11</td><td>Other rhythm</td></tr></tbody></table>	Value	Meaning	1	Sinus rhythm	2	Atrial fibrillation	3	Atrial flutter	4	Second degree heart block	5	Complete heart block	6	Supraventricular tachycardia	7	Idioventricular rhythm	8	Ventricular tachycardia	9	Ventricular fibrillation	10	Paced	11	Other rhythm
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1	Sinus rhythm																								
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9	Ventricular fibrillation																								
10	Paced																								
11	Other rhythm																								
<i>Supplementary values:</i>	99 Not stated/inadequately described																								

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

Related metadata references:

Supersedes [Person – heart rhythm type, code N\[N\]](#) Health,
Superseded 01/10/2008

*Implementation in Data Set
Specifications:*

[Electrocardiogram cluster](#) Health, Standard 01/10/2008

Height (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – height (measured), total centimetres NN[N].N
<i>METeOR identifier:</i>	270361
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The height of a person measured in centimetres.
<i>Context:</i>	Public health and health care
<i>Data Element Concept:</i>	Person – height

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	NN[N].N				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999.9</td><td>Not measured</td></tr></tbody></table>	Value	Meaning	999.9	Not measured
Value	Meaning				
999.9	Not measured				
<i>Unit of measure:</i>	Centimetre (cm)				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.</p> <p>Measurements of height should be assessed in relation to children and adolescents' age and pubertal status.</p>
<i>Collection methods:</i>	<p>The measurement protocol described below are those recommended by the <i>International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996), and the World Health Organization (WHO Expert Committee 1995), which was adapted from Lohman et al. (1988).</i></p> <p>Measurement protocol:</p> <p>Height measurements can be based on recumbent length or standing height. In general, length measurements are recommended for children under 2 years of age and height measurements for others.</p> <p>The measurement of height requires a vertical metric rule, a horizontal headboard, and a non-compressible flat even surface on which the subject stands. The equipment may be fixed or portable, and should be described and reported.</p> <p>The graduations on the metric rule should be at 0.1 cm intervals, and the metric rule should have the capacity to measure up to at least 210 cm.</p>

Measurement intervals and labels should be clearly readable under all conditions of use of the instrument.

Apparatus that allows height to be measured while the subject stands on a platform scale is not recommended.

Adults and children who can stand:

The subject should be measured without shoes (i.e. is barefoot or wears thin socks) and wears little clothing so that the positioning of the body can be seen. Anything that may affect or interfere with the measurement should be noted on the data collection form (e.g. hairstyles and accessories, or physical problems). The subject stands with weight distributed evenly on both feet, heels together, and the head positioned so that the line of vision is at right angles to the body. The correct position for the head is in the Frankfort horizontal plan (Norton et al. 1996). The arms hang freely by the sides. The head, back, buttocks and heels are positioned vertically so that the buttocks and the heels are in contact with the vertical board. To obtain a consistent measure, the subject is asked to inhale deeply and stretch to their fullest height. The measurer applies gentle upward pressure through the mastoid processes to maintain a fully erect position when the measurement is taken. Ensure that the head remains positioned so that the line of vision is at right angles to the body, and the heels remain in contact with the base board.

The movable headboard is brought onto the top of the head with sufficient pressure to compress the hair.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement. If the two measurements disagree by more than 0.5 cm, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured height is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage & Berry 1994). For example, a mean value of 172.25 cm would be rounded to 172.2 cm, while a mean value of 172.35 cm would be rounded to 172.4 cm.

Infants:

For the measurement of supine length of children up to and including 2 years of age, two observers are required. One observer positions the head correctly while the other ensures the remaining position is correct and brings the measuring board in contact with the feet. The subject lies in a supine position on a recumbent length table or measuring board. The crown of the head must touch the stationary, vertical headboard. The subject's head is held with the line of vision aligned perpendicular to the plane of the measuring surface. The shoulders and buttocks must be flat against the table top, with the shoulders and hips aligned

at right angles to the long axis of the body. The legs must be extended at the hips and knees and lie flat against the table top and the arms rest against the sides of the trunk. The measurer must ensure that the legs remain flat on the table and must shift the movable board against the heels. In infants care has to be taken to extend the legs gently. In some older children two observers may also be required.

In general, length or height is measured and reported to the nearest 0.1 cm. For any child, the length measurement is approximately 0.5 - 1.5 cm greater than the height measurement. It is therefore recommended that when a length measurement is applied to a height-based reference for children over 24 months of age (or over 85 cm if age is not known), 1.0 cm be subtracted before the length measurement is compared with the reference. It is also recommended that as a matter of procedure and data recording accuracy, the date be recorded when the change is made from supine to standing height measure.

Validation and quality control measures:

All equipment, whether fixed or portable should be checked prior to each measurement session to ensure that both the headboard and floor (or footboard) are at 90 degrees to the vertical rule. With some types of portable anthropometer it is necessary to check the correct alignment of the headboard, during each measurement, by means of a spirit level. Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement of height, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 5 mm and be less than 5 mm within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference. Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

Comments:

This metadata item applies to persons of all ages. It is recommended for use in population surveys and health care settings.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men, women, children and adolescents although the range will depend on the population:

Height

70 cm = Height

75 cm = Height

... in 5 cm categories

185 cm = Height

Height => 190 cm

Relational attributes

Related metadata references:

Supersedes [Height - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (28.7 KB)

Is used in the formation of [Adult – body mass index \(measured\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Is used in the formation of [Child – body mass index \(self-reported\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Is used in the formation of [Child – body mass index \(measured\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Is used in the formation of [Adult – body mass index \(self-reported\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Height (self-reported)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – height (self-reported), total centimetres NN[N]
<i>METeOR identifier:</i>	270365
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's self-reported height, measured in centimetres.
<i>Data Element Concept:</i>	Person – height

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	NN[N]						
<i>Maximum character length:</i>	3						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>888</td><td>Unknown</td></tr><tr><td>999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	888	Unknown	999	Not stated/inadequately described
Value	Meaning						
888	Unknown						
999	Not stated/inadequately described						
<i>Unit of measure:</i>	Centimetre (cm)						

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.</p> <p>The data collection form should include a question asking the respondent what their height is. For example, the Australian Bureau of Statistics National Health Survey 1995 included the question 'How tall are you without shoes?'. The data collection form should allow for both metric (to the nearest 1 cm) and imperial (to the nearest 0.5 inch) units to be recorded.</p> <p>If practical, it is preferable to enter the raw data into the database before conversion of measures in imperial units to metric. However if this is not possible, height reported in imperial units can be converted to metric prior to data entry using a conversion factor of 2.54 cm to the inch.</p> <p>Rounding to the nearest 1 cm will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 cm. The following rounding conventions are desirable to reduce systematic over-reporting (Armitage & Berry 1994):</p>
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NNN.x where x

NNN.x where $x > 5$ - round up, e.g. 172.7 cm would be rounded to 173 cm.

NNN.x where $x = 5$ - round to the nearest even number, e.g. 172.5 cm would be rounded to 172 cm, while 173.5 cm would be rounded to 174 cm.

Comments:

This metadata item is recommended for persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure height.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present height data in categories. It is recommended that 5 cm groupings are used for this purpose. Height data should not be rounded before categorisation. The following categories may be appropriate for describing the heights of Australian men and women, although the range will depend on the population. The World Health Organization's range for height is 140-190 cm.

Height <140 cm

140 cm = Height < 145 cm

145 cm = Height < 150 cm

... in 5 cm categories

185 cm = Height < 190 cm

Height => 190 cm

On average, height tends to be overestimated when self-reported by respondents. Data for Australian men and women aged 20-69 years in 1989 indicated that men overestimated by an average of 1.1 cm (SEM* of 0.04 cm) and women by an average of 0.5 cm (SEM of 0.05 cm) (Waters 1993). The extent of overestimation varied with age.

*Note: SEM is the standard error of measurement.

Relational attributes

Related metadata references:

Supersedes [Height - self-reported, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (21.0 KB)

Is used in the formation of [Child – body mass index \(self-reported\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Is used in the formation of [Adult – body mass index \(self-reported\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

Hip circumference (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – hip circumference (measured), total centimetres NN[N].N
<i>METeOR identifier:</i>	270366
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An adult's hip circumference at the level of maximum posterior extension of the buttocks measured in centimetres.
Data Element Concept:	Person – hip circumference

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NN[N].N
<i>Maximum character length:</i>	4
<i>Supplementary values:</i>	Value Meaning 999.9 Not measured
<i>Unit of measure:</i>	Centimetre (cm)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	As there are no cut-off points for waist-to-hip ratio for children and adolescents, it is not necessary to collect this metadata item for those aged under 18 years.
<i>Collection methods:</i>	<p>The measurement protocol described below is that recommended by the <i>World Health Organization (WHO Expert Committee 1995)</i>.</p> <p>Measurement protocol:</p> <p>The data collection form should allow for up to three measurements of hip circumference to be recorded in centimetres to 1 decimal place. The data collection form should also have the capacity to record any reasons for the non-collection of hip circumference data.</p> <p>The measurement of hip circumference requires a narrow (</p> <p>The subject should wear only non-restrictive briefs or underwear, a light smock over underwear or light clothing. Belts and heavy outer clothing should be removed. Hip measurement should be taken over one layer of light clothing only.</p> <p>The subject stands erect with arms at the sides, feet together and the gluteal muscles relaxed. The measurer sits at the side of the subject so that the level of maximum posterior extension of the</p>

buttocks can be seen. An inelastic tape is placed around the buttocks in a horizontal plane. To ensure contiguity of the two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body. The tape is in contact with the skin but does not compress the soft tissues. Fatty aprons should be excluded from the hip circumference measurement.

The measurement is recorded to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, then take a third measurement.

All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured hip circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over reporting. For example, a mean value of 102.25 cm would be rounded to 102.2 cm, while a mean value of 102.35 cm would be rounded to 102.4 cm.

Validation and quality control measures:

Steel tapes should be checked against a 1-metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996)) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured hip circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

This metadata item applies to persons aged 18 years or older. It is recommended for use in population surveys and health care settings.

Its main use is to enable the calculation of adult waist-to-hip ratio which requires the measurement of hip circumference and waist circumference.

Comments:

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the errors in waist-to-hip ratio measurements.

Waist-to-hip ratio is therefore no longer a commonly used measure.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present hip circumference data in categories. It is recommended that 5 cm groupings be used for this purpose. Hip circumference data should not be rounded before categorisation.

Relational attributes

Related metadata references:

Supersedes [Hip circumference - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (23.1 KB)

Is used in the formation of [Adult – waist-to-hip ratio, N.NN Health, Standard 01/03/2005](#)

Histopathological grade

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – histopathological grade, code N
<i>METeOR identifier:</i>	370019
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	<p>The histopathological grade or differentiation describes how much the tumour resembles the normal tissue from which it arose, as represented by a code.</p> <p>For lymphohaematopoietic neoplasms (leukaemias and lymphomas) this data element is used to denote cell lineage.</p>
Data Element Concept:	Person with cancer – histopathological grade

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Grade 1: Low grade; well differentiated, differentiated, NOS</td></tr><tr><td>2</td><td>Grade 2: Intermediate grade, moderately differentiated, moderately well differentiated, intermediate differentiation</td></tr><tr><td>3</td><td>Grade 3: High grade, poorly differentiated</td></tr><tr><td>4</td><td>Grade 4: Undifferentiated, anaplastic</td></tr><tr><td>5</td><td>T-cell: T-cell</td></tr><tr><td>6</td><td>B-cell: B-cell, Pre-B, B-Precursor</td></tr><tr><td>7</td><td>Null-cell: Null cell, Non T- non B</td></tr><tr><td>8</td><td>NK-cell: Natural killer cell</td></tr><tr><td><i>Supplementary values:</i></td><td>9</td></tr></tbody></table>	Value	Meaning	1	Grade 1: Low grade; well differentiated, differentiated, NOS	2	Grade 2: Intermediate grade, moderately differentiated, moderately well differentiated, intermediate differentiation	3	Grade 3: High grade, poorly differentiated	4	Grade 4: Undifferentiated, anaplastic	5	T-cell: T-cell	6	B-cell: B-cell, Pre-B, B-Precursor	7	Null-cell: Null cell, Non T- non B	8	NK-cell: Natural killer cell	<i>Supplementary values:</i>	9
Value	Meaning																				
1	Grade 1: Low grade; well differentiated, differentiated, NOS																				
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7	Null-cell: Null cell, Non T- non B																				
8	NK-cell: Natural killer cell																				
<i>Supplementary values:</i>	9																				
	Grade/differentiation unknown: Grade/cell type not determined, not stated or not applicable																				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Only one code can be recorded.</p> <p>When more than one grade is documented for the primary tumour within the same specimen report, use the highest grade. For example, if grade 2-3 is documented, record the grade as 3.</p> <p>If the grades differ on multiple pathology reports for the same</p>
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tumour, use the value from the larger specimen (for example, the grade from a surgical excision specimen would be used over the grade from a specimen from a diagnostic biopsy).

Breast cancer coding rules:

Use the Nottingham grade (Elston-Ellis modification of Bloom-Richardson grading system). This classification only uses grades 1-3, 9.

For an invasive tumour with an in situ component, record the grade for the invasive component only. If the grade of the invasive component is not reported, record the grade as unknown.

Collection methods:

Cancer registry use:

Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

Source and reference attributes

Origin:

World Health Organisation

Commission on Cancer American College of Surgeons

Reference documents:

World Health Organisation International Classification of Diseases Oncology, Third edition (ICD-O-3) (2000)

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

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 [Person with cancer – histopathological grade, code N](#) Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Hospital insurance status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Patient – hospital insurance status, code N
<i>METeOR identifier:</i>	270253
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>Hospital insurance as represented by a code under one of the following categories:</p> <ul style="list-style-type: none">Registered insurance - hospital insurance with a health insurance fund registered under the National Health Act 1953 (Cwlth)General insurance - hospital insurance with a general insurance company under a guaranteed renewable policy providing benefits similar to those available under registered insuranceNo hospital insurance or benefits coverage under the above.
Data Element Concept:	Patient – hospital insurance status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Hospital insurance</td></tr><tr><td>2</td><td>No hospital insurance</td></tr><tr><td>9</td><td>Unknown</td></tr></tbody></table>	Value	Meaning	1	Hospital insurance	2	No hospital insurance	9	Unknown
Value	Meaning								
1	Hospital insurance								
2	No hospital insurance								
9	Unknown								
<i>Supplementary values:</i>									

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Persons covered by insurance for benefits of ancillary services only are included in 2 - no hospital insurance.</p> <p>The 'unknown' category should not be used in primary collections but can be used to record unknown insurance status in databases.</p> <p>This metadata item is to determine whether the patient has hospital insurance, not their method of payment for the episode of care.</p>
<i>Comments:</i>	<p>Insurance status was reviewed and modified to reflect changes to new private health insurance arrangements under the Health Legislation (Private Health Insurance Reform) Amendment Act 1995.</p>

Employee health benefits schemes became illegal with the implementation of Schedule 2 of the private health insurance reforms, effective on 1 October 1995.

Under Schedule 4 of the private health insurance reforms, on 1 July 1997, the definition of the 'basic private table' or 'basic table', and 'supplementary hospital table' and any references to these definitions was omitted from the National Health Act 1953. All hospital tables offered by registered private health insurers since 29 May 1995 have been referred to as 'Applicable Benefits Arrangements' and marketed under the insurer's own product name.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Hospital insurance status, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.6 KB)

Implementation in Data Set Specifications: [Admitted patient care NMDS Health](#), Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009
Implementation start date: 01/07/2009
Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009
Implementation start date: 01/07/2010

Hours on-call (not worked) by medical practitioner

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Medical practitioner – hours on-call, total NNN
<i>METeOR identifier:</i>	270138
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The number of hours in a week that a medical practitioner is required to be available to provide advice, respond to any emergencies etc.
Data Element Concept:	Medical practitioner – hours on-call

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	String
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning
	999 Not stated/inadequately described
<i>Unit of measure:</i>	Hour (h)

Collection and usage attributes

<i>Guide for use:</i>	Total hours expressed as 000, 001 etc.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This metadata item relates to each position (job) held by a medical practitioner.
<i>Collection methods:</i>	There are inherent problems in asking for information on number of hours on-call not worked per week, for example, reaching a satisfactory definition and communicating this definition to the respondents in a self-administered survey. Whether hours on-call not worked are collected for main job only, or main job and one or more additional jobs, it is important that a total for all jobs is included.

Relational attributes

<i>Related metadata references:</i>	Supersedes Hours on-call (not worked) by medical practitioner, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.5 KB)
<i>Implementation in Data Set Specifications:</i>	Health labour force NMDS Health, Standard 01/03/2005 <i>Implementation start date:</i> 01/07/2005

Hours worked in health profession—clinical

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – hours worked in clinical role, total hours NNN
<i>METeOR identifier:</i>	375301
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The total number of hours a health professional worked in their registered profession undertaking diagnosis, care and treatment of patients.
<i>Context:</i>	Health labour force
<i>Data Element Concept:</i>	Registered health professional – hours worked in clinical role

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	String
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning
	999 Not stated/inadequately described
<i>Unit of measure:</i>	Hour (h)

Collection and usage attributes

<i>Guide for use:</i>	Total hours expressed as 000, 001 etc.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Total hours worked are for both employed and self-employed health professionals. Total hours worked in clinical role: <ul style="list-style-type: none">• includes travel to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities. Registered health professionals on leave at the time of registration are asked to report their usual hours worked.
<i>Collection methods:</i>	Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references:

Supersedes [Medical practitioner – hours worked \(in direct patient care\), total NNN](#) Health, Superseded 10/12/2009

See also [Registered health professional – hours worked in public sector, total hours NNN](#) Health, Standard 10/12/2009

See also [Registered health professional – hours worked in private sector, total hours NNN](#) Health, Standard 10/12/2009

See also [Registered health professional – hours worked in health profession, total hours NNN](#) Health, Standard 10/12/2009

See also [Registered health professional – hours worked in non-clinical role](#) Health, Standard 10/12/2009

See also [Work setting hours cluster](#) Health, Standard 10/12/2009

See also [Registered health professional – hours worked in non-clinical role, total hours NNN](#) Health, Standard 10/12/2009

Implementation in Data Set Specifications:

[Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009

[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard 10/12/2009

[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard 10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard 10/12/2009

[Registered psychology labour force DSS](#) Health, Standard 10/12/2009

Hours worked in health profession—non-clinical

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – hours worked in non-clinical role, total hours NNN
<i>METeOR identifier:</i>	375305
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The total number of hours a health professional worked in a non-clinical role in their registered profession.
<i>Context:</i>	Health labour force
<i>Data Element Concept:</i>	Registered health professional – hours worked in non-clinical role

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	String
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning
	999 Not stated/inadequately described
<i>Unit of measure:</i>	Hour (h)

Collection and usage attributes

<i>Guide for use:</i>	Total hours expressed as 000, 001 etc.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Total hours worked are for both employed and self-employed health professionals. Total hours worked in non-clinical role <u>includes</u> : <ul style="list-style-type: none">• time spent as an administrator, teacher/educator, researcher or other non-clinician role in the profession; and• travel to home visits or calls out. Total hours worked in non-clinical role <u>excludes</u> : <ul style="list-style-type: none">• time spent in the diagnosis, care and treatment of patients;• time travelling between work locations; and• unpaid professional and/or voluntary activities. Registered health professionals on leave at the time of registration are asked to report their usual hours worked.
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Collection methods: Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also [Registered health professional – hours worked in public sector, total hours NNN](#) Health, Standard 10/12/2009
See also [Registered health professional – hours worked in private sector, total hours NNN](#) Health, Standard 10/12/2009
See also [Registered health professional – hours worked in health profession, total hours NNN](#) Health, Standard 10/12/2009
See also [Registered health professional – hours worked in clinical role, total hours NNN](#) Health, Standard 10/12/2009
See also [Work setting hours cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specifications: [Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009
[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009
[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009
[Registered midwifery labour force DSS](#) Health, Standard 10/12/2009
[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009
[Registered optometry labour force DSS](#) Health, Standard 10/12/2009
[Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009
[Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009
[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009
[Registered podiatry labour force DSS](#) Health, Standard 10/12/2009
[Registered psychology labour force DSS](#) Health, Standard 10/12/2009

Hours worked in health profession—private sector

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – hours worked in private sector, total hours NNN
<i>METeOR identifier:</i>	382906
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The total number of hours a health professional worked in non-government sector employment in their registered profession.
<i>Context:</i>	Health labour force
<i>Data Element Concept:</i>	Registered health professional – hours worked in private sector

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	String
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning
	999 Not stated/inadequately described
<i>Unit of measure:</i>	Hour (h)

Collection and usage attributes

<i>Guide for use:</i>	Total hours expressed as 000, 001 etc.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Total hours worked are for both employed and self-employed health professionals.</p> <p>Total hours worked in private sector:</p> <ul style="list-style-type: none">• includes travel to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities. <p>Registered health professionals on leave at the time of registration are asked to report their usual hours worked.</p> <p>Private sector employment is employment by an establishment that may receive some government funding but is run by the non-government sector. Private sector establishments are not controlled by government, are directed by a group of officers, an executive committee or a similar body elected by a majority of members, and may be an income tax exempt charity.</p>
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Collection methods: Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also [Registered health professional – hours worked in health profession, total hours NNN](#) Health, Standard 10/12/2009
See also [Work setting hours cluster](#) Health, Standard 10/12/2009
See also [Registered health professional – hours worked in non-clinical role, total hours NNN](#) Health, Standard 10/12/2009
See also [Registered health professional – hours worked in public sector, total hours NNN](#) Health, Standard 10/12/2009
See also [Registered health professional – hours worked in clinical role, total hours NNN](#) Health, Standard 10/12/2009

Implementation in Data Set Specifications: [Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009
[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009
[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009
[Registered midwifery labour force DSS](#) Health, Standard 10/12/2009
[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009
[Registered optometry labour force DSS](#) Health, Standard 10/12/2009
[Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009
[Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009
[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009
[Registered podiatry labour force DSS](#) Health, Standard 10/12/2009
[Registered psychology labour force DSS](#) Health, Standard 10/12/2009

Hours worked in health profession—public sector

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – hours worked in public sector, total hours NNN
<i>METeOR identifier:</i>	382908
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The total number of hours a health professional worked in government sector employment in their registered profession.
<i>Context:</i>	Health labour force
<i>Data Element Concept:</i>	Registered health professional – hours worked in public sector

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	String
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning
	999 Not stated/inadequately described
<i>Unit of measure:</i>	Hour (h)

Collection and usage attributes

<i>Guide for use:</i>	Total hours expressed as 000, 001 etc.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Total hours worked are for both employed and self-employed health professionals.</p> <p>Total hours worked in public sector:</p> <ul style="list-style-type: none">• includes travel to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities. <p>Registered health professionals on leave at the time of registration are asked to report their usual hours worked.</p> <p>Public sector employment is employment with an establishment run by the government sector. A public sector establishment:</p> <ul style="list-style-type: none">• operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,• is part of the general government sector or is controlled by some part of the general government sector,
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- provides government services free of charge or at nominal prices, and
- is financed mainly from taxation.

Collection methods:

Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

See also [Registered health professional – hours worked in health profession, total hours NNN](#) Health, Standard 10/12/2009

See also [Work setting hours cluster](#) Health, Standard 10/12/2009

See also [Registered health professional – hours worked in non-clinical role, total hours NNN](#) Health, Standard 10/12/2009

See also [Registered health professional – hours worked in private sector, total hours NNN](#) Health, Standard 10/12/2009

See also [Registered health professional – hours worked in clinical role, total hours NNN](#) Health, Standard 10/12/2009

Implementation in Data Set Specifications:

[Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009

[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard 10/12/2009

[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard 10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard 10/12/2009

[Registered psychology labour force DSS](#) Health, Standard 10/12/2009

Hours worked in health profession—total

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – hours worked in health profession, total hours NNN
<i>METeOR identifier:</i>	375286
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The total number of hours a health professional worked in their registered profession.
<i>Context:</i>	Health labour force
<i>Data Element Concept:</i>	Registered health professional – hours worked in health profession

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	String
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning
	999 Not stated/inadequately described
<i>Unit of measure:</i>	Hour (h)

Collection and usage attributes

<i>Guide for use:</i>	Total hours expressed as 000, 001 etc.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Total hours worked are for both employed and self-employed health professionals. Total hours worked in health profession: <ul style="list-style-type: none">• includes travel to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities. Registered health professionals on leave at the time of registration are asked to report their usual hours worked.
<i>Collection methods:</i>	Total hours worked refers to hours worked in the week before registration.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references:

Supersedes [Medical practitioner – hours worked, total NNN](#) Health, Superseded 10/12/2009

See also [Registered health professional – hours worked in clinical role, total hours NNN](#) Health, Standard 10/12/2009

See also [Registered health professional – hours worked in non-clinical role, total hours NNN](#) Health, Standard 10/12/2009

See also [Registered health professional – hours worked in private sector, total hours NNN](#) Health, Standard 10/12/2009

See also [Registered health professional – hours worked in public sector, total hours NNN](#) Health, Standard 10/12/2009

Supersedes [Health professional – hours worked \(in all jobs\), total NNN](#) Health, Superseded 10/12/2009

Implementation in Data Set Specifications:

[Main job of registered chiropractor cluster](#) Health, Standard 10/12/2009

[Main job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

[Main job of registered medical professional cluster](#) Health, Standard 10/12/2009

[Main job of registered midwife cluster](#) Health, Standard 10/12/2009

[Main job of registered nursing professional cluster](#) Health, Standard 10/12/2009

[Main job of registered optometrist cluster](#) Health, Standard 10/12/2009

[Main job of registered osteopath cluster](#) Health, Standard 10/12/2009

[Main job of registered pharmacist cluster](#) Health, Standard 10/12/2009

[Main job of registered physiotherapist cluster](#) Health, Standard 10/12/2009

[Main job of registered podiatrist cluster](#) Health, Standard 10/12/2009

[Main job of registered psychologist cluster](#) Health, Standard 10/12/2009

[Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009

[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard 10/12/2009

[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard 10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard 10/12/2009

[Registered psychology labour force DSS](#) Health, Standard 10/12/2009

[Second job of registered chiropractor cluster](#) Health, Standard 10/12/2009

[Second job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

[Second job of registered medical professional cluster](#) Health, Standard 10/12/2009

[Second job of registered midwife cluster](#) Health, Standard 10/12/2009

[Second job of registered nursing professional cluster](#) Health, Standard 10/12/2009

[Second job of registered optometrist cluster](#) Health, Standard 10/12/2009

[Second job of registered osteopath cluster](#) Health, Standard 10/12/2009

[Second job of registered pharmacist cluster](#) Health, Standard 10/12/2009

[Second job of registered physiotherapist cluster](#) Health, Standard 10/12/2009

[Second job of registered podiatrist cluster](#) Health, Standard 10/12/2009

[Second job of registered psychologist cluster](#) Health, Standard 10/12/2009

[Work setting hours cluster](#) Health, Standard 10/12/2009

House/property number (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – house/property identifier, text [X(12)]
<i>Synonymous names:</i>	Australian street number
<i>METeOR identifier:</i>	270030
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The identifier of a house or property where a person resides, as represented by text.
Data Element Concept:	Person (address) – house/property identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(12)]
<i>Maximum character length:</i>	12

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Generally, only one house/property number is used. However, if the house/property number includes a number range, the range of applicable numbers should be included, separated by a hyphen (-), with no spaces between numerals, i.e. 17-19</p> <ul style="list-style-type: none">• House/property number 1 - refers to physical House/property number and for ranges is the starting number (5 numeric characters)• House/property number Suffix 1 - a single character identifying the House/property number suffix (1 alphanumeric character)• House/property number 2 - refers to a physical House/property number and for ranges is the finishing number (5 numeric characters)• House/property number suffix 2 - a single character identifying the House/property number suffix (1 alphanumeric character) with no space between the numeric and the alpha characters. <p>For example; '401A 403B'</p> <p>'401' is House/property number first in range 'A' is the House/Property suffix 1 '403' is House/property number last in range 'B' is House/Property suffix 2</p>
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Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare
Origin: Australia Post Address Presentation Standard
Reference documents: AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes [House/property number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.6 KB)
Is used in the formation of [Person \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005
Is used in the formation of [Person \(address\) – health address line, text \[X\(180\)\]](#) Health, Superseded 04/05/2005

Implementation in Data Set Specifications: [Health care client identification DSS](#) Health, Superseded 03/12/2008
[Health care client identification DSS](#) Health, Standard 03/12/2008
[Health care provider identification DSS](#) Health, Superseded 04/07/2007
[Health care provider identification DSS](#) Health, Superseded 03/12/2008
[Health care provider identification DSS](#) Health, Standard 03/12/2008

House/property number (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – house/property identifier, text [X(12)]
<i>METeOR identifier:</i>	290241
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The unique identifier of a house or property where an organisation is located.
Data Element Concept:	Service provider organisation (address) – house/property identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(12)]
<i>Maximum character length:</i>	12

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Generally, only one house/property number is used. However, if the house/property number includes a number range, the range of applicable numbers should be included, separated by a hyphen (-), with no spaces between numerals, i.e. 17-19</p> <ul style="list-style-type: none">• House/property number 1 - refers to physical House/property number and for ranges is the starting number (5 numeric characters)• House/property number Suffix 1 - a single character identifying the House/property number suffix (1 alphanumeric character)• House/property number 2 - refers to a physical House/property number and for ranges is the finishing number (5 numeric characters)• House/property number suffix 2 - a single character identifying the House/property number suffix (1 alphanumeric character) with no space between the numeric and the alpha characters. <p>For example; '401A 403B' '401' is House/property number first in range 'A' is the House/Property suffix 1</p>
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'403' is House/property number last in range
'B' is House/Property suffix 2

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare
Origin: Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Is used in the formation of [Service provider organisation \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications: [Health care provider identification DSS](#) Health, Superseded 04/07/2007
[Health care provider identification DSS](#) Health, Superseded 03/12/2008
[Health care provider identification DSS](#) Health, Standard 03/12/2008

Household annual gross income range

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Household – gross income (annual), dollar range code N
<i>METeOR identifier:</i>	290737
<i>Registration status:</i>	Health, Standard 04/05/2005
<i>Definition:</i>	The value of gross annual income from all sources (before deductions for income tax, superannuation, etc.) for all household members as represented by a dollar range code.
<i>Context:</i>	Gross household income ranges are used as an indicator of the economic status of the household.
<i>Data Element Concept:</i>	Household – gross income

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Less than \$ 20,000</td></tr><tr><td>2</td><td>\$ 20,001-\$ 30,000</td></tr><tr><td>3</td><td>\$ 30,001-\$ 50,000</td></tr><tr><td>4</td><td>\$ 50,001 - \$ 100,000</td></tr><tr><td>5</td><td>More than \$ 100,000</td></tr></tbody></table>	Value	Meaning	1	Less than \$ 20,000	2	\$ 20,001-\$ 30,000	3	\$ 30,001-\$ 50,000	4	\$ 50,001 - \$ 100,000	5	More than \$ 100,000
Value	Meaning												
1	Less than \$ 20,000												
2	\$ 20,001-\$ 30,000												
3	\$ 30,001-\$ 50,000												
4	\$ 50,001 - \$ 100,000												
5	More than \$ 100,000												
<i>Supplementary values:</i>	<table><tbody><tr><td>6</td><td>Don't know/not sure</td></tr><tr><td>7</td><td>Not stated</td></tr></tbody></table>	6	Don't know/not sure	7	Not stated								
6	Don't know/not sure												
7	Not stated												

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The main components of gross income are:</p> <ul style="list-style-type: none">• current usual wages and salary;• income derived from self-employment;• government pensions, benefits and allowances; and• other income comprising investments (including interest, dividends, royalties and rent) and other regular income (including superannuation, private scholarships received in cash, workers' compensation, accident compensation, maintenance or alimony, and any other allowances regularly received).
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Gross income is regarded as all receipts which are received regularly and are of a recurring nature. Certain receipts such as lump sum receipts, windfall gains and withdrawals from savings are not considered to conform to these criteria and are not included as income.

Please note that this data element is not consistent with the ABS standards for cash income.

Source and reference attributes

Submitting organisation:

National Public Health Information Working Group

Reference documents:

Refer to the ABS website Statistical Standards/Standards for Social, Labour and Demographic Variables/Cash Income Variables:

[1200.0 - Standards for Social, Labour and Demographic Variables, 1999](#)

Relational attributes

Implementation in Data Set Specifications:

[Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008](#)

[Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008](#)

Household annual gross income range (\$10,000 range)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Household – gross income (annual), ten thousand dollar range code N[N]
<i>METeOR identifier:</i>	290742
<i>Registration status:</i>	Health, Standard 04/05/2005
<i>Definition:</i>	The value of gross annual income from all sources (before deductions for income tax, superannuation, etc.) for all household members as represented by a ten thousand dollar range code.
<i>Context:</i>	Gross household income (\$10,000 ranges) is used as an indicator of the economic status of the household.
<i>Data Element Concept:</i>	Household – gross income

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																												
<i>Data type:</i>	Number																												
<i>Format:</i>	N[N]																												
<i>Maximum character length:</i>	2																												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Less than \$ 10,000</td></tr><tr><td>2</td><td>\$ 10,000 - \$ 20,000</td></tr><tr><td>3</td><td>\$ 20,001 - \$ 30,000</td></tr><tr><td>4</td><td>\$ 30,001 - \$ 40,000</td></tr><tr><td>5</td><td>\$ 40,001 - \$ 50,000</td></tr><tr><td>6</td><td>\$ 50,001 - \$ 60,000</td></tr><tr><td>7</td><td>\$ 60,001 - \$ 70,000</td></tr><tr><td>8</td><td>\$ 70,001 - \$ 80,000</td></tr><tr><td>9</td><td>\$ 80,001 - \$ 90,000</td></tr><tr><td>10</td><td>\$ 90,001 - \$ 100,000</td></tr><tr><td>11</td><td>More than \$ 100,000</td></tr><tr><td><i>Supplementary values:</i></td><td>12 Don't know / not sure</td></tr><tr><td></td><td>13 Not stated</td></tr></tbody></table>	Value	Meaning	1	Less than \$ 10,000	2	\$ 10,000 - \$ 20,000	3	\$ 20,001 - \$ 30,000	4	\$ 30,001 - \$ 40,000	5	\$ 40,001 - \$ 50,000	6	\$ 50,001 - \$ 60,000	7	\$ 60,001 - \$ 70,000	8	\$ 70,001 - \$ 80,000	9	\$ 80,001 - \$ 90,000	10	\$ 90,001 - \$ 100,000	11	More than \$ 100,000	<i>Supplementary values:</i>	12 Don't know / not sure		13 Not stated
Value	Meaning																												
1	Less than \$ 10,000																												
2	\$ 10,000 - \$ 20,000																												
3	\$ 20,001 - \$ 30,000																												
4	\$ 30,001 - \$ 40,000																												
5	\$ 40,001 - \$ 50,000																												
6	\$ 50,001 - \$ 60,000																												
7	\$ 60,001 - \$ 70,000																												
8	\$ 70,001 - \$ 80,000																												
9	\$ 80,001 - \$ 90,000																												
10	\$ 90,001 - \$ 100,000																												
11	More than \$ 100,000																												
<i>Supplementary values:</i>	12 Don't know / not sure																												
	13 Not stated																												

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The main components of gross income are: <ul style="list-style-type: none">• current usual wages and salary;
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- income derived from self-employment;
- government pensions, benefits and allowances; and
- other income comprising investments (including interest, dividends, royalties and rent) and other regular income (including superannuation, private scholarships received in cash, workers' compensation, accident compensation, maintenance or alimony, and any other allowances regularly received).

Gross income is regarded as all receipts which are received regularly and are of a recurring nature. Certain receipts such as lump sum receipts, windfall gains and withdrawals from savings are not considered to conform to these criteria and are not included as income.

Please note that this data element is not consistent with the ABS standards for cash income.

Refer to the ABS website Standards for Social, Labour and Demographic Variables/Cash Income Variables:
[1200.0 - Standards for Social, Labour and Demographic Variables, 1999](#)

Source and reference attributes

Submitting organisation:

National Public Health Information Working Group

Relational attributes

Implementation in Data Set Specifications:

[Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008](#)

[Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008](#)

Human epidermal growth factor receptor-2 test result

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – human epidermal growth factor receptor-2 test result, code N
<i>Synonymous names:</i>	HER2 test result
<i>METeOR identifier:</i>	370572
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The result of a person's human epidermal growth factor receptor-2 (HER2) test, as represented by a code.
Data Element Concept:	Person with cancer – human epidermal growth factor receptor-2 test result

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Positive</td></tr><tr><td>2</td><td>Negative</td></tr><tr><td>3</td><td>Equivocal</td></tr></tbody></table>	Value	Meaning	1	Positive	2	Negative	3	Equivocal
Value	Meaning								
1	Positive								
2	Negative								
3	Equivocal								
<i>Supplementary values:</i>	<table><tbody><tr><td>7</td><td>Unknown (test results not available)</td></tr><tr><td>8</td><td>Not applicable (test not done)</td></tr></tbody></table>	7	Unknown (test results not available)	8	Not applicable (test not done)				
7	Unknown (test results not available)								
8	Not applicable (test not done)								

Collection and usage attributes

<i>Guide for use:</i>	<p>Record the reported conclusion of the HER2.</p> <p>If no conclusion is reported use the following guidelines (from the National Breast and Ovarian Cancer Centre and Australian Cancer Network's pathology reporting guide (3rd ed.) for breast cancer):</p> <p>CODE 1 Positive</p> <ul style="list-style-type: none">• For in situ hybridisation: Result is more than 6 copies of the HER2 gene per nucleus OR a ratio of HER2 gene signals to chromosome 17 signals of more than 2.2.• For Immunocytochemistry: Result is described as 3+ or +++ OR >30% of cancer cells show strong complete membrane staining without cytoplasmic staining and without staining of normal tissue. <p>CODE 2 Negative</p>
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- **For in situ hybridisation:**
Result is less than 4 copies of the HER2 gene per nucleus OR a ratio of HER2 gene signals to chromosome 17 signals of less than 1.8.
- **For Immunocytochemistry:**
Result described as 0, 1+ or + OR <10% of cancer cells show staining.

CODE 3 Equivocal

- **For in situ hybridisation:**
Result is an average of between 4 and 6 HER2 gene copies per nucleus with a single probe OR a ratio of HER2 gene signals to chromosome 17 signals in the range of 1.8-2.2.
- **For Immunocytochemistry:**
Result described as 2+ or ++ OR <10% of cancer cells show strong complete membrane staining (rare) OR 10-30% of cancer cells show weak to moderate complete membrane staining OR Strong cytoplasmic staining is present, making assessment of membrane staining difficult.

Supplementary codes

CODE 7 Unknown (test results not available)

Use this code when the test has been performed but the results are not yet available for analysis.

CODE 8 Not applicable (test not done)

This code is used as a validation measure, to show that the reason for the lack of results is due to the test not being performed.

Data element attributes

Collection and usage attributes

Collection methods:

For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or subsequent metastatic disease.

Where different values are available from multiple specimens, the appropriate values to enter are selected according to the following hierarchy of rules:

When multiple HER2 values are available, the value established by the most accurate test is used as per the hierarchy: FISH > CISH/SISH > IHC. (See Person with cancer – HER2 test type, code N) If the HER2 values differ on multiple pathology reports for the same tumour, use the value from the larger specimen.

For multifocal tumours, use the HER2 value from the largest focus or from a metastatic deposit; e.g. Lymph node metastasis. A smaller focus that is HER2 positive may in fact be the source of a metastasis and in this setting the patient would derive benefit from the therapy offered as a result of HER2 positive status.

Comments:

Human epidermal growth factor receptor-2 (HER2) promotes the growth of cancer cells. HER2 is also known as c-erbB-2 and Her2/neu. Tumours that are HER2-positive tend to grow more quickly than other types of cancer. HER2 status is an important prognostic marker and predicts the response to several therapies.

Source and reference attributes

Origin:

National Breast and Ovarian Cancer Centre (NBOCC)

Australasian Association of Cancer Registries (AACR)

Australian Institute of Health and Welfare (AIHW)

Reference documents:

National Breast and Ovarian Cancer Centre and Australian Cancer Network. The Pathology reporting of breast cancer. A guide for pathologists, surgeons, radiologists and oncologists (3rd edition). National Breast and Ovarian Cancer Centre, Surry Hills, NSW, 2008.

Relational attributes

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard
06/03/2009

Human epidermal growth factor receptor-2 test type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – human epidermal growth factor receptor-2 test type, code N
<i>Synonymous names:</i>	HER2 test type
<i>METeOR identifier:</i>	370607
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The type of test used to determine the results of human epidermal growth factor receptor-2 (HER2) at the time of diagnosis of the primary tumour, as represented by a code.
Data Element Concept:	Person with cancer – human epidermal growth factor receptor-2 test type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Fluorescence in situ hybridisation (FISH)</td></tr><tr><td>2</td><td>Brightfield in situ hybridisation</td></tr><tr><td>3</td><td>Immunochemistry (IHC)</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Test type not stated or unknown</td></tr></tbody></table>	Value	Meaning	1	Fluorescence in situ hybridisation (FISH)	2	Brightfield in situ hybridisation	3	Immunochemistry (IHC)	8	Other	9	Test type not stated or unknown
Value	Meaning												
1	Fluorescence in situ hybridisation (FISH)												
2	Brightfield in situ hybridisation												
3	Immunochemistry (IHC)												
8	Other												
9	Test type not stated or unknown												
<i>Supplementary values:</i>													

Collection and usage attributes

<i>Guide for use:</i>	CODE 2 Brightfield in situ hybridisation Includes Chromogenic in situ hybridisation (CISH) and Silver in situ hybridisation (SISH).
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the test type corresponding to the test result recorded in 'Person with Cancer - human epidermal growth factor receptor-2 test result'.
<i>Comments:</i>	Immunochemistry (IHC) measures how much HER2 protein is present in the tumour sample. Fluorescence in situ hybridisation (FISH), chromogenic in situ hybridisation (CISH) and silver in situ hybridisation (SISH) measure the amount of amplification of the gene responsible for HER2. The type of HER2 test used to determine HER2 status affects the accuracy of the information.

Source and reference attributes

Origin: National Breast and Ovarian Cancer Centre (NBOCC)
Australasian Association of Cancer Registries (AACR)
Australian Institute of Health and Welfare (AIHW)

Relational attributes

Implementation in Data Set Specifications: [Breast cancer \(Cancer registries\) DSS](#) Health, Standard
06/03/2009

Hypertension—treatment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – hypertension treatment with antihypertensive medication indicator (current), code N
<i>METeOR identifier:</i>	302442
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether a person is currently being treated for hypertension (high blood pressure) using antihypertensive medication, as represented by a code.
Data Element Concept:	Person – hypertension treatment with antihypertensive medication indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes Record if a person is currently being treated for hypertension using antihypertensive medication. CODE 2 No Record if a person is not currently being treated for hypertension using antihypertensive medication.
<i>Collection methods:</i>	Ask the individual if he/she is currently treated with anti-hypertensive medications. Alternatively obtain the relevant information from appropriate documentation.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
<i>Reference documents:</i>	<p>Pahor M, Psaty BM, Furberg CD. Treatment of hypertensive patients with diabetes. Lancet 1998; 351:689-90. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. UK Prospective Diabetes Study Group [erratum appears in Br Med J 1999; 318:29]. Br Med J 1998; 317:703-13.</p> <p>Grossman E, Messerli FH, Goldbourt U, Curb JD, Pressel SL, Cutler JA, Savage PJ, Applegate WB, Black H, et al. Effect of diuretic-based antihypertensive treatment on cardiovascular disease risk in older diabetic patients with isolated systolic hypertension. Systolic Hypertension in the Elderly Program Cooperative Research Group. JAMA 1996; 276:1886-92.</p> <p>Hypertension in diabetes [Australian Prescriber Feb 2002]. American Journal of Preventive Medicine 2002;21.</p>

Relational attributes

<i>Related metadata references:</i>	Supersedes Person – hypertension treatment status (antihypertensive medication), code N Health, Superseded 21/09/2005
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Diabetes (clinical) DSS Health, Standard 21/09/2005

Hypoglycaemia—severe

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – severe hypoglycaemia indicator, code N
<i>METeOR identifier:</i>	302825
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether a person has had severe hypoglycaemia , as represented by a code.
Data Element Concept:	Person – severe hypoglycaemia indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if the person has a history of severe hypoglycaemia. CODE 2 No: Record if the person has no history of severe hypoglycaemia.
<i>Collection methods:</i>	Ask the individual if he/she has had a severe hypoglycaemia requiring assistance. Alternatively obtain the relevant information from appropriate documentation.
<i>Comments:</i>	The medications used in the treatment of diabetes may cause the blood glucose value to fall below the normal range and this is called hypoglycaemia.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
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Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents: Definition corresponds with the Diabetes Control and Complications Trial (DCCT): DCCT New England Journal of Medicine, 329(14), September 30, 1993. Report of the Health Care Committee Expert Panel on Diabetes; Commonwealth of Australia 1991; ISBN 0644143207.

Relational attributes

Related metadata references: Supersedes [Person – severe hypoglycaemia history, status code N](#) Health, Superseded 21/09/2005

Implementation in Data Set Specifications: [Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Impairment of body function

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – extent of impairment of body function, code (ICF 2001) N
<i>METeOR identifier:</i>	320138
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	A person's degree of impairment in a specified body function, as represented by a code.
<i>Context:</i>	Human functioning and disability
<i>Data Element Concept:</i>	Person – extent of impairment of body function

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001	
<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	0	No impairment
	1	Mild impairment
	2	Moderate impairment
	3	Severe impairment
	4	Complete impairment
<i>Supplementary values:</i>	8	Not specified
	9	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.</p> <p>Impairments of body structure or body function are problems in body structure or function such as a loss or significant departure from population standards or averages.</p> <p>CODE 0 No impairment</p> <p>Used when there is no significant variation from accepted population standards in the biomedical status of the body structure or its functions [0-4%].</p>
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CODE 1 Mild impairment

Used when there is a slight or low variation from accepted population standards in the biomedical status of the body structure or its functions [5-24%].

CODE 2 Moderate impairment

Used when there is a medium (significant but not severe) variation from accepted population standards in the biomedical status of the body structure or its functions [25-49%].

CODE 3 Severe impairment

Used when there is an extreme variation from accepted population standards in the biomedical status of the body structure or its functions [50-95%].

CODE 4 Complete impairment

Used when there is a total variation from accepted population standards in the biomedical status of the body structure or its functions [96-100%].

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.cfm>

Data element attributes

Collection and usage attributes

Guide for use:

This coding is to be used in conjunction with specified Body Functions domains. For example, 'a mild impairment of functions related to the brain' to indicate the area of impairment and, potentially, the sorts of interventions that may result in improved functioning. The body function in which an individual experiences an impairment is indicated using the metadata item Person – body function, code (ICF 2001) AN[NNNN].

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references: See also [Person – body function, code \(ICF 2001\) AN\[NNNN\]](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications: [Body functions cluster](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Impairment of body structure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – extent of impairment of body structure, code (ICF 2001) N
<i>METeOR identifier:</i>	320165
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	A person's degree of impairment in a specified body structure, as represented by a code.
Data Element Concept:	Person – extent of impairment of body structure

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001	
<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	0	No impairment
	1	Mild impairment
	2	Moderate impairment
	3	Severe impairment
	4	Complete impairment
<i>Supplementary values:</i>	8	Not specified
	9	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.</p> <p>Impairments of body structure or body function are problems in body structure or function such as a loss or significant departure from population standards or averages.</p> <p>CODE 0 No impairment</p> <p>Used when there is no significant variation from accepted population standards in the biomedical status of the body structure or its functions [0-4%].</p> <p>CODE 1 Mild impairment</p> <p>Used when there is a slight or low variation from accepted</p>
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population standards in the biomedical status of the body structure or its functions [5-24%].

CODE 2 Moderate impairment

Used when there is a medium (significant but not severe) variation from accepted population standards in the biomedical status of the body structure or its functions [25-49%].

CODE 3 Severe impairment

Used when there is an extreme variation from accepted population standards in the biomedical status of the body structure or its functions [50-95%].

CODE 4 Complete impairment

Used when there is a total variation from accepted population standards in the biomedical status of the body structure or its functions [96-100%].

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.cfm>

Data element attributes

Collection and usage attributes

Guide for use:

This data element is used in conjunction with specified body structures, for example 'mild impairment of structures related to movement'. This data element may also be used in conjunction with Person—nature of impairment of body structure, code (ICF 2001) N and Person—location of impairment of body structure, code (ICF 2001) N.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also [Person – location of impairment of body structure, code \(ICF 2001\) N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also [Person – nature of impairment of body structure, code \(ICF 2001\) N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

[Body structures cluster](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Indicator procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – indicator procedure, code NN
<i>METeOR identifier:</i>	334976
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	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

<i>Classification scheme:</i>	Australian Classification of Health Interventions (ACHI) 5th edition	
<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	NN	
<i>Maximum character length:</i>	2	
<i>Permissible values:</i>	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
<i>Supplementary values:</i>	16	Not applicable

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 comments below. Where a patient is awaiting more than one indicator procedure, all codes should be listed. This is because the intention is to count procedures rather than patients in this instance.

These are planned procedures for the waiting list, not what is actually performed during hospitalisation.

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 (5th edition) codes, for the indicator procedures:

Cataract extraction:

42698-00 [195] 42702-00 [195] 42702-01 [195] 42698-01 [196] 42702-02 [196]
42702-03 [196] 42698-02 [197] 42702-04 [197] 42702-05 [197] 42698-03 [198]
42702-06 [198] 42702-07 [198] 42698-04 [199] 42702-08 [199] 42702-09 [199]
42731-01 [200] 42698-05 [200] 42702-10 [200] 42734-00 [201] 42788-00 [201]
42719-00 [201] 42731-00 [201] 42719-02 [201] 42791-02 [201] 42716-00 [202]
42702-11 [200] 42719-00 [201] 42722-00 [201]

Cholecystectomy:

30443-00 [965] 30454-01 [965] 30455-00 [965] 30445-00 [965] 30446-00 [965]
30448-00 [965] 30449-00 [965]

Coronary Artery bypass graft:

38497-00 [672] 38497-01 [672] 39497-02 [672] 38497-03 [672] 38497-

04 [673]
38497-05 [673] 38497-06 [673] 39497-07 [673] 38500-00 [674] 38503-00 [674]
38500-01 [675] 38503-01 [675] 38500-02 [676] 38503-02 [676] 38500-03 [677]
38503-03 [677] 38500-04 [678] 38503-04 [678] 90201-00 [679] 90201-01 [679]
90201-02 [679] 90201-03 [679]

Cystoscopy:

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

Haemorrhoidectomy:

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

Hysterectomy:

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

Inguinal herniorrhaphy:

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

Myringoplasty:

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

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]

Total knee replacement:

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

Varicose veins stripping and ligation:

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

00 [728]
32514-00 [737]

Source and reference attributes

Origin: National Health Data Committee

Reference documents: National Centre for Classification in Health (NCCH) 2006. The Australian Classification of Health Interventions (ACHI) – Fifth Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Relational attributes

Related metadata references: Supersedes [Elective surgery waiting list episode – indicator procedure, code NN](#) Health, Superseded 07/12/2005

Implementation in Data Set Specifications: [Elective surgery waiting times \(census data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

[Elective surgery waiting times \(census data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Indigenous status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – Indigenous status, code N
<i>METeOR identifier:</i>	291036
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 15/04/2010
<i>Definition:</i>	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code. This is in accord with the first two of three components of the Commonwealth definition.
Data Element Concept:	Person – Indigenous status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Aboriginal but not Torres Strait Islander origin</td></tr><tr><td>2</td><td>Torres Strait Islander but not Aboriginal origin</td></tr><tr><td>3</td><td>Both Aboriginal and Torres Strait Islander origin</td></tr><tr><td>4</td><td>Neither Aboriginal nor Torres Strait Islander origin</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Aboriginal but not Torres Strait Islander origin	2	Torres Strait Islander but not Aboriginal origin	3	Both Aboriginal and Torres Strait Islander origin	4	Neither Aboriginal nor Torres Strait Islander origin	9	Not stated/inadequately described
Value	Meaning												
1	Aboriginal but not Torres Strait Islander origin												
2	Torres Strait Islander but not Aboriginal origin												
3	Both Aboriginal and Torres Strait Islander origin												
4	Neither Aboriginal nor Torres Strait Islander origin												
9	Not stated/inadequately described												
<i>Supplementary values:</i>	9 Not stated/inadequately described												

Collection and usage attributes

Guide for use: This metadata item is based on the Australian Bureau of Statistics (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS Website as indicated in the Reference documents.

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

Indigenous:

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

Non-Indigenous:

- Neither Aboriginal nor Torres Strait Islander origin.

Not stated/ inadequately described:

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

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

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

Data element attributes

Collection and usage attributes

Collection methods:

The standard question for Indigenous Status is as follows:

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

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

No.....

Yes, Aboriginal.....

Yes, Torres Strait Islander.....

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

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

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

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

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

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

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

This approach may be problematical in some data collections, for example when data are collected by interview or using screen based data capture systems. An additional response category Yes, both Aboriginal and Torres Strait Islander...

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

Comments:

The following definition, commonly known as 'The Commonwealth Definition', was given in a High Court judgement in the case of *Commonwealth v Tasmania* (1983) 46 ALR 625.

'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'.

There are three components to the Commonwealth definition:

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

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

Source and reference attributes

Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

Australian Bureau of Statistics 1999. [Standards for Social, Labour and Demographic Variables. Cultural Diversity Variables](#), Canberra. Viewed 3 August 2005.

Relational attributes

Related metadata references:

Supersedes [Person – Indigenous status, code N](#) Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded
05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded
04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded
22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Admitted patient palliative care NMDS 2006-2007](#) Health,
Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009
[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010
Implementation start date: 01/07/2009
Implementation end date: 30/06/2010
[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010
Implementation start date: 01/07/2010
[Alcohol and other drug treatment services NMDS](#) Health,
Superseded 21/03/2006
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Alcohol and other drug treatment services NMDS](#) Health,
Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Alcohol and other drug treatment services NMDS 2007-2008](#)
Health, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
[Alcohol and other drug treatment services NMDS 2008-2010](#)
Health, Superseded 22/12/2009
Implementation start date: 01/07/2008
Implementation end date: 30/06/2010
[Alcohol and other drug treatment services NMDS 2010-2011](#)
Health, Standard 22/12/2009
Implementation start date: 01/07/2010
[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
15/02/2006
[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard
22/12/2009

[Community mental health care 2004-2005](#) Health, Superseded
08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

[Community mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Computer Assisted Telephone Interview demographic module
DSS](#) Health, Superseded 03/12/2008

[Computer Assisted Telephone Interview demographic module
DSS](#) Health, Standard 03/12/2008

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

[Elective surgery waiting times \(census data\) NMDS 2009-](#) Health,
Standard 03/12/2008

Implementation start date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2009-](#)
Health, Standard 03/12/2008

Implementation start date: 01/07/2009

[Health care client identification DSS](#) Health, Superseded

03/12/2008

[Health care client identification DSS](#) Health, Standard

03/12/2008

[Non-admitted patient emergency department care NMDS](#)

Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Non-admitted patient emergency department care NMDS](#)

Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#)

Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Perinatal NMDS](#) Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Registered chiropractic labour force DSS](#) Health, Standard

10/12/2009

[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard
10/12/2009

[Registered nursing professional labour force DSS](#) Health,
Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard
10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard
10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard
10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard
10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard
10/12/2009

[Registered psychology labour force DSS](#) Health, Standard
10/12/2009

[Residential mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Individual sessions (public psychiatric, alcohol and drug hospital)—emergency and outpatient

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment (public psychiatric or alcohol and drug hospital) – number of individual session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care (public psychiatric, alcohol & drug) - emergency and outpatient individual sessions
<i>METeOR identifier:</i>	270216
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the emergency and outpatient functional unit of a public psychiatric or alcohol and drug hospital.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Emergency patients and outpatients are persons who receive non-admitted care. Individual non-admitted care is care provided to a person who receives direct care within the emergency department or other designated clinics within the hospital and who is not formally admitted at the time when the care is provided. A person who first contacts the hospital and receives non-admitted care, for example through the emergency department, and is subsequently admitted should have both components of care enumerated separately.
<i>Comments:</i>	A group is defined as two or more patients receiving a service together where all individuals are not members of the same family. Family services are to be treated as occasions of service to an individual.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Type of non-admitted patient care \(public psychiatric, alcohol & drug\), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (21.1 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions (public psychiatric, alcohol and drug hospital)—outreach and community

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment (public psychiatric or alcohol and drug hospital) – number of individual session occasions of service for non-admitted patients (outreach and community), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care (public psychiatric, alcohol & drug) - outreach and community individual sessions
<i>METeOR identifier:</i>	270218
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by outreach and community services units of a public psychiatric or alcohol and drug hospital.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	For outreach/community patients, care is delivered by hospital employees to the patient in the home, place of work or other non-hospital site.
<i>Comments:</i>	A group is defined as two or more patients receiving a service together where all individuals are not members of the same family. Family services are to be treated as occasions of service to an individual.

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

Related metadata references:

Supersedes [Type of non-admitted patient care \(public psychiatric, alcohol & drug\), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (21.1 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—alcohol and drug

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - alcohol and drug individual sessions
<i>METeOR identifier:</i>	270508
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the alcohol and drug functional unit of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For occasions of service as individual sessions to non-admitted patients attending designated drug and alcohol units within hospitals.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p> <p>The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or</p>
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departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDs](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDs](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDs 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—allied health services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (allied health services), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - allied health services individual sessions
<i>METeOR identifier:</i>	270502
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by allied health services units or clinics of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Allied health service units include those units primarily concerned with physiotherapy, speech therapy, family planning, dietary advice, optometry, occupational therapy, and so on.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p> <p>The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or</p>
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departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS Health, Superseded 21/03/2006](#)

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS Health, Superseded 23/10/2006](#)

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008](#)

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008](#)

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010](#)

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010](#)

Implementation start date: 01/07/2010

Individual sessions—community health services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (community health services), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - community health services individual sessions
<i>METeOR identifier:</i>	270395
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in designated community health services units of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For occasions of service to non-admitted patients provided by designated community health units within the establishment.</p> <p>Community health units include:</p> <ul style="list-style-type: none">• baby clinics• immunisation units• aged care assessment teams• other <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently</p>
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admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—dental

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (dental), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - dental individual sessions
<i>METeOR identifier:</i>	270513
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in designated dental units of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For all occasions of service as individual sessions to non-admitted patients attending designated dental units within hospitals.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p> <p>The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset,</p>
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an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a separation is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDS Health, Superseded 21/03/2006](#)

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS Health, Superseded 23/10/2006](#)

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008](#)

Implementation start date: 01/07/2007

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[Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008](#)

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010 Health,](#)

Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—dialysis

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (dialysis), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - dialysis individual sessions
<i>METeOR identifier:</i>	270503
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the dialysis functional unit of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Dialysis:</p> <p>This represents all non-admitted patients receiving dialysis within the establishment. Where patients receive treatment in a ward or clinic classified elsewhere (for example, an emergency department), those patients are to be counted as dialysis patients and to be excluded from the other category. All forms of dialysis which are undertaken as a treatment necessary for renal failure are to be included.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
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The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a separation is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

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Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008](#)

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
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Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—district nursing services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (district nursing services), total N[NNNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - district nursing services individual sessions
<i>METeOR identifier:</i>	270512
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients by the district nursing services functional unit of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For occasions of service as individual sessions by district nursing services to non-admitted patients.</p> <p>District nursing services:</p> <ul style="list-style-type: none">• are for medical/surgical/psychiatric care• are provided by a nurse, paramedic or medical officer• involve travel by the service provider*• are not provided by staff from a unit classified in the community health category above. <p>*Travel does not include movement within an establishment, movement between sites in a multi-campus establishment or between establishments. Such cases should be classified under the appropriate non-admitted patient category.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p>
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A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

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Implementation start date: 01/07/2006

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[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—emergency services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (emergency services), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care
<i>METeOR identifier:</i>	270506
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the emergency services functional unit of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Emergency services:</p> <p>Services to patients who are not admitted and who receive treatment that was either unplanned or carried out in designated emergency departments within a hospital. Unplanned patients are patients who have not been booked into the hospital before receiving treatment. In general it would be expected that most patients would receive surgical or medical treatment. However, where patients receive other types of treatment that are provided in emergency departments these are to be included. The exceptions are for dialysis and endoscopy and related procedures which have been recommended for separate counting.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care</p>
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enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service. The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Implementation in Data Set Specifications:

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[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

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Superseded 03/12/2008

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Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—endoscopy and related procedures

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - endoscopy and related procedures individual sessions
<i>METeOR identifier:</i>	270507
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the endoscopy and related procedures functional unit of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For all occasions of endoscopy and related procedures provided as individual sessions to non-admitted patients.</p> <p>Endoscopy and related procedures include:</p> <ul style="list-style-type: none">• cystoscopy• gastroscopy• oesophagoscopy• duodenoscopy• colonoscopy• bronchoscopy• laryngoscopy. <p>Where one of these procedures is carried out in a ward or clinic classified elsewhere, for example in the emergency department, the occasion is to be included under endoscopy and related procedures, and to be excluded from the other category. Care</p>
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must be taken to ensure procedures for admitted patients are excluded from this category.

This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

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Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

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[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—mental health

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (mental health), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - mental health individual sessions
<i>METeOR identifier:</i>	270504
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the mental health functional unit of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For all occasions of service as individual sessions to non-admitted patients attending designated psychiatric or mental health units within hospitals.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p> <p>The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or</p>
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departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

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Standard 05/01/2010

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Individual sessions—other medical/surgical/diagnostic

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care - other medical/surgical/diagnostic individual sessions
<i>METeOR identifier:</i>	270511
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other service provided to a patient in a medical/surgical/diagnostic unit of a health service establishment not defined elsewhere. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For any occasion of service to a non-admitted patient given at a designated unit primarily responsible for the provision of medical/surgical or diagnostic services which have not already been covered in other data elements.</p> <p>Other medical/surgical/diagnostic services include:</p> <ul style="list-style-type: none">• electrocardiogram (ECG)• obstetrics• nuclear medicine• general medicine• general surgery• fertility etc. <p>This metadata item identifies types of services provided to</p>
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non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.

A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary from admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

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23/10/2006

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Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—other outreach services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (other outreach services), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care
<i>METeOR identifier:</i>	270514
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients through the outreach services of an establishment not defined elsewhere.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For occasions of outreach services as individual sessions to non-admitted patients.</p> <p>Other outreach services:</p> <ul style="list-style-type: none">• involve travel by the service provider*• are not classified in allied health or community health services above. <p>*Travel does not include movement within an establishment, movement between sites in a multi-campus establishment or between establishments. Such cases should be classified under the appropriate non-admitted patient category.</p> <p>It is intended that these activities should represent non-medical/surgical/psychiatric services. Activities such as home cleaning, meals on wheels, home maintenance and so on should be included.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p>
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A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.

The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Comments:

Outreach/community care is care delivered by hospital employees to the patient in the home, place of work or other non-hospital site. The distinction between non-admitted patient care and outreach care is that for non-admitted patient care the patients travel to the health care providers while for outreach care the health care providers travel to the patients.

This distinction creates difficulties for community health centres. These centres are to be included in the national minimum data set where they are funded as sections within establishments that fall within the scope of the National Health Data Dictionary. For example, baby clinics, immunisation groups or aged care assessment teams, which are funded through acute hospitals, may provide care to some clients within the hospital grounds or externally. It is intended that all community health activity be measured under community health regardless of where the services are provided.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—pathology

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (pathology), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care
<i>METeOR identifier:</i>	270505
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the pathology functional unit of an establishment. Each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For all occasions of service as individual sessions to non-admitted patients from designated pathology laboratories.</p> <p>Occasions of service to all patients from other establishments should be counted separately.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p> <p>The list of Type of non-admitted patient care categories was to be</p>
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developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,

Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—pharmacy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (pharmacy), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care
<i>METeOR identifier:</i>	270509
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the pharmacy functional unit of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For all occasions of service as individual sessions to non-admitted patients from pharmacy departments.</p> <p>Those drugs dispensed/administered in other departments such as the emergency department, or outpatient departments, are to be counted by the respective departments.</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p> <p>The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within</p>
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existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Collection methods:

The definition does not distinguish case complexity for non-admitted patients.

For example, an occasion of service could vary in complexity from a simple urine glucose test to a complete biochemical analysis of all body fluids. Ideally, average case complexity values would be available for the various categories of non-admitted patients in the same way that average diagnosis related group weighted separations are becoming available for acute admitted patients. However, such measures would require the development of patient record databases for non-admitted patients. This does not imply an inadequacy in definition.

For admitted patients the concept of a **separation** is widely accepted. Separations can vary between admission for overnight observation to open heart surgery. The issue of case complexity for both admitted and non-admitted patients is a separate issue and beyond the scope of the proposed summary establishment-level activity data.

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Implementation in Data Set Specifications:

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Individual sessions—radiology and organ imaging

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of individual session occasions of service for non-admitted patients (radiology and organ imaging), total N[NNNNNN]
<i>Synonymous names:</i>	Type of non-admitted patient care
<i>METeOR identifier:</i>	270510
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other services provided as individual sessions to non-admitted patients in the radiology and organ imaging functional unit of an establishment.
Data Element Concept:	Establishment – number of individual session occasions of service for non-admitted patients

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For all occasions of radiology and organ imaging services as individual sessions to non-admitted patients.</p> <p>Radiology and organ imaging includes services undertaken in radiology (X-ray) departments as well as in specialised organ imaging clinics carrying out ultrasound, computerised tomography (CT) and magnetic resonance imaging (MRI).</p> <p>This metadata item identifies types of services provided to non-admitted patients in different institutional ways in different systems. It is not a summary casemix classification.</p> <p>A patient who first contacts the hospital and receives non-admitted care, for example through emergency departments, and is subsequently admitted, should have both components of care enumerated separately. Where possible, non-admitted occasions of service that are provided to patients who are subsequently admitted should be identified as a subset of the total occasions of service.</p>
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The list of Type of non-admitted patient care categories was to be developed using typical functional units or cost centres within existing institutions. These would include designated wards or departments and specialised clinics. Although the current statistical/financial returns submitted to the various health authorities by their hospitals do not provide a minimum subset, an effort has been made to define the categories in respect to those areas commonly collected. Many functional units provide services to both admitted patients and non-admitted patients, for example pathology. Only occasions of service for non-admitted patients should be included in this section.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Type of non-admitted patient care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Supersedes [Occasions of service, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Individual/group session indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service contact – group session status, individual/group session indicator code ANN.N
<i>METeOR identifier:</i>	291057
<i>Registration status:</i>	Health, Standard 04/05/2005
<i>Definition:</i>	Whether two or more patients received services at the same time from the same hospital staff, as represented by a code.
Data Element Concept:	Service contact – group session status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	String						
<i>Format:</i>	ANN.N						
<i>Maximum character length:</i>	5						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>A12.1</td><td>Individual sessions</td></tr><tr><td>A12.2</td><td>Group sessions</td></tr></tbody></table>	Value	Meaning	A12.1	Individual sessions	A12.2	Group sessions
Value	Meaning						
A12.1	Individual sessions						
A12.2	Group sessions						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This excludes the situation where individuals all belong to the same family. In such cases, the service is being provided to the family unit and as a result the session should be counted as a single occasion of service to an individual.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Individual/group session, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)
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Infant weight, neonate, stillborn

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth—birth weight, total grams NNNN
<i>METeOR identifier:</i>	269938
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The first weight, in grams, of the live-born or stillborn baby obtained after birth, or the weight of the neonate or infant on the date admitted if this is different from the date of birth.
Data Element Concept:	Birth—birth weight

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4
<i>Unit of measure:</i>	Gram (g)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 g groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.</p> <p>In perinatal collections the birthweight is to be provided for liveborn and stillborn babies.</p> <p>Weight on the date the infant is admitted should be recorded if the weight is less than or equal to 9000g and age is less than 365 days.</p>
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Infant weight, neonate, stillborn, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)
<i>Implementation in Data Set Specifications:</i>	Perinatal NMDS Health, Superseded 06/09/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

[Perinatal NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Influence of environmental factor

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – extent of environmental factor influence, code (ICF 2001) [X]N
<i>METeOR identifier:</i>	320198
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The degree to which a specified environmental factor influences the body function or structure, the activity or participation of a person, as represented by a code.
<i>Context:</i>	The environment in which a person functions or experiences disability.
Data Element Concept:	Person – extent of environmental factor influence

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001	
<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	[X]N	
<i>Maximum character length:</i>	2	
<i>Permissible values:</i>	Value	Meaning
	0	No barrier
	1	Mild barrier
	2	Moderate barrier
	3	Severe barrier
	4	Complete barrier
	+0	No facilitator
	+1	Mild facilitator
	+2	Moderate facilitator
	+3	Substantial facilitator
	+4	Complete facilitator
<i>Supplementary values:</i>	8	Barrier not specified
	+8	Facilitator not specified
	9	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.
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Extent of influence of environmental factors corresponds to the degree, strength or magnitude of the influence and the amount of time the influence is experienced by the person. It is essentially a summary measure, in which are embedded the concepts of availability, quality and importance, that indicates the effect the specified environmental factor has on the person.

Whether, and by how much, environmental factors are influencing an individual's level of functioning, and whether the influence is a facilitator or barrier, may indicate the sorts of interventions that will optimise the individual's functioning. This information may be for policy development, service provision, or advocacy purposes. Preventative strategies could be indicated by this information.

This value domain can be used to collect information across the whole spectrum of influence, for example, tactile flooring may be a facilitator to a person with visual impairment and a barrier to a person with mobility impairments. In line with the ICF approach to functioning and disability, this value domain recognises, and gives the means to record, the positive influence of environmental factors as well as those factors that limit the level of functioning of a person.

The codes are mutually exclusive. The choice of codes depends on the context of the data collection. For example; if collecting information about the positive influence of an environmental factor such as a community service it would be appropriate to use Code 0 No facilitator if the service was not influencing the person's level of functioning (even if the service were not a barrier to the person's functioning).

Code +0 No facilitator:

Used when the environment factor does not impact in a positive way on the body structure or function, activity or participation of a person.

Code +1 Mild facilitator:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 5-24% of the time the person participates in the specified domain of functioning or has a low level of impact on the person's functioning.

Code +2 Moderate facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 25-49% of the time the person participates in the specified domain of functioning or has a significant, but moderate impact on the person's functioning.

Code +3 Substantial facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 50-95% of the time the person participates in the specified domain of functioning or has an extreme effect on the person's functioning.

Code +4 Complete facilitators:

Used when the environmental factor impacts in a positive way on the body structure or function, activity or participation of a person between 96-100% of the time the person participates in the specified domain of functioning or the person functions optimally with this environmental factor.

Code +8 Facilitator not specified:

Used when there is insufficient information to record the Extent of environmental influence code (ICF 2001) N in classes +1 to +4.

Code 0 No barrier:

Used when the environment factor does not impact in a negative way on the body structure or function, activity or participation of a person.

Code 1 Mild barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 5-24% of the time the person participates in the specified domain of functioning or has a low level of impact on the person's functioning.

Code 2 Moderate barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 25-49% of the time the person participates in that specified domain of functioning or has a significant, but moderate impact on the person's functioning.

Code 3 Severe barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 50-95% of the time the person participates in that specified domain of functioning or has an extreme effect on the person's functioning.

Code 4 Complete barriers:

Used when the environmental factor impacts in a negative way on the body structure or function, activity or participation of a person between 96-100% of the time the person participates in the specified domain of functioning or is of such magnitude that the person is unable to function.

Code 8 Barrier not specified:

Used when there is insufficient information to record the Extent of environmental influence code (ICF 2001) N in classes 1 to 4.

Code 9 Not applicable:

Used when environmental factors impacts in neither a positive or negative way on the body structure or function, activity or participation of a person or for between 0-4% of the time the person participates in that specified area and has minimal impact on the person's level of functioning in the specified domain.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.
<i>Origin:</i>	WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
<i>Reference documents:</i>	Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites: <ul style="list-style-type: none">• WHO ICF website http://www.who.int/classifications/icf/en/• Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Environmental factors represent the circumstances in which the individual lives. These factors are conceived as immediate (e.g. physical features of the environment, social environment) and societal (formal and informal social structures, services and systems). Different environments may have a very different impact on the same individual with a given health condition.</p> <p>The influence of environmental factors may be positive, increasing the level of functioning (a facilitator), or negative, decreasing the level of functioning (a barrier).</p> <p>The extent of influence of the Environmental factors is affected both by the degree, strength of influence, and the amount of time the influence is experienced by the person.</p> <p>This metadata item is recorded in conjunction with <i>Environmental factor code N</i> to indicate the extent to which specified environmental factors influence the body function or structure, the activity or participation of a person.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.
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Relational attributes

<i>Related metadata references:</i>	See also Person – environmental factor, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006
<i>Implementation in Data Set Specifications:</i>	Environmental factors cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Informal carer existence indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – informal carer existence indicator, code N
<i>Synonymous names:</i>	Informal carer availability, Informal carer existence flag, Carer arrangements (informal)
<i>METeOR identifier:</i>	320939
<i>Registration status:</i>	Health, Standard 04/07/2007 Community services, Standard 29/04/2006
<i>Definition:</i>	Whether a person has an informal carer , as represented by a code.
Data Element Concept:	Person – informal carer existence indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	9	Not stated/inadequately described				
9	Not stated/inadequately described						

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Informal carers may include those people who receive a pension or benefit for their caring role and people providing care under family care agreements. Excluded from the definition of informal carers are volunteers organised by formal services and paid workers.</p> <p>This metadata item is purely descriptive of a client's circumstances. It is not intended to reflect whether the informal carer is considered by the service provider to be capable of undertaking the caring role. The expressed views of the client and/or their carer should be used as the basis for determining whether the client is recorded as having an informal carer or not.</p> <p>When asking a client whether they have an informal carer, it is</p>
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important for agencies or establishments to recognise that a carer does not always live with the person for whom they care. That is, a person providing significant care and assistance to the client does not have to live with the client in order to be called an informal carer.

Collection methods:

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

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

Examples of questions that have been used for data collection include:

Home and Community Care NMDS

'Do you have someone who helps look after you?'

Commonwealth State/Territory Disability Agreement NMDS

*'Does the service user have an informal carer, such as **family** member, friend or neighbour, who provides care and assistance on a regular and sustained basis?'*

Comments:

Recent years have witnessed a growing recognition of the critical role that informal support networks play in caring for frail older people and people with disabilities within the community. Not only are informal carers responsible for maintaining people with often high levels of functional dependence within the community, but the absence of an informal carer is a significant risk factor contributing to institutionalisation. Increasing interest in the needs of carers and the role they play has prompted greater interest in collecting more reliable and detailed information about carers and the relationship between informal care and the provision of and need for formal services.

This definition of informal carer is not the same as the Australian Bureau of Statistics (ABS) definition of principal carer, 2003 Survey of Disability, Ageing and Carers and primary carer used in the 1998 survey. The ABS definitions require that the carer has or will provide care for a certain amount of time and that they provide certain types of care.

The ABS defines a primary carer as a person of any age who provides the most informal assistance, in terms of help or supervision, to a person with one or more disabilities. The assistance has to be ongoing, or likely to be ongoing, for at least six months and be provided for one or more of the core activities (communication, mobility and self care). This may not be appropriate for community services agencies wishing to obtain information about a person's carer regardless of the amount of time that care is for, or the types of care provided.

Information such as the amount of time for which care is provided can of course be collected separately but, if it were not needed, it would place a burden on service providers.

Source and reference attributes

Origin:

Australian Institute of Health and Welfare

National Health Data Committee

National Community Services Data Committee

Reference documents:

Australian Bureau of Statistics (ABS) 1993 Disability, Ageing and Carers Survey and 2003 Survey of Disability, Ageing and Carers.

Australian Institute of Health and Welfare (2005) Commonwealth State/Territory Disability Agreement National Minimum Data Set collection (CSTDA NMDS) Data Guide: 2005-06.

National HACC Minimum Data Set User Guide Version 2 July 2005. Home and Community Care (HACC) Program.

Relational attributes

Related metadata references:

Supersedes [Person \(requiring care\) – carer availability status, code N](#) Health, Superseded 04/07/2007, Community services, Superseded 29/04/2006

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Initial visit indicator—diabetes mellitus

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Patient – initial visit since diagnosis indicator (diabetes mellitus), code N
<i>METeOR identifier:</i>	302470
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether the visit to a health professional is an initial visit for diabetes, or other related condition, after a diagnosis of diabetes, as represented by a code.
Data Element Concept:	Patient – initial visit since diagnosis indicator (diabetes mellitus)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if this is the initial visit of the patient for diabetes, or a related condition, after diagnosis. CODE 2 No: Record if this is not the initial visit of the patient for diabetes, or a related condition, after diagnosis.
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Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

<i>Related metadata references:</i>	Supersedes Patient – initial visit since diagnosis status (diabetes
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*Implementation in Data Set
Specifications:*

[mellitus\), code N](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Injecting drug use status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Client – injecting drug use status, code N
<i>METeOR identifier:</i>	270113
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The client’s use of injection as a method of administering drugs, as represented by a code.
Data Element Concept:	Client – injecting drug use status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Last injected three months ago or less</td></tr><tr><td>2</td><td>Last injected more than three months ago but less than or equal to twelve months ago</td></tr><tr><td>3</td><td>Last injected more than twelve months ago</td></tr><tr><td>4</td><td>Never injected</td></tr></tbody></table>	Value	Meaning	1	Last injected three months ago or less	2	Last injected more than three months ago but less than or equal to twelve months ago	3	Last injected more than twelve months ago	4	Never injected
Value	Meaning										
1	Last injected three months ago or less										
2	Last injected more than three months ago but less than or equal to twelve months ago										
3	Last injected more than twelve months ago										
4	Never injected										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	To be collected on commencement of treatment with a service. For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.
<i>Comments:</i>	<p>This metadata item has been developed for use in clinical settings. A code that refers to a three-month period to define ‘current’ injecting drug use is required as a clinically relevant period of time.</p> <p>The metadata item may also be used in population surveys that require a longer timeframe, for example to generate 12-month prevalence rates, by aggregating Codes 1 and 2. However, caution must be exercised when comparing clinical samples with population samples.</p> <p>This metadata item is important for identifying patterns of drug use and harms associated with injecting drug use.</p>

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes [Injecting drug use status, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.8 KB)

Implementation in Data Set Specifications: [Alcohol and other drug treatment services NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Instrumented bleeding location

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with acute coronary syndrome – bleeding location, instrumented code N(N)
<i>Synonymous names:</i>	Instrumented bleeding site
<i>METeOR identifier:</i>	344787
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The location of the person's bleeding episode, arising from an instrumented site, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome – bleeding location

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N[N]																				
<i>Maximum character length:</i>	2																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Percutaneous coronary procedure arterial access site</td></tr><tr><td>2</td><td>Coronary artery bypass graft site</td></tr><tr><td>3</td><td>Gastrointestinal site</td></tr><tr><td>4</td><td>Genitourinary site</td></tr><tr><td>5</td><td>Intracranial site</td></tr><tr><td>6</td><td>Pulmonary site</td></tr><tr><td>7</td><td>Pericardial site</td></tr><tr><td>8</td><td>Other site(s)</td></tr><tr><td>9</td><td>Unidentified site</td></tr></tbody></table>	Value	Meaning	1	Percutaneous coronary procedure arterial access site	2	Coronary artery bypass graft site	3	Gastrointestinal site	4	Genitourinary site	5	Intracranial site	6	Pulmonary site	7	Pericardial site	8	Other site(s)	9	Unidentified site
Value	Meaning																				
1	Percutaneous coronary procedure arterial access site																				
2	Coronary artery bypass graft site																				
3	Gastrointestinal site																				
4	Genitourinary site																				
5	Intracranial site																				
6	Pulmonary site																				
7	Pericardial site																				
8	Other site(s)																				
9	Unidentified site																				
<i>Supplementary values:</i>	99 Not stated/inadequately described																				

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Percutaneous coronary procedure arterial access site</p> <p>Use this code when the person's bleeding is originating from the site of arterial access for a percutaneous coronary procedure. Procedures may include cardiac catheterisation, percutaneous coronary intervention, angiogram, intra-aortic balloon pump and/or arterial pressure monitoring sheaths.</p> <p>CODE 2 Coronary artery bypass graft site</p> <p>Use this code when the person's bleeding is originating from the site of a coronary artery bypass graft.</p>
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CODE 3 Gastrointestinal site

Use this code when the person's bleeding is originating from the gastrointestinal area with mechanical instrumentation.

CODE 4 Genitourinary site

Use this code when the person's bleeding is originating from the genitourinary area with mechanical instrumentation.

CODE 5 Intracranial site

Use this code when the person's bleeding is originating from an intracranial site with mechanical instrumentation.

CODE 6 Pulmonary site

Use this code when the person's bleeding is originating from a pulmonary site with mechanical instrumentation.

CODE 7 Pericardial site

Use this code when the person's bleeding is originating from the pericardium, following percutaneous coronary intervention. This code does not include bleeding that is secondary to a coronary artery bypass graft.

CODE 8 Other site(s)

Use this code when the person's bleeding is originating from a site with mechanical instrumentation that is not listed in codes 1-7, such as central line access.

CODE 9 Unidentified site

Use this code when the person has a fall in haemoglobin without an identifiable instrumented site of bleeding.

CODE 99 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

Record the location of all bleeding events that occur. More than one code can be applied.

Relational attributes

Related metadata references:

See also [Person – bleeding episode status, Thrombolysis in Myocardial Infarction \(TIMI\) code N](#) Health, Standard 01/10/2008

See also [Person with acute coronary syndrome – bleeding location, non-instrumented code N\(N\)](#) Health, Standard 01/10/2008

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Intended length of hospital stay

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – intended length of hospital stay, code N
<i>METeOR identifier:</i>	270399
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The intention of the responsible clinician at the time of the patient's admission to hospital or at the time the patient is placed on an elective surgery waiting list, to discharge the patient either on the day of admission or a subsequent date, as represented by a code.
Data Element Concept:	Episode of admitted patient care – intended length of hospital stay

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Intended same-day</td></tr><tr><td>2</td><td>Intended overnight</td></tr></tbody></table>	Value	Meaning	1	Intended same-day	2	Intended overnight
Value	Meaning						
1	Intended same-day						
2	Intended overnight						

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	The intended length of stay should be ascertained for all admitted patients at the time the patient is admitted to hospital.
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Intended length of hospital stay, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB) Is used in the formation of Episode of admitted patient care – major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009 Is used in the formation of Episode of admitted patient care – diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009
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Implementation in Data Set Specifications:

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v5.1\) ANNA](#) Health, Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v5.1\) NN](#) Health, Superseded 22/12/2009

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Intended place of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – setting of birth (intended), code N
<i>METeOR identifier:</i>	269980
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The intended place of birth at the onset of labour, as represented by a code.
<i>Context:</i>	Perinatal care
Data Element Concept:	Birth event – setting of birth

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Hospital, excluding birth centre</td></tr><tr><td>2</td><td>Birth centre, attached to hospital</td></tr><tr><td>3</td><td>Birth centre, free standing</td></tr><tr><td>4</td><td>Home</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	1	Hospital, excluding birth centre	2	Birth centre, attached to hospital	3	Birth centre, free standing	4	Home	8	Other	9	Not stated
Value	Meaning														
1	Hospital, excluding birth centre														
2	Birth centre, attached to hospital														
3	Birth centre, free standing														
4	Home														
8	Other														
9	Not stated														
<i>Supplementary values:</i>															

Collection and usage attributes

<i>Comments:</i>	The development of a definition of a birth centre is currently under consideration by the Commonwealth in conjunction with the states and territories.
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Data element attributes

Collection and usage attributes

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

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

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Intended place of birth, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.9 KB)

Intended years in health profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – intended years in profession, total years NN
<i>METeOR identifier:</i>	375487
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The total number of years a health professional expects to remain practising in the registered profession.
<i>Context:</i>	Registered health labour force
<i>Data Element Concept:</i>	Registered health professional – intended years in profession

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	String				
<i>Format:</i>	NN				
<i>Maximum character length:</i>	2				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	99	Not stated/inadequately described
Value	Meaning				
99	Not stated/inadequately described				
<i>Unit of measure:</i>	Year				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Total years expressed as 00, 01 etc.
<i>Comments:</i>	The data element is an estimate of the future plans of the health professional, providing an indication of the future losses from the health labour force. It should be noted that the health professional's intentions may change therefore these data should be used with care.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Registered chiropractic labour force DSS Health, Standard 10/12/2009 Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009 Registered medical professional labour force DSS Health, Standard 10/12/2009 Registered midwifery labour force DSS Health, Standard 10/12/2009
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[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard 10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard 10/12/2009

[Registered psychology labour force DSS](#) Health, Standard 10/12/2009

Intention of treatment for cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – intention of treatment, code N
<i>METeOR identifier:</i>	288690
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The intention of the initial treatment for cancer for the particular patient, as represented by a code.
Data Element Concept:	Cancer treatment – intention of treatment

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Prophylactic</td></tr><tr><td>2</td><td>Curative</td></tr><tr><td>3</td><td>Non-curative or palliative</td></tr></tbody></table>	Value	Meaning	1	Prophylactic	2	Curative	3	Non-curative or palliative
Value	Meaning								
1	Prophylactic								
2	Curative								
3	Non-curative or palliative								
<i>Supplementary values:</i>	<table><tbody><tr><td>0</td><td>Did not have treatment</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	0	Did not have treatment	9	Not stated				
0	Did not have treatment								
9	Not stated								

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 0 Did not have treatment This code is used when the patient did not have treatment as part of the initial management plan</p> <p>CODE 1 Prophylactic This code is used when the cancer has not developed</p> <p>CODE 2 Curative This code is used when treatment is given for control of the disease</p> <p>CODE 3 Non-curative or Palliative This code is used when the cure is unlikely to be achieved and treatment is given primarily for the purpose of pain control. Other benefits of the treatment are considered secondary contributions to the patient's quality of life</p> <p>CODE 9 Intention was not stated Patient had treatment for cancer but the intention was not stated.</p>
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Data element attributes

Collection and usage attributes

Guide for use: This item is collected for surgical treatment, radiation therapy and systemic therapy agent treatment.

Source and reference attributes

Submitting organisation: National Cancer Control Initiative

Origin: Commission on Cancer, American College of Surgeons
New South Wales Health Department

Reference documents: Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)
Public Health Division NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references: Supersedes [Intention of treatment for cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.9 KB)

Implementation in Data Set Specifications: [Cancer \(clinical\) DSS Health, Superseded 07/12/2005](#)

[Cancer \(clinical\) DSS Health, Superseded 06/03/2009](#)

[Cancer \(clinical\) DSS Health, Superseded 22/12/2009](#)

[Cancer \(clinical\) DSS Health, Standard 22/12/2009](#)

Inter-hospital contracted patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – inter-hospital contracted patient status, code N
<i>METeOR identifier:</i>	270409
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	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 admitted patient care – inter-hospital contracted patient status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Inter-hospital contracted patient from public sector hospital</td></tr><tr><td>2</td><td>Inter-hospital contracted patient from private sector hospital</td></tr><tr><td>3</td><td>Not contracted</td></tr><tr><td>9</td><td>Not reported</td></tr></tbody></table>	Value	Meaning	1	Inter-hospital contracted patient from public sector hospital	2	Inter-hospital contracted patient from private sector hospital	3	Not contracted	9	Not reported
Value	Meaning										
1	Inter-hospital contracted patient from public sector hospital										
2	Inter-hospital contracted patient from private sector hospital										
3	Not contracted										
9	Not reported										
<i>Supplementary values:</i>											

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>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.</p> <p>This data element item will be derived as follows.</p> <p>If Contract role = B (Hospital B, that is, the provider of the hospital service; contracted hospital), and Contract type = 2, 3, 4 or 5 (that is, a hospital (Hospital A) purchases the activity, rather than a health authority or other external purchaser, and admits the patient for all or part of the episode of care, and/or records</p>
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the contracted activity within the patient's record for the episode of care). Then record a value of 1, if Hospital A is a public hospital or record a value of 2, if Hospital A is a private hospital. Otherwise if the Contract role is not B, and/or the Contract type is not 2, 3, 4 or 5 record a value of 3.

Collection methods:

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

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Is formed using [Hospital – contract type, code N](#) Health, Standard 01/03/2005

Is formed using [Hospital – contract role, code A](#) Health, Standard 01/03/2005

Supersedes [Inter-hospital contracted patient, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)

Implementation in Data Set Specifications:

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Interpreter services required

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – interpreter service required, yes/no code N
<i>Synonymous names:</i>	Need for interpreter service
<i>METeOR identifier:</i>	304294
<i>Registration status:</i>	Health, Standard 08/02/2006 Community services, Standard 10/04/2006
<i>Definition:</i>	Whether an interpreter service is required by or for the person, as represented by a code.
Data Element Concept:	Person – interpreter service required

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Includes verbal language, non verbal language and languages other than English. CODE 1 Yes Use this code where interpreter services are required. CODE 2 No Use this code where interpreter services are not required. Persons requiring interpreter services for any form of sign language should be coded as Interpreter required.
<i>Collection methods:</i>	Recommended question: Do you [does the person] require an interpreter? Yes No

Relational attributes

<i>Related metadata references:</i>	Supersedes Person – interpreter service required status (health), code N Health, Superseded 08/02/2006
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Jobseeker status in registered profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – jobseeker status in registered profession, code N
<i>METeOR identifier:</i>	383449
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	Whether a registered health professional is looking for work in their registered profession, as represented by a code.
Data Element Concept:	Registered health professional – jobseeker status in registered profession

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Looking for work in Australia</td></tr><tr><td>2</td><td>Not looking for work in Australia</td></tr><tr><td>9</td><td>Unknown/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Looking for work in Australia	2	Not looking for work in Australia	9	Unknown/inadequately described
Value	Meaning								
1	Looking for work in Australia								
2	Not looking for work in Australia								
9	Unknown/inadequately described								
<i>Supplementary values:</i>									

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This data element is applicable to all health professionals who are not employed in Australia in the registered profession. It includes health professionals who are:</p> <ul style="list-style-type: none">• employed in the registered profession overseas• employed outside of the registered profession, and• not employed at all. <p>Data are self-reported based on the jobseeker status in the registered profession in the week before registration.</p> <p>CODE 1 LOOKING FOR WORK IN AUSTRALIA</p> <p>This category includes persons who are not currently employed in the registered profession in Australia and who are actively looking for work in the registered profession in Australia.</p> <p>‘Actively looking for work’ includes writing, telephoning or</p>
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applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

CODE 2 NOT LOOKING FOR WORK IN AUSTRALIA

All persons who are not 'looking for work in Australia' as defined above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Labour force status cluster](#) Health, Standard 10/12/2009

Killip classification code

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – Killip classification, code N
<i>METeOR identifier:</i>	285151
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The Killip class, as a measure of haemodynamic compromise, of the person at the time of presentation, as represented by a code.
Data Element Concept:	Person – Killip classification

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Class 1</td></tr><tr><td>2</td><td>Class 2</td></tr><tr><td>3</td><td>Class 3</td></tr><tr><td>4</td><td>Class 4</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Class 1	2	Class 2	3	Class 3	4	Class 4	8	Other	9	Not stated/inadequately described
Value	Meaning														
1	Class 1														
2	Class 2														
3	Class 3														
4	Class 4														
8	Other														
9	Not stated/inadequately described														
<i>Supplementary values:</i>															

Collection and usage attributes

<i>Guide for use:</i>	<p>Rales or crepitations represent evidence of pulmonary interstitial oedema on lung auscultation and an S₃ is an audible extra heart sound by cardiac auscultation.</p> <p>CODE 1 Class 1 Absence of crepitations/rales over the lung fields and absence of S₃.</p> <p>CODE 2 Class 2 Crepitations/rales over 50% or less of the lung fields or the presence of an S₃.</p> <p>CODE 3 Class 3 Crepitations/rales over more than 50% of the lung fields.</p> <p>CODE 4 Class 4 Cardiogenic Shock. Clinical criteria for cardiogenic shock are hypotension (a systolic blood pressure of less than 90 mmHg for at least 30 minutes or the need for supportive measures to maintain a systolic blood pressure of greater than or equal to 90 mmHg), end-organ hypoperfusion (cool extremities or a urine</p>
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output of less than 30 ml/h, and a heart rate of greater than or equal to 60 beats per minute). The haemodynamic criteria are a cardiac index of no more than 2.2 l/min per square meter of body-surface area and a pulmonary-capillary wedge pressure of at least 15 mmHg.

Data element attributes

Source and reference attributes

Submitting organisation: Acute coronary syndrome data working group
Steward: The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references: Supersedes [Killip classification code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.7 KB)
Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008
[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005
[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Labour force status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – labour force status, code N
<i>METeOR identifier:</i>	270112
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	The self reported status the person currently has in being either in the labour force (employed/unemployed) or not in the labour force, as represented by a code.
Data Element Concept:	Person – labour force status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Employed</td></tr><tr><td>2</td><td>Unemployed</td></tr><tr><td>3</td><td>Not in the labour force</td></tr></tbody></table>	Value	Meaning	1	Employed	2	Unemployed	3	Not in the labour force
Value	Meaning								
1	Employed								
2	Unemployed								
3	Not in the labour force								
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	9	Not stated/inadequately described						
9	Not stated/inadequately described								

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Employed:</p> <p>Persons aged 15 years and over who, during the reference week:</p> <p>(a) worked for one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (comprising 'Employees', 'Employers' and 'Own Account Workers'); or</p> <p>(b) worked for one hour or more without pay in a family business or on a farm (i.e. 'Contributing Family Worker'); or</p> <p>(c) were 'Employees' who had a job but were not at work and were:</p> <ul style="list-style-type: none">• on paid leave• on leave without pay, for less than four weeks, up to the end of the reference week• stood down without pay because of bad weather or plant breakdown at their place of employment, for less than four weeks up to the end of the reference week• on strike or locked out
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- on workers' compensation and expected to be returning to their job, or
- receiving wages or salary while undertaking full-time study; or

(d) were 'Employers', 'Own Account Workers' or 'Contributing Family Workers' who had a job, business or farm, but were not at work.

CODE 2 Unemployed:

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

(a) had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week. Were available for work in the reference week, or would have been available except for temporary illness (i.e. lasting for less than four weeks to the end of the reference week). Or were waiting to start a new job within four weeks from the end of the reference week and would have started in the reference week if the job had been available then; or

(b) were waiting to be called back to a full-time or part-time job from which they had been stood down without pay for less than four weeks up to the end of the reference week (including the whole of the reference week) for reasons other than bad weather or plant breakdown. Note: Actively looking for work includes writing, telephoning or applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

CODE 3 Not in the Labour Force:

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

Collection methods:

For information about collection, refer to the ABS website:

<http://www.abs.gov.au/Ausstats/abs@.nsf/0/AEB5AA310D68DF8FCA25697E0018FED8?Open>

Source and reference attributes

Origin:

Australian Bureau of Statistics 1995. Directory of Concepts and Standards for Social, Labour and Demographic Variables. Australia 1995. Cat. no. 1361.0.30.001. Canberra: AGPS.

<http://www.abs.gov.au/Ausstats/abs@.nsf/0/AEB5AA310D68DF8FCA25697E0018FED8?Open> (last viewed 21 December 2005)

Data element attributes

Collection and usage attributes

Comments: Labour force status is one indicator of the socio-economic status of a person and is a key element in assessing the circumstances and needs of individuals and families.

Source and reference attributes

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes [Labour force status, version 3, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf](#) (19.5 KB)

Implementation in Data Set Specifications: [Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Laterality of primary cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – laterality of primary cancer, code [N]
<i>METeOR identifier:</i>	270177
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The side of a paired organ that is the origin of the primary cancer, as represented by a code.
Data Element Concept:	Person with cancer – laterality of primary cancer

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	A	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	R	Right
	L	Left
	B	Bilateral
<i>Supplementary values:</i>	N	Not applicable
	U	Unknown

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The valid International Classification of Diseases for Oncology values for the variable are provided in the list below: Right Origin of primary site is on the right side of a paired organ. Left Origin of primary site is on the left side of a paired organ. Paired organs are: Breast (C50), Lung (C34), Kidney (C64), Ovary (C56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3,), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62), Parathyroid glands (C75.0), Adrenal glands (C74.9, C74.0, C74.1), Tonsils (C09.9, C02.4, C11.1, C09.0, C09.1, C03.9), Ureter (C66.9), Carotid body (C75.4), Vas deferens (C63.1), Optic nerve (C72.3) Bilateral Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2),
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(M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3) Note: Bilateral cancers are very rare.

Unknown

It is unknown whether, for a paired organ the origin of the cancer was on the left or right side of the body.

Collection methods:

This information should be obtained from the patient's pathology report, the patient's medical record, or the patient's medical practitioner/nursing staff.

Source and reference attributes

Origin:

World Health Organization

Reference documents:

Percy C, Van Holten V, Muir C (eds). International Classification of Diseases for Oncology, 2nd edition. Geneva: WHO, 1990

Relational attributes

Related metadata references:

Supersedes [Laterality of primary cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.4 KB)

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Leave days from residential care

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of residential care – number of leave days, total N[NN]
<i>METeOR identifier:</i>	270304
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The number of days spent on leave from a residential care service during an episode of residential care.
Data Element Concept:	Episode of residential care – number of leave days

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A day is measured from midnight to midnight.</p> <p>Leave days can occur for a variety of reasons, including:</p> <ul style="list-style-type: none">• treatment by specialised mental health service• treatment by a non-specialised health service• time in the community. <p>The following rules apply in the calculation of leave days:</p> <ul style="list-style-type: none">• the day the resident goes on leave is counted as a leave day• days the resident is on leave is counted as leave days• the day the resident returns from leave is not counted as a leave day• if the resident starts a residential stay and goes on leave on the same day, this is not counted as a leave day• if the resident returns from leave and then goes on leave again on the same day, this is counted as a leave day• if the resident returns from leave and ends residential care on the same day, the day should not be counted as leave day• leave days at the end of a residential stay after the commencement of leave are not counted. <p>If a period of leave is greater than seven days or the resident fails to return from leave, then the residential stay is formally ended.</p>
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Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Leave days from residential care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.6 KB)

[Residential mental health care NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Length of employment in health profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – length of employment in profession in Australia, total years NN
<i>METeOR identifier:</i>	375478
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The total number of years a health professional has been employed in the registered profession in Australia.
<i>Context:</i>	Registered health labour force
<i>Data Element Concept:</i>	Registered health professional – length of employment in profession in Australia

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total	
<i>Data type:</i>	String	
<i>Format:</i>	NN	
<i>Maximum character length:</i>	2	
<i>Supplementary values:</i>	Value	Meaning
	99	Not stated/inadequately described
<i>Unit of measure:</i>	Year	

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Total years expressed as 00, 01 etc with values rounded up to the next value of years if the remaining time is greater than six full months. The health professional may be employed in more than one profession. This data element applies only to the profession of registration, regardless of length of time spent working in related professions.
<i>Collection methods:</i>	In total, how many years have you worked in the registered profession in Australia? Include full-time and part-time work. Exclude time spent not working and unpaid leave.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Implementation in Data Set Specifications:

[Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009

[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard 10/12/2009

[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard 10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard 10/12/2009

[Registered psychology labour force DSS](#) Health, Standard 10/12/2009

Length of non-admitted patient emergency department service episode

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – service episode length, total minutes NNNNN
<i>METeOR identifier:</i>	270404
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The amount of time, measured in minutes, between when a patient presents at an emergency department for an emergency department service episode, and when the non-admitted component of the emergency department service episode has concluded.
Data Element Concept:	Non-admitted patient emergency department service episode – service episode length

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNNNN
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Minute (m)

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National reference group for non-admitted patient data development, 2001-02
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Relational attributes

<i>Related metadata references:</i>	Supersedes Length of non-admitted patient emergency department service episode, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)
	Is formed using Health service event – presentation date, DDMMYYYY Health, Standard 01/03/2005
	Is formed using Health service event – presentation time, hhmm Health, Standard 01/03/2005
<i>Implementation in Data Set Specifications:</i>	Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006
	<i>Implementation start date:</i> 01/07/2005
	<i>Implementation end date:</i> 30/06/2006
	Non-admitted patient emergency department care NMDS

Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#)

Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Length of stay

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – length of stay (excluding leave days), total N[NN]
<i>METeOR identifier:</i>	269982
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The length of stay of a patient, excluding leave days, measured in days.
<i>Data Element Concept:</i>	Episode of admitted patient care – length of stay (excluding leave days)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Formula: LOS = Separation date - Admission date - Total leave days The calculation is inclusive of admission and separation dates.
<i>Comments:</i>	Perinatal length of stay metadata items include leave days and so are not included in this metadata item.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Length of stay, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB) 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 – separation date, DDMMYYYY Health, Standard 01/03/2005 Is formed using Episode of admitted patient care – number of leave periods, total N[N] Health, Standard 01/03/2005 Is formed using Episode of admitted patient care – admission date, DDMMYYYY Health, Standard 01/03/2005
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Length of stay (including leave days)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – length of stay (including leave days), total N[NN]
<i>METeOR identifier:</i>	329889
<i>Registration status:</i>	Health, Standard 04/07/2007
<i>Definition:</i>	The total length of stay (LOS) of a patient, including leave days, measured in days.
Data Element Concept:	Episode of admitted patient care – length of stay (including leave days)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Formula:</p> <p>LOS (including leave days) = separation date - admission date</p> <p>Total LOS is calculated by subtracting the patient's date of admission from their date of separation. It includes contract days and leave days.</p> <p>For babies born in hospital: 1) only calculate the total LOS of live births and 2) their admission date is the same as their date of birth.</p> <p>A same-day patient should be allocated a length of stay of one day.</p> <p>Total LOS relates to the episode of care associated with the birth. Babies born before arrival and still births are not within scope of this data element and should not have a total length of stay reported.</p>
<i>Comments:</i>	All admitted patient episodes of care where it is required to know the total LOS in hospital (including leave days).

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
<i>Origin:</i>	National Health Data Committee

Relational attributes

Related metadata references:

Is formed using [Episode of admitted patient care – separation date, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Episode of admitted patient care – admission date, DDMMYYYY](#) Health, Standard 01/03/2005

Supersedes [Episode of admitted patient care – length of stay \(including leave days\), total N\[NN\]](#) Health, Superseded 04/07/2007

Length of stay (including leave days) (antenatal)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – length of stay (including leave days) (antenatal), total N[NN]
<i>METeOR identifier:</i>	290577
<i>Registration status:</i>	Health, Standard 04/07/2007
<i>Definition:</i>	The length of stay (LOS) of a woman before the birth of her baby, including leave days, measured in days.
<i>Context:</i>	Perinatal
<i>Data Element Concept:</i>	Episode of admitted patient care – length of stay (including leave days)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Formula:</p> <p>LOS (antenatal) = baby's date of birth - mother's admission date</p> <p>Antenatal LOS is calculated by subtracting the mother's admission date from the baby's date of birth. It includes contract days and leave days.</p> <p>If the mother's admission date and the baby's date of birth are on the same date, count the LOS as 1 day.</p> <p>Antenatal length of stay refers only to the admission associated with the birth.</p> <p>Antenatal LOS relates only to the episode of admitted patient care associated with the birth.</p> <p>In a multiple pregnancy, the date of birth of the first baby born should be used to calculate the mother's antenatal LOS.</p> <p>To calculate the total LOS, use the data element - Episode of admitted patient care - length of stay (including leave days) total.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

Related metadata references:

Is formed using [Person – date of birth, DDMMYYYY](#) Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Is formed using [Episode of admitted patient care – admission date, DDMMYYYY](#) Health, Standard 01/03/2005

Supersedes [Episode of admitted patient care \(antenatal\) – length of stay \(including leave days\), total N\[NN\]](#) Health, Superseded 04/07/2007

Length of stay (including leave days) (postnatal)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – length of stay (including leave days) (postnatal), total N[NN]
<i>METeOR identifier:</i>	300076
<i>Registration status:</i>	Health, Standard 04/07/2007
<i>Definition:</i>	The length of stay (LOS) of a woman following the birth of her baby, including leave days, measured in days.
<i>Context:</i>	Perinatal.
<i>Data Element Concept:</i>	Episode of admitted patient care – length of stay (including leave days)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Formula:</p> <p>$LOS \text{ (postnatal)} = \text{mother's separation date} - \text{baby's date of birth}$</p> <p>Postnatal LOS is calculated by subtracting the baby's date of birth from the mother's date of separation. It includes contract days and leave days.</p> <p>If the mother's separation date and the baby's date of birth are on the same date, count the LOS as 1 day.</p> <p>In a multiple pregnancy, the date of birth of the first baby born should be used to calculate the mother's postnatal LOS.</p> <p>Postnatal length of stay refers only to the episode of care associated with the birth.</p> <p>To calculate the total length of stay, use the data element - Episode of admitted patient care - length of stay (including leave days) total.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

Related metadata references:

Is formed using [Episode of admitted patient care – separation date, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Person – date of birth, DDMMYYYY](#) Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Supersedes [Episode of admitted patient care \(postnatal\) – length of stay \(including leave days\), total N\[NN\]](#) Health, Superseded 04/07/2007

Level of palliative care service

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – level of service delivery, palliative care code N
<i>METeOR identifier:</i>	334508
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The level of specialisation of the palliative care service delivered by a palliative care agency , as represented by a code.
Data Element Concept:	Service provider organisation – level of service delivery

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Primary palliative care</td></tr><tr><td>2</td><td>Specialist palliative care level 1</td></tr><tr><td>3</td><td>Specialist palliative care level 2</td></tr><tr><td>4</td><td>Specialist palliative care level 3</td></tr></tbody></table>	Value	Meaning	1	Primary palliative care	2	Specialist palliative care level 1	3	Specialist palliative care level 2	4	Specialist palliative care level 3
Value	Meaning										
1	Primary palliative care										
2	Specialist palliative care level 1										
3	Specialist palliative care level 2										
4	Specialist palliative care level 3										

Source and reference attributes

<i>Origin:</i>	Palliative Care Australia 2005. A guide to palliative care service development: A population-based approach. Canberra: Palliative Care Australia, p39.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Primary palliative care</p> <p>Capability: Clinical management and care coordination including assessment, triage, and referral using a palliative approach for patients with uncomplicated needs associated with a life limiting illness and/or end of life care. Has formal links with a specialist palliative care provider for purposes of referral, consultation and access to specialist care as necessary.</p> <p>Typical resource profile: General medical practitioner, nurse practitioner, registered nurse, generalist community nurse, aboriginal health worker, allied health staff. Specialist health care providers in other disciplines would be included at this level.</p>
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CODE 2 Specialist palliative care level 1

Capability: Provides palliative care for patients, primary carers and families whose needs exceed the capability of primary palliative care providers. Provides assessment and care consistent with needs and provides consultative support, information and advice to primary palliative care providers. Has formal links to primary palliative care providers and level 2 and/or 3 specialist palliative care providers to meet the needs of patients, carers and families with complex problems. Has quality and audit program.

Typical resource profile: Multi-disciplinary team including medical practitioner with skills and experience in palliative care, clinical nurse specialist/consultant, allied health staff, pastoral care and volunteers. A designated staff member if available, coordinates a volunteer service.

CODE 3 Specialist palliative care level 2

Capability: As for level 1, able to support higher resource level due to population base (e.g. regional area). Provides formal education programs to primary palliative care and level 1 providers and the community. Has formal links with primary palliative care providers and level 3 specialist palliative care services for patients, primary carers and families with complex needs.

Typical resource profile: Interdisciplinary team including medical practitioner and clinical nurse specialist/consultant with specialist qualifications. Includes designated allied health and pastoral care staff.

CODE 4 Specialist palliative care level 3

Capability: Provides comprehensive care for the needs of patients, primary carers and families with complex needs. Provides local support to primary palliative care providers, regional level 1 and/or 2 services including education and formation of standards. Has a comprehensive research and teaching role. Has formal links with local primary palliative care providers and with specialist palliative care providers level 1 and 2, and relevant academic units including professorial chairs where available.

Typical resource profile: Interdisciplinary team including a medical director and clinical nurse consultant/nurse practitioner and allied health staff with specialist qualifications in palliative care.

Source and reference attributes

Submitting organisation:

Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

[Palliative care performance indicators DSS](#) Health, Standard 05/12/2007

Lifestyle counselling type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with acute coronary syndrome – lifestyle counselling type, code N
<i>METeOR identifier:</i>	344710
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The counselling a person has received to modify lifestyle behaviour/s relevant to acute coronary syndromes, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome – lifestyle counselling type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Diet
	2	Physical activity
	3	Smoking cessation
	4	Weight management
<i>Supplementary values:</i>	9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Counselling includes any method of individual or group counselling or advice directed towards any of the specific lifestyle behaviours.</p> <p>This metadata item refers to counselling that was conducted by a healthcare professional during the hospital stay. This may include counselling that was performed in conjunction with referral to a cardiac rehabilitation service.</p> <p>CODE 1 Diet</p> <p>Use this code where a person has received counselling on their diet.</p> <p>CODE 2 Physical activity</p> <p>Use this code where a person has received counselling encouraging at least 30 to 60 minutes of physical activity in at least five sessions per week.</p>
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CODE 3 Smoking cessation

Use this code where a person has received counselling regarding the importance of stopping smoking.

CODE 4 Weight management

Use this code where a person, whose weight is greater than 120% of the ideal weight for height, has received counselling on weight management.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard
01/10/2008

Lipid-lowering therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – lipid-lowering therapy status, code NN
<i>METeOR identifier:</i>	285159
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The person's lipid-lowering therapy status, as represented by a code.
Data Element Concept:	Person – lipid-lowering therapy status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	NN														
<i>Maximum character length:</i>	2														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>10</td><td>Given</td></tr><tr><td>21</td><td>Not given - patient refusal</td></tr><tr><td>22</td><td>Not given - true allergy to lipid lowering therapy</td></tr><tr><td>23</td><td>Not given - previous myopathy</td></tr><tr><td>24</td><td>Not given - hepatic dysfunction</td></tr><tr><td>25</td><td>Not given - other</td></tr></tbody></table>	Value	Meaning	10	Given	21	Not given - patient refusal	22	Not given - true allergy to lipid lowering therapy	23	Not given - previous myopathy	24	Not given - hepatic dysfunction	25	Not given - other
Value	Meaning														
10	Given														
21	Not given - patient refusal														
22	Not given - true allergy to lipid lowering therapy														
23	Not given - previous myopathy														
24	Not given - hepatic dysfunction														
25	Not given - other														
<i>Supplementary values:</i>	90 Not stated/inadequately described														

Collection and usage attributes

<i>Guide for use:</i>	CODES 21 - 25 Not given If recording 'Not given', record the principal reason if more than one code applies.
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Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome working group
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Lipid-lowering therapy status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
07/12/2005

Listing date for care

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective care waiting list episode – listing date for care, DDMMYYYY
<i>METeOR identifier:</i>	269957
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a hospital or a community health service accepts notification that a patient/client requires care/treatment.
Data Element Concept:	Elective care waiting list episode – listing date for care

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For elective surgery, the listing date is the date on which the patient is added to an elective surgery waiting list.</p> <p>The acceptance of the notification by the hospital or community health service is conditional upon the provision of adequate information about the patient and the appropriateness of the patient referral.</p>
<i>Comments:</i>	The hospital or community health service should only accept a patient onto the waiting list when sufficient information has been provided to fulfil state/territory, local and national reporting requirements.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	<p>Supersedes Listing date for care, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)</p> <p>Is used in the formation of Elective surgery waiting list episode – waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005</p> <p>Is used in the formation of Elective surgery waiting list episode – waiting time (at a census date), total days N[NNN] Health, Standard 01/03/2005</p>
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Implementation in Data Set Specifications:

[Elective surgery waiting times \(census data\) NMDS Health](#), Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(census data\) NMDS 2006-2009 Health](#), Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

[Elective surgery waiting times \(census data\) NMDS 2009- Health, Standard](#) 03/12/2008

Implementation start date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS Health](#), Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(removals data\) NMDS 2006-2009 Health](#), Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2009- Health, Standard](#) 03/12/2008

Implementation start date: 01/07/2009

Living arrangement

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – living arrangement, health sector code N
<i>METeOR identifier:</i>	299712
<i>Registration status:</i>	Health, Standard 14/06/2005
<i>Definition:</i>	Whether a person usually resides alone or with others, as represented by a code.
<i>Context:</i>	Client support needs and clinical setting.
<i>Data Element Concept:</i>	Person – living arrangement

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Lives alone</td></tr><tr><td>2</td><td>Lives with others</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Lives alone	2	Lives with others	9	Not stated/inadequately described
Value	Meaning								
1	Lives alone								
2	Lives with others								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	This item does not seek to describe the quality of the arrangements but merely the fact of the arrangement. It is recognised that this item may change on a number of occasions during the course of an episode of care.
<i>Comments:</i>	<p>Whether or not a person lives alone is a significant determinant of risk.</p> <p>Living alone may preclude certain treatment approaches (e.g. home dialysis for end-stage renal disease). Social isolation has also been shown to have a negative impact on prognosis in males with known coronary artery disease with several studies suggesting increased mortality rates in those living alone or with no confidant.</p>

Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular Data Working Group
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Relational attributes

Related metadata references:

Supersedes [Living arrangement, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.0 KB)

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Location of impairment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person—location of impairment of body structure, code (ICF 2001) N
<i>METeOR identifier:</i>	320177
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The location of a person's impairment in a specified body structure, as represented by a code.
<i>Context:</i>	Human functioning and disability
Data Element Concept:	Person—location of impairment of body structure

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Functioning, Disability and Health 2001	
<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	0	More than one region
	1	Right
	2	Left
	3	Both sides
	4	Front
	5	Back
	6	Proximal
	7	Distal
<i>Supplementary values:</i>	8	Not specified
	9	Not applicable

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.</p> <p><i>Impairments of body structure</i> are problems in body structure such as a loss or significant departure from population standards or averages.</p> <p>Use only one code. Select the one that best describes the situation with this structure. Combinations are not possible.</p>
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CODE 0 More than one region (except both sides)

Used when the impairment is present in more than one body location (but not bilaterally see code 3); for example when burn scars affect many areas of skin.

CODE 1 Right

Used when the impairment is present to the right of the midline of the person's body.

CODE 2 Left

Used when the impairment is present to the left of the midline of the person's body.

CODE 3 Both sides (bilateral)

Used when the impairment is two-sided and disposed on opposite sides of the midline axis of the body, for example bilateral joint deformities.

CODE 4 Front

Used when the impairment is present in front of a line passing through the midline of the body when viewed from the side.

CODE 5 Back

Used when the impairment is present behind a line passing through the midline of the body when viewed from the side.

CODE 6 Proximal

Used when the impairment is situated towards the point of origin or attachment, as of a limb or bone (opposed to distal), for example the end of the structure that is closer to the centre of the body.

CODE 7 Distal

Used when the impairment is situated away from the point of origin or attachment, as of a limb or bone (opposed to proximal), for example the end of structure that is further away from the centre of the body.

CODE 8 Not specified

Used when there is an impairment of body structure but the location of the impairment is not recorded.

CODE 9 Not applicable

Used when it is not appropriate to code the location of an impairment of body structure.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website
<http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.cfm>

Data element attributes

Collection and usage attributes

Guide for use:

This data element is to be used in conjunction with specified body structures, for example, 'impairment of proximal structures related to movement'. This data element may also be used in conjunction with Person – extent of impairment of body structure, code (ICF 2001) N and Person – nature of impairment of body structure, code (ICF 2001).

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Related metadata references:

See also [Person – nature of impairment of body structure, code \(ICF 2001\) N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

See also [Person – extent of impairment of body structure, code \(ICF 2001\) N](#) Health, Standard 29/11/2006, Community services, Standard 16/10/2006

Implementation in Data Set Specifications:

[Body structures cluster](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Lot/section number (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – lot/section identifier, N[X(14)]
<i>Synonymous names:</i>	Australian lot number, section, allotment
<i>METeOR identifier:</i>	270031
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The unique identifier for the lot/section of the location where a person resides.
Data Element Concept:	Person (address) – lot/section identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	N[X(14)]
<i>Maximum character length:</i>	15

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This standard is suitable for postal purposes as well as the physical identification of addresses.</p> <p>A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property.</p> <p>For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space.</p> <p>Examples are as follows:</p> <p>Section 123456 Lot 716 Lot 534A Lot 17 Jones Street</p>
<i>Collection methods:</i>	The lot/section number is positioned before the Street name and type, located in the same line containing the Street name.
<i>Comments:</i>	Lot/section numbers are generally used only until an area has been developed.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Origin: AS 4590 Interchange of client information, Australia Post Address Presentation Standard

Reference documents: AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references: Supersedes [Lot/section number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.3 KB)

Is used in the formation of [Person \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of [Person \(address\) – health address line, text \[X\(180\)\]](#) Health, Superseded 04/05/2005

Implementation in Data Set Specifications: [Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Lot/section number (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – lot/section identifier, N[X(14)]
<i>METeOR identifier:</i>	290230
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The unique identifier for the lot/section of the location of an organisation.
Data Element Concept:	Service provider organisation (address) – lot/section identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	N[X(14)]
<i>Maximum character length:</i>	15

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This standard is suitable for postal purposes as well as the physical identification of addresses.</p> <p>A lot number shall be used only when a street number has not been specifically allocated or is not readily identifiable with the property.</p> <p>For identification purposes, the word 'Lot' or 'Section' should precede the lot number and be separated by a space.</p> <p>Examples are as follows:</p> <p>Section 123456</p> <p>Lot 716</p> <p>Lot 534A</p> <p>Lot 17 Jones Street</p>
<i>Collection methods:</i>	The lot/section number is positioned before the Street name and type, located in the same line containing the Street name.
<i>Comments:</i>	Lot/section numbers are generally used only until an area has been developed.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	AS 4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:

Is used in the formation of [Service provider organisation \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications:

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Lower limb amputation due to vascular disease

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – lower limb amputation due to vascular disease, code N
<i>METeOR identifier:</i>	270162
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether a person has undergone an amputation of toe, forefoot or leg (above or below knee), due to vascular disease, as represented by a code.
Data Element Concept:	Person – lower limb amputation due to vascular disease

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Lower limb amputation - occurred in the last 12 months</td></tr><tr><td>2</td><td>Lower limb amputation - occurred prior to the last 12 months</td></tr><tr><td>3</td><td>Lower limb amputation - occurred both in and prior to the last 12 months</td></tr><tr><td>4</td><td>No history of lower limb amputation due to vascular disease</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Lower limb amputation - occurred in the last 12 months	2	Lower limb amputation - occurred prior to the last 12 months	3	Lower limb amputation - occurred both in and prior to the last 12 months	4	No history of lower limb amputation due to vascular disease	9	Not stated/inadequately described
Value	Meaning												
1	Lower limb amputation - occurred in the last 12 months												
2	Lower limb amputation - occurred prior to the last 12 months												
3	Lower limb amputation - occurred both in and prior to the last 12 months												
4	No history of lower limb amputation due to vascular disease												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Collection and usage attributes

<i>Collection methods:</i>	Ask the individual if he/she has had an amputated toe or forefoot or leg (above or below knee), not due to trauma or causes other than vascular disease. If so determine when it was undertaken; within or prior to the last 12 months (or both). Alternatively obtain this information from appropriate documentation.
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Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Reference documents:

Duffy MD, John C and Patout MD, Charles A. 1990. Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease. *Military Medicine*, 155:575-579.

Edmonds M, Boulton A, Buckenham T et al. Report of the Diabetic Foot and Amputation Group. *Diabet Med* 1996; 13: S27-42.

Sharon R O'Rourke and Stephen Colagiuri: The Lower Limb in People With Diabetes; Content 1997/98 Australian Diabetes Society.

Colagiuri S, Colagiuri R, Ward J. National Diabetes Strategy and Implementation Plan. Canberra: Diabetes Australia, 1998.

Relational attributes

Related metadata references:

Supersedes [Lower limb amputation due to vascular disease, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.6 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS Health](#), Superseded 21/09/2005

[Diabetes \(clinical\) DSS Health](#), Standard 21/09/2005

Lymphovascular invasion

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – lymphovascular invasion, code N
<i>METeOR identifier:</i>	370618
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The presence or absence of the invasion of cancer cells into blood vessel(s) and/or the lymphatic system, as represented by a code.
Data Element Concept:	Person with cancer – lymphovascular invasion

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Present</td></tr><tr><td>2</td><td>Absent</td></tr><tr><td>3</td><td>Suspicious</td></tr><tr><td>9</td><td>Not stated or unknown</td></tr></tbody></table>	Value	Meaning	1	Present	2	Absent	3	Suspicious	9	Not stated or unknown
Value	Meaning										
1	Present										
2	Absent										
3	Suspicious										
9	Not stated or unknown										
<i>Supplementary values:</i>											

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The presence of lymphovascular invasion should be recorded as Code 1, regardless of whether the extent of the invasion is described or not.
<i>Collection methods:</i>	For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease. If pathology report pertaining to initial diagnosis is for a metastasis, and not the primary tumour, record as 9.
<i>Comments:</i>	Invasion of the lymphatics or blood vessels by cancer cells is an important prognostic factor that indicates that the tumour is likely to spread. This item is included in data items defined for reporting in the pathology reporting guidelines as prepared by the National Breast and Ovarian Cancer Centre and Australian Cancer Network.

Source and reference attributes

<i>Origin:</i>	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR)
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Reference documents:

Australian Institute of Health and Welfare (AIHW)
National Breast and Ovarian Cancer Centre and Australian
Cancer Network. The Pathology reporting of breast cancer. A
guide for pathologists, surgeons, radiologists and oncologists
(3rd edition). National Breast and Ovarian Cancer Centre, Surry
Hills, NSW, 2008.

Relational attributes

*Implementation in Data Set
Specifications:*

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard
06/03/2009

Main language other than English spoken at home

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – main language other than English spoken at home, code (ASCL 2005) NN{NN}
<i>METeOR identifier:</i>	304133
<i>Registration status:</i>	Health, Standard 08/02/2006 Community services, Standard 29/04/2006 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	The language reported by a person as the main language other than English spoken by that person in his/her home (or most recent private residential setting occupied by the person) to communicate with other residents of the home or setting and regular visitors, as represented by a code.
Data Element Concept:	Person – main language other than English spoken at home

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Australian Standard Classification of Languages 2005
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NN{NN}
<i>Maximum character length:</i>	4

Collection and usage attributes

Guide for use: The Australian Standard Classification of Languages (ASCL) has a three-level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages.

For example, the Lithuanian language has a code of 3102. In this case 3 denote that it is an Eastern European language, while 31 denote that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denote that it is an Australian Indigenous language and 87 denote that the language is Western Desert language.

Language data may be output at the Broad Group level, Narrow Group level or base level of the classification. If necessary significant Languages within a Narrow Group can be presented separately while the remaining Languages in the Narrow Group

are aggregated. The same principle can be adopted to highlight significant Narrow Groups within a Broad Group.

Data element attributes

Collection and usage attributes

Collection methods:

Recommended question:

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

No (English only) ____

Yes, Italian ____

Yes, Greek ____

Yes, Cantonese ____

Yes, Arabic ____

Yes, Mandarin ____

Yes, Vietnamese ____

Yes, Spanish ____

Yes, German ____

Yes, Hindi ____

Yes, Other (please specify) _____

This list reflects the nine most common languages other than English spoken in Australia.

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

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

Comments:

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

This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties. In conjunction with Indigenous status, Proficiency in spoken English and Country of birth this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics (ABS).

Data on main language other than English spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/ translation services.

Source and reference attributes

Origin:

Health Data Standards Committee

National Community Services Data Committee

Australian Bureau of Statistics 2005. [Australian Standard Classification of Languages \(ASCL\) 2005. Cat. no. 1267.0. 2nd Edition](#), Canberra: ABS. Viewed 29 July 2005.

Relational attributes

Related metadata references:

Supersedes [Person – main language other than English spoken at home, code \(ASCL 1997\) NN{NN}](#) Health, Superseded 08/02/2006, Community services, Superseded 29/04/2006, Housing assistance, Not progressed 13/10/2005

See also [Person – preferred language, code \(ASCL 2005\) NN{NN}](#) Health, Standard 08/02/2006, Community services, Standard 29/04/2006

Main occupation of person

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – occupation (main), code (ANZSCO 1st edition) N[NNN]{NN}
<i>METeOR identifier:</i>	350899
<i>Registration status:</i>	Health, Standard 04/07/2007 Community services, Standard 27/03/2007 Housing assistance, Standard 10/08/2007
<i>Definition:</i>	The job in which the person is principally engaged, as represented by a code.
Data Element Concept:	Person – occupation (main)

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN]{NN}
<i>Maximum character length:</i>	6

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A job in any given establishment is a set of tasks designed to be performed by one individual in return for a wage or salary. For persons with more than one job, the main job is the one in which the person works the most hours.</p> <p>Caution is advised in its use with regard to service providers as their activity as a service provider may not be their main occupation.</p>
<i>Collection methods:</i>	<p>This metadata item should only be collected from people whose Labour force status is employed.</p> <p>Occupation is too complex and diverse an issue to fit neatly into any useable small group of categories. Therefore ABS recommend that this metadata item be collected by using the following two open-ended questions:</p> <p>Q1. In the main job held last week (or other recent reference period), what was your/the person's occupation?</p> <p>Q2. What are the main tasks that you/the person usually perform in that occupation? The information gained from these two questions can then be used to select an appropriate code from the ANZSCO at any of the available levels (see Guide for use section).</p>

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

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

Comments:

This metadata item may be useful in gaining an understanding of a client's situation and needs. For example, the occupation of a person with a disability may be directly relevant to the type of aids that they require.

National Health Data Dictionary (NHDD) specific:

Injury surveillance - There is considerable user demand for data on occupation-related injury and illness, including from WorkSafe Australia and from industry, where unnecessary production costs are known in some areas and suspected to be related to others in work-related illness, injury and disability.

Source and reference attributes

Origin:

Australian Bureau of Statistics 2006. Australian New Zealand Standard Classification of Occupations (ANZSCO) (Cat. no. 1220.0) (First edition), Viewed 13 March 2007.

Relational attributes

Related metadata references:

Supersedes [Person – occupation \(main\), code \(ASCO 2nd edn\) N\[NNN\]{-NN}](#) Health, Superseded 04/07/2007, Community services, Superseded 27/03/2007, Housing assistance, Superseded 10/08/2007

See also [Person – labour force status, code N](#) Health, Standard 01/03/2005, Community services, Standard 01/03/2005, Housing assistance, Standard 01/03/2005

Main treatment type for alcohol and other drugs

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – treatment type (main), code N
<i>METeOR identifier:</i>	270056
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The main activity determined at assessment by the treatment provider to treat the client's alcohol and/or drug problem for the principal drug of concern, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs – treatment type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	N																		
<i>Maximum character length:</i>	1																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Withdrawal management (detoxification)</td></tr><tr><td>2</td><td>Counselling</td></tr><tr><td>3</td><td>Rehabilitation</td></tr><tr><td>4</td><td>Pharmacotherapy</td></tr><tr><td>5</td><td>Support and case management only</td></tr><tr><td>6</td><td>Information and education only</td></tr><tr><td>7</td><td>Assessment only</td></tr><tr><td>8</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Withdrawal management (detoxification)	2	Counselling	3	Rehabilitation	4	Pharmacotherapy	5	Support and case management only	6	Information and education only	7	Assessment only	8	Other
Value	Meaning																		
1	Withdrawal management (detoxification)																		
2	Counselling																		
3	Rehabilitation																		
4	Pharmacotherapy																		
5	Support and case management only																		
6	Information and education only																		
7	Assessment only																		
8	Other																		

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Withdrawal management (detoxification)</p> <p>This code refers to any form of withdrawal management, including medicated and non-medicated, in any delivery setting.</p> <p>CODE 2 Counselling</p> <p>This code refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This code excludes counselling activity that is part of a rehabilitation program as defined in Code 3.</p> <p>CODE 3 Rehabilitation</p> <p>This code refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational</p>
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activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings. Counselling that is included within an overall rehabilitation program should be coded to Code 3 for Rehabilitation, not to Code 2 as a separate treatment episode for counselling.

CODE 4 Pharmacotherapy

Refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use Code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes treatment episodes for clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

CODE 5 Support and case management only

Refers to when there is no treatment provided to the client other than support and case management (e.g. treatment provided through youth alcohol and drug outreach services). This choice only applies where support and case management treatment is recorded as individual client data and the treatment activity is not included in any other category.

CODE 6 Information and education only

Refers to when there is no treatment provided to the client other than information and education. It is noted that, in general, service contacts would include a component of information and education.

CODE 7 Assessment only

Refers to when there is no treatment provided to the client other than assessment. It is noted that, in general, service contacts would include an assessment component.

Data element attributes

Collection and usage attributes

Guide for use:

Only one code to be selected.

To be completed at assessment or commencement of treatment.

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

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

Comments:

Information about treatment provided is of fundamental importance to service delivery and planning.

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes [Main treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (18.9 KB)

Implementation in Data Set Specifications: [Alcohol and other drug treatment services NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Major diagnostic category

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – major diagnostic category, code (AR-DRG v 6) NN
<i>METeOR identifier:</i>	391298
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	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

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

Data element attributes

Collection and usage attributes

<i>Comments:</i>	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.
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Source and reference attributes

<i>Submitting organisation:</i>	Department of Health and Ageing, Acute and Co-ordinated Care Branch
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Relational attributes

<i>Related metadata references:</i>	See also Episode of admitted patient care – diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009 Supersedes Episode of admitted patient care – major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009
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Is formed using [Episode of care – mental health legal status, code N](#) Health, Standard 01/03/2005

Is formed using [Episode of admitted patient care – number of leave days, total N\[NN\]](#) Health, Standard 01/03/2005

Is formed using [Person – weight \(measured\), total grams NNNN](#) Health, Standard 01/03/2005

Is formed using [Episode of admitted patient care – intended length of hospital stay, code N](#) Health, Standard 01/03/2005

Is formed using [Episode of admitted patient care – separation mode, code N](#) Health, Standard 01/03/2005

Is formed using [Episode of admitted patient care – separation date, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Person – sex, code N](#) Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006

Is formed using [Episode of admitted patient care – admission date, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Person – date of birth, DDMMYYYY](#) Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 20/06/2005

Is formed using [Episode of care – principal diagnosis, code \(ICD-10-AM 7th edn\) ANN{.N\[N\]}](#) Health, Standard 22/12/2009

Is formed using [Episode of care – additional diagnosis, code \(ICD-10-AM 7th edn\) ANN{.N\[N\]}](#) Health, Standard 22/12/2009

Is formed using [Episode of admitted patient care – procedure, code \(ACHI 7th edn\) NNNNN-NN](#) Health, Standard 22/12/2009

Implementation in Data Set Specifications:

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Marital status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – marital status, code N
<i>METeOR identifier:</i>	291045
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.
Data Element Concept:	Person – marital status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Never married</td></tr><tr><td>2</td><td>Widowed</td></tr><tr><td>3</td><td>Divorced</td></tr><tr><td>4</td><td>Separated</td></tr><tr><td>5</td><td>Married (registered and de facto)</td></tr><tr><td>6</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Never married	2	Widowed	3	Divorced	4	Separated	5	Married (registered and de facto)	6	Not stated/inadequately described
Value	Meaning														
1	Never married														
2	Widowed														
3	Divorced														
4	Separated														
5	Married (registered and de facto)														
6	Not stated/inadequately described														
<i>Supplementary values:</i>															

Collection and usage attributes

<i>Guide for use:</i>	Refers to the current marital status of a person. CODE 2 Widowed This code usually refers to registered marriages but when self reported may also refer to de facto marriages. CODE 4 Separated This code refers to registered marriages but when self reported may also refer to de facto marriages. CODE 5 Married (registered and de facto) Includes people who have been divorced or widowed but have since re-married, and should be generally accepted as applicable to all de facto couples, including of the same sex. CODE 6 Not stated/inadequately described This code is not for use on primary collection forms. It is
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primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Origin: The ABS standards for the collection of Social and Registered marital status appear on the ABS Website. Australian Bureau of Statistics. [Family, household and income unit variables. Cat. no. 1286.0.](#) Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods: This metadata item collects information on social marital status. The recommended question module is:

Do you/Does the person usually live with a partner in a registered or de facto marriage?

Yes, in a registered marriage

Yes, in a de facto marriage

No, never married

No, separated

No, divorced

No, widowed

It should be noted that information on marital status is collected differently by the ABS, using a set of questions. However, the question outlined above is suitable and mostly sufficient for use within the health and community services fields. See Source document for information on how to access the ABS standards.

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

Comments: The ABS standards identify two concepts of marital status:

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

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

While marital status is an important factor in assessing the type and extent of support needs, such as for the elderly living in the home environment, marital status does not adequately address the need for information about social support and living

arrangement and other data elements need to be formulated to capture this information.

Source and reference attributes

Origin: National Health Data Standards Committee
National Community Services Data Committee

Relational attributes

Related metadata references: Supersedes [Person – marital status, code N](#) Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications: [Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010
Implementation start date: 01/07/2009
Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010
Implementation start date: 01/07/2010

[Community mental health care 2004-2005](#) Health, Superseded 08/12/2004
Implementation start date: 01/07/2004
Implementation end date: 30/06/2005

[Community mental health care NMDS 2005-2006](#) Health, Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Computer Assisted Telephone Interview demographic module DSS](#) Health, Superseded 03/12/2008

[Computer Assisted Telephone Interview demographic module DSS](#) Health, Standard 03/12/2008

[Residential mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Maternal medical conditions

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female (pregnant) – maternal medical condition, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	391328
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	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.
<i>Context:</i>	Perinatal statistics
Data Element Concept:	Female (pregnant) – maternal medical condition

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	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.
<i>Comments:</i>	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

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Female (pregnant) – maternal medical condition, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009
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Maximum stenosis coronary artery

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – maximum stenosis coronary artery, percentage N[NN]
<i>METeOR identifier:</i>	344335
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The percentage of stenosis at its maximal point in a person's coronary artery.
Data Element Concept:	Person – maximum stenosis coronary artery

Value domain attributes

Representational attributes

<i>Representation class:</i>	Percentage				
<i>Data type:</i>	Number				
<i>Format:</i>	N[NN]				
<i>Maximum character length:</i>	3				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	999	Not stated/inadequately described
Value	Meaning				
999	Not stated/inadequately described				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Stenosis represents the percentage of occlusion, from 0 to 100%, associated with the identified vessel system. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the 'normal' vessel proximal and distal to the lesion. In instances where multiple lesions are present in a coronary artery, record the highest percentage stenosis noted.
<i>Collection methods:</i>	This data is derived from visual recording by the physician reporting the angiogram.

Relational attributes

<i>Related metadata references:</i>	See also Person – coronary artery stenosis location, code N Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Coronary artery cluster Health, Standard 01/10/2008

Medicare card number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – government funding identifier, Medicare card number N(11)
<i>METeOR identifier:</i>	270101
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Recorded 27/03/2007
<i>Definition:</i>	Person identifier, allocated by the Health Insurance Commission to eligible persons under the Medicare scheme, that appears on a Medicare card.
<i>Context:</i>	Medicare utilisation statistics. Persons eligible for Medicare services.
Data Element Concept:	Person – government funding identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	N(11)
<i>Maximum character length:</i>	11

Collection and usage attributes

<i>Guide for use:</i>	Full Medicare number for an individual (i.e. family number plus person (individual reference) number).
<i>Comments:</i>	<p>The Medicare card number is printed on a Medicare card and is used to access Medicare records for an eligible person.</p> <p>Up to 9 persons can be included under the one Medicare card number with up to five persons appearing on one physical card.</p> <p>Persons grouped under one Medicare card number are often a family, however, there is no requirement for persons under the same Medicare card number to be related.</p> <p>A person may be shown under separate Medicare card numbers where, for example, a child needs to be included on separate Medicare cards held by their parents. As a person can be identified on more than one Medicare card this is not a unique identifier for a person.</p>

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The Medicare card number should only be collected from persons eligible to receive health services that are to be funded by the Commonwealth government. The number should be reported to
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the appropriate government agency to reconcile payment for the service provided. The data should not be used by private sector organisations for any other purpose unless specifically authorised by law. For example, data linkage should not be carried out unless specifically authorised by law.

Comments:

Note: Veterans may have a Medicare card number and a Department of Veterans' Affairs (DVA) number or only a DVA number.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

AS5017 Health care client identification

Relational attributes

Related metadata references:

Supersedes [Medicare card number, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.6 KB)

Implementation in Data Set Specifications:

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

[Health care client identification](#) Health, Superseded 04/05/2005

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

Medicare eligibility status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – eligibility status, Medicare code N
<i>METeOR identifier:</i>	351922
<i>Registration status:</i>	Health, Standard 04/07/2007
<i>Definition:</i>	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.
<i>Context:</i>	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

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Eligible</td></tr><tr><td>2</td><td>Not eligible</td></tr></tbody></table>	Value	Meaning	1	Eligible	2	Not eligible
Value	Meaning						
1	Eligible						
2	Not eligible						
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated/unknown</td></tr></tbody></table>	9	Not stated/unknown				
9	Not stated/unknown						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Eligible persons are</p> <ul style="list-style-type: none">• Permanent residents of Australia• Persons who have an application for permanent residence (not an aged parent visa), and have either:<ul style="list-style-type: none">- 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:<ul style="list-style-type: none">- 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.
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- 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.

Relational attributes

Related metadata references:

Supersedes [Person – eligibility status, Medicare code N](#) Health,
Superseded 04/07/2007

Mental health legal status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – mental health legal status, code N
<i>METeOR identifier:</i>	270351
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient care, an episode of residential care or treatment of a patient/client by a community based service during a reporting period, as represented by a code.
Data Element Concept:	Episode of care – mental health legal status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Involuntary patient</td></tr><tr><td>2</td><td>Voluntary patient</td></tr><tr><td>3</td><td>Not permitted to be reported under legislative arrangements in the jurisdiction</td></tr></tbody></table>	Value	Meaning	1	Involuntary patient	2	Voluntary patient	3	Not permitted to be reported under legislative arrangements in the jurisdiction
Value	Meaning								
1	Involuntary patient								
2	Voluntary patient								
3	Not permitted to be reported under legislative arrangements in the jurisdiction								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Involuntary patient</p> <p>Involuntary patient should only be used by facilities which are approved for this purpose. While each state and territory mental health legislation differs in the number of categories of involuntary patient that are recognised, and the specific titles and legal conditions applying to each type, the legal status categories which provide for compulsory detention or compulsory treatment of the patient can be readily differentiated within each jurisdiction. These include special categories for forensic patients who are charged with or convicted of some form of criminal activity. Each state/territory health authority should identify which sections of their mental health legislation provide for detention or compulsory treatment of the patient and code these as involuntary status.</p> <p>CODE 2 Voluntary patient</p> <p>Voluntary patient to be used for reporting to the NMDS-Community mental health care, where applicable.</p>
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CODE 3 Not permitted to be reported under legislative arrangements in the jurisdiction

Not permitted to be reported under legislative arrangements in the jurisdiction, is to be used for reporting to the National Minimum Data Set - Community mental health care, where applicable.

Data element attributes

Collection and usage attributes

Guide for use:

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

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

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

Collection methods:

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

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

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

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v 6\) NN](#) Health, Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v 6\) ANNA](#) Health, Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v5.1\) ANNA](#) Health, Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v5.1\) NN](#) Health, Superseded 22/12/2009

Implementation in Data Set Specifications:

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

[Community mental health care 2004-2005](#) Health, Superseded
08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

[Community mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Residential mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health,

Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Mental health service contact date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Mental health service contact – service contact date, DDMMYYYY
<i>METeOR identifier:</i>	295481
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The date of each mental health service contact between a health service provider and patient/client.
Data Element Concept:	Mental health service contact – service contact date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	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.
<i>Comments:</i>	The service contact is required for clinical audit and other quality assurance purposes.

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Community mental health care NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Community mental health care NMDS 2007-2008 Health,
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Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Mental health service contact duration

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Mental health service contact – service contact duration, total minutes NNN
<i>METeOR identifier:</i>	286682
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The time from the start to finish of a service contact.
<i>Data Element Concept:</i>	Mental health service contact – mental health service contact duration

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>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.</p> <p>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.</p> <p>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.</p>
<i>Comments:</i>	<p>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.</p>

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005
	<i>Implementation start date:</i> 01/07/2005
	<i>Implementation end date:</i> 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Mental health service contact—patient/client participation indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Mental health service contact – patient/client participation indicator, yes/no code N
<i>METeOR identifier:</i>	286859
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	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

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Service contacts are not restricted to in-person communication but can include telephone, video link or other forms of direct communication.</p> <ul style="list-style-type: none">• Code 1 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 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.
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005
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Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Mental health service contact—session type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Mental health service contact—session type, code N
<i>METeOR identifier:</i>	286832
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	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

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Individual session</td></tr><tr><td>2</td><td>Group session</td></tr></tbody></table>	Value	Meaning	1	Individual session	2	Group session
Value	Meaning						
1	Individual session						
2	Group session						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A service contact is regarded as an individual session where the service is provided for one patient/client with or without third party involvement.</p> <p>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.</p> <p>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.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005
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Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Mental health services grants to non-government organisations by non-health departments

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	State or Territory Government – mental health services grants to non-government organisations by non-health departments, total Australian currency N[N(8)]
<i>METeOR identifier:</i>	298940
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	Total amount of money in the form of grants made by state or territory departments outside the health portfolios directly to non-government organisations specifically for the provision of mental health activities or programs (other than staffed residential services).
Data Element Concept:	State or Territory Government – mental health services grants to non-government organisations by non-health departments

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the exact dollar amount is unable to be provided an estimate should be derived from information available to the state or territory health department.
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
	Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Method of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – birth method, code N
<i>METeOR identifier:</i>	295349
<i>Registration status:</i>	Health, Standard 06/09/2006
<i>Definition:</i>	The method of complete expulsion or extraction from its mother of a product of conception in a birth event, as represented by a code.
Data Element Concept:	Birth event – birth method

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Vaginal - non-instrumental</td></tr><tr><td>2</td><td>Vaginal - forceps</td></tr><tr><td>4</td><td>Caesarean section</td></tr><tr><td>5</td><td>Vaginal - vacuum extraction</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Vaginal - non-instrumental	2	Vaginal - forceps	4	Caesarean section	5	Vaginal - vacuum extraction	9	Not stated/inadequately described
Value	Meaning												
1	Vaginal - non-instrumental												
2	Vaginal - forceps												
4	Caesarean section												
5	Vaginal - vacuum extraction												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>In a vaginal breech with forceps to the after coming head, code as vaginal - forceps.</p> <p>In a vaginal breech that has been manually rotated, code as vaginal - non-instrumental.</p> <p>Where forceps/vacuum extraction are used to assist the extraction of the baby at caesarean section, code as caesarean section.</p> <p>Where a hysterotomy is performed to extract the baby, code as caesarean section.</p>
<i>Collection methods:</i>	In the case of multiple births, method of birth should be recorded for each baby born.

Comments: Note: Code 3, 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.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Birth event – delivery method, code N](#) Health, Superseded 06/09/2006

Implementation in Data Set Specifications: [Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008
Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Method of use for principal drug of concern

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Client – method of drug use (principal drug of concern), code N
<i>METeOR identifier:</i>	270111
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The client’s self-reported usual method of administering the principal drug of concern, as represented by a code.
Data Element Concept:	Client – method of drug use (principal drug of concern)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Ingests</td></tr><tr><td>2</td><td>Smokes</td></tr><tr><td>3</td><td>Injects</td></tr><tr><td>4</td><td>Sniffs (powder)</td></tr><tr><td>5</td><td>Inhales (vapour)</td></tr><tr><td>6</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Ingests	2	Smokes	3	Injects	4	Sniffs (powder)	5	Inhales (vapour)	6	Other
Value	Meaning														
1	Ingests														
2	Smokes														
3	Injects														
4	Sniffs (powder)														
5	Inhales (vapour)														
6	Other														
<i>Supplementary values:</i>	9 Not stated/inadequately described														

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Refers to eating or drinking as the method of administering the principal drug of concern.
<i>Collection methods:</i>	Collect only for principal drug of concern. To be collected on commencement of treatment with a service.
<i>Comments:</i>	Identification of drug use methods is important for minimising specific harms associated with drug use, and is consequently of value for informing treatment approaches.

Source and reference attributes

<i>Submitting organisation:</i>	Intergovernmental Committee on Drugs National Minimum Data Set Working Group
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Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Method of use for principal drug of concern, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Microalbumin level—albumin/creatinine ratio (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – microalbumin level (measured), albumin/creatinine ratio N[NN].N
<i>METeOR identifier:</i>	270339
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's microalbumin level, measured as an albumin/creatinine ratio.
<i>Data Element Concept:</i>	Person – microalbumin level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Ratio
<i>Data type:</i>	Number
<i>Format:</i>	N[NN].N
<i>Maximum character length:</i>	4
<i>Supplementary values:</i>	Value Meaning 999.9 Not stated/inadequately described
<i>Unit of measure:</i>	Milligram per millimole (mg/mmol)
<i>Unit of measure precision:</i>	1

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.</p> <p>Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.</p> <p>As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate, and if the albumin/creatinine ratio is found to be greater than 3.5 mg/mmol then a timed overnight sample should be obtained for estimation of the albumin excretion rate.</p> <p>Test for albuminuria by measuring microalbumin in timed or first morning urine sample.</p> <p>The results considered elevated are</p> <ul style="list-style-type: none">• spot urine 30 to 300 mg/L; or• timed urine (24 hour collection) 20 to 200 µg/min.
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Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:

See also [Laboratory standard – upper limit of normal range for microalbumin, albumin/creatinine ratio N\[NN\].N](#) Health, Standard 01/03/2005

Supersedes [Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.5 KB)

Supersedes [Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Microalbumin level—micrograms per minute (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – microalbumin level (measured), total micrograms per minute N[NNN].N
<i>METeOR identifier:</i>	270336
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's microalbumin level measured in microgram per minute (µg/min).
Data Element Concept:	Person – microalbumin level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN].N
<i>Maximum character length:</i>	5
<i>Supplementary values:</i>	Value Meaning 9999.9 Not stated/inadequately described
<i>Unit of measure:</i>	Microgram per minute (µg/min)
<i>Unit of measure precision:</i>	1

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.</p> <p>Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.</p> <p>As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.</p> <p>Test for albuminuria by measuring microalbumin in timed or first morning urine sample.</p> <p>The results considered elevated are</p> <ul style="list-style-type: none">• spot urine 30 to 300mg/L; or• timed urine (24 hr collection) 20 to 200 µg/min.
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Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:

Supersedes [Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)

Supersedes [Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.5 KB)

See also [Laboratory standard – upper limit of normal range for microalbumin, total micrograms per minute N\[NN\].N](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Microalbumin level—milligrams per 24 hour (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – microalbumin level (measured), total milligrams per 24 hour N[NNN].N
<i>METeOR identifier:</i>	270337
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's microalbumin level measured in milligrams per 24 hours.
<i>Data Element Concept:</i>	Person – microalbumin level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN].N
<i>Maximum character length:</i>	5
<i>Supplementary values:</i>	Value Meaning 9999.9 Not stated/inadequately described
<i>Unit of measure:</i>	Milligram per 24-hour period (mg/24h)
<i>Unit of measure precision:</i>	1

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.</p> <p>Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.</p> <p>As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.</p> <p>Test for albuminuria by measuring microalbumin in timed or first morning urine sample.</p> <p>The results considered elevated are</p> <ul style="list-style-type: none">• spot urine 30 to 300mg/L; or• timed urine (24 hr collection) 20 to 200 ug/min.
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Source and reference attributes

Submitting organisation: National Diabetes Data Working Group
Origin: National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references: Supersedes [Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.5 KB)
Supersedes [Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)
See also [Laboratory standard – upper limit of normal range for microalbumin, total milligrams per 24 hour N\[NN\].N](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications: [Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005
[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Microalbumin level—milligrams per litre (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – microalbumin level (measured), total milligrams per litre N[NNN].N
<i>METeOR identifier:</i>	270335
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's microalbumin level measured in milligrams per litre (mg/L).
<i>Data Element Concept:</i>	Person – microalbumin level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN].N
<i>Maximum character length:</i>	5
<i>Supplementary values:</i>	Value Meaning 9999.9 Not stated/inadequately described
<i>Unit of measure:</i>	Milligram per litre (mg/L)
<i>Unit of measure precision:</i>	1

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.</p> <p>Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.</p> <p>As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.</p> <p>Test for albuminuria by measuring microalbumin in timed or first morning urine sample.</p> <p>The results considered elevated are:</p> <ul style="list-style-type: none">• spot urine 30 to 300mg/L; or• timed urine (24 hr collection) 20 to 200 ug/min.
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Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:

Supersedes [Microalbumin/protein - measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.5 KB)

Supersedes [Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)

See also [Laboratory standard – upper limit of normal range for microalbumin, total milligrams per litre N\[NN\].N](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (albumin/creatinine ratio)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for microalbumin, albumin/creatinine ratio N[NN].N
<i>Synonymous names:</i>	Albumin/creatinine ratio
<i>METeOR identifier:</i>	270344
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The laboratory standard for the value of microalbumin measured as an albumin/creatinine ratio that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

<i>Representation class:</i>	Ratio				
<i>Data type:</i>	Number				
<i>Format:</i>	N[NN].N				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999.9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	999.9	Not stated/inadequately described
Value	Meaning				
999.9	Not stated/inadequately described				
<i>Unit of measure:</i>	Milligram per millimole (mg/mmol)				
<i>Unit of measure precision:</i>	1				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the microalbumin normal reference range for the laboratory.
<i>Collection methods:</i>	<p>Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.</p> <p>Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.</p> <p>As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate and if the albumin/creatinine ratio is found to be greater than 3.5mg/mmol</p>

then a timed overnight sample should be obtained for estimation of the albumin excretion rate.

Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes [Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.8 KB)

Supersedes [Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)

See also [Person – microalbumin level \(measured\), albumin/creatinine ratio N\[NN\].N](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (micrograms per minute)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for microalbumin, total micrograms per minute N[NN].N
<i>METeOR identifier:</i>	270341
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The laboratory standard for the value of microalbumin measured in micrograms per minute ($\mu\text{g}/\text{min}$), that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[NN].N				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999.9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	999.9	Not stated/inadequately described
Value	Meaning				
999.9	Not stated/inadequately described				
<i>Unit of measure:</i>	Microgram per minute ($\mu\text{g}/\text{min}$)				
<i>Unit of measure precision:</i>	1				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the microalbumin normal reference range for the laboratory.
<i>Collection methods:</i>	<p>Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.</p> <p>Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.</p> <p>As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.</p>

Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group
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Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

Related metadata references:

Supersedes [Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.8 KB)

Supersedes [Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (milligrams per 24 hour)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for microalbumin, total milligrams per 24 hour N[NN].N
<i>METeOR identifier:</i>	270343
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The laboratory standard for the value of microalbumin measured in milligrams per 24 hour, that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[NN].N				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999.9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	999.9	Not stated/inadequately described
Value	Meaning				
999.9	Not stated/inadequately described				
<i>Unit of measure:</i>	Milligram per 24-hour period (mg/24h)				
<i>Unit of measure precision:</i>	1				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the microalbumin normal reference range for the laboratory.
<i>Collection methods:</i>	<p>Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.</p> <p>Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.</p> <p>As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.</p>

Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group
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Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes [Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)

Supersedes [Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.8 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Microalbumin level—upper limit of normal range (milligrams per litre)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for microalbumin, total milligrams per litre N[NN].N
<i>METeOR identifier:</i>	270334
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The laboratory standard for the value of microalbumin measured in milligrams per litre (mg/L), that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range for microalbumin

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[NN].N				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999.9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	999.9	Not stated/inadequately described
Value	Meaning				
999.9	Not stated/inadequately described				
<i>Unit of measure:</i>	Milligram per litre (mg/L)				
<i>Unit of measure precision:</i>	1				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of the microalbumin normal reference range for the laboratory.
<i>Collection methods:</i>	<p>Microalbumin is not detected by reagent strips for urinary proteins, and requires immunoassay.</p> <p>Measurement of microalbumin levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authority.</p> <p>As urinary albumin varies with posture and exercise it is important to collect the urine under very standard conditions; short-term (2 hours) during rest, overnight (approximately 8 hours) or an early morning sample. For screening purposes an early morning urine specimen is adequate.</p>

Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group
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Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes [Microalbumin - units, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)

Supersedes [Microalbumin - upper limit of normal range, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.8 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Minutes of operating theatre time

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Admitted patient hospital stay – operating theatre time, total minutes NNNN
<i>METeOR identifier:</i>	270350
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Total time, in minutes, spent by a patient in operating theatres during current episode of hospitalisation.
Data Element Concept:	Admitted patient hospital stay – operating theatre time

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4
<i>Unit of measure:</i>	Minute (m)

Collection and usage attributes

<i>Collection methods:</i>	Right justified, zero filled.
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Data element attributes

Collection and usage attributes

<i>Comments:</i>	This metadata item was recommended for inclusion in the <i>National Health Data Dictionary</i> by Hindle (1988a, 1988b) to assist with diagnosis related group costing studies in Australia. This metadata item has not been accepted for inclusion in the National Minimum Data Set (NMDS) - Admitted patient care.
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Source and reference attributes

<i>Origin:</i>	Health Data Standards Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Minutes of operating theatre time, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.3 KB)
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Mode of admission

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – admission mode, code N
<i>METeOR identifier:</i>	269976
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The mechanism by which a person begins an episode of care, as represented by a code.
Data Element Concept:	Episode of admitted patient care – admission mode

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Admitted patient transferred from another hospital</td></tr><tr><td>2</td><td>Statistical admission - episode type change</td></tr><tr><td>3</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Admitted patient transferred from another hospital	2	Statistical admission - episode type change	3	Other
Value	Meaning								
1	Admitted patient transferred from another hospital								
2	Statistical admission - episode type change								
3	Other								

Collection and usage attributes

<i>Guide for use:</i>	CODE 2 Statistical admission - episode type change Use this code where a new episode of care is commenced within the same hospital stay. CODE 3 Other Use this code for all planned admissions and unplanned admissions (except transfers into the hospital from another hospital).
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Data element attributes

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Mode of admission, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
<i>Implementation in Data Set Specifications:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded
05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded
04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded
22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Mode of separation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – separation mode, code N
<i>METeOR identifier:</i>	270094
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Status at separation of person (discharge/transfer/death) and place to which person is released, as represented by a code.
Data Element Concept:	Episode of admitted patient care – separation mode

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Discharge/transfer to (an)other acute hospital</td></tr><tr><td>2</td><td>Discharge/transfer to a residential aged care service, unless this is the usual place of residence</td></tr><tr><td>3</td><td>Discharge/transfer to (an)other psychiatric hospital</td></tr><tr><td>4</td><td>Discharge/transfer to other health care accommodation (includes mothercraft hospitals)</td></tr><tr><td>5</td><td>Statistical discharge - type change</td></tr><tr><td>6</td><td>Left against medical advice/discharge at own risk</td></tr><tr><td>7</td><td>Statistical discharge from leave</td></tr><tr><td>8</td><td>Died</td></tr><tr><td>9</td><td>Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))</td></tr></tbody></table>	Value	Meaning	1	Discharge/transfer to (an)other acute hospital	2	Discharge/transfer to a residential aged care service, unless this is the usual place of residence	3	Discharge/transfer to (an)other psychiatric hospital	4	Discharge/transfer to other health care accommodation (includes mothercraft hospitals)	5	Statistical discharge - type change	6	Left against medical advice/discharge at own risk	7	Statistical discharge from leave	8	Died	9	Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))
Value	Meaning																				
1	Discharge/transfer to (an)other acute hospital																				
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3	Discharge/transfer to (an)other psychiatric hospital																				
4	Discharge/transfer to other health care accommodation (includes mothercraft hospitals)																				
5	Statistical discharge - type change																				
6	Left against medical advice/discharge at own risk																				
7	Statistical discharge from leave																				
8	Died																				
9	Other (includes discharge to usual residence, own accommodation/welfare institution (includes prisons, hostels and group homes providing primarily welfare services))																				

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 4 Discharge/transfer to other health care accommodation (includes mothercraft hospitals)</p> <p>In jurisdictions where mothercraft facilities are considered to be acute hospitals, patients separated to a mothercraft facility should have a mode of separation of Code 1. If the residential aged care service is the patient's place of usual residence then they should have a mode of separation of Code 9.</p>
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Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Mode of separation, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.3 KB)

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v 6\) NN](#) Health, Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v 6\) ANNA](#) Health, Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v5.1\) ANNA](#) Health, Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v5.1\) NN](#) Health, Superseded 22/12/2009

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Month and year of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – date of birth, MMYYYY
<i>METeOR identifier:</i>	375191
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The month and year of birth of the person.
Data Element Concept:	Person – date of birth

Value domain attributes

Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	MMYYYY
<i>Maximum character length:</i>	6

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	In some collections data may be reported in DDMMYYYY format. Agencies providing data to other agencies may choose to provide the abbreviated version (MMYYYY) to protect the privacy of respondents.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	National Health Data Committee National Community Services Data Committee
<i>Reference documents:</i>	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

<i>Related metadata references:</i>	See also Person – age, total years N[NN] Health, Standard 08/02/2006, Community services, Standard 29/04/2006, Housing assistance, Standard 10/02/2006 See also Date – accuracy indicator, code AAA Health, Standard 04/05/2005, Community services, Standard 30/09/2005
<i>Implementation in Data Set Specifications:</i>	Registered chiropractic labour force DSS Health, Standard 10/12/2009 Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard 10/12/2009

[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard 10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard 10/12/2009

[Registered psychology labour force DSS](#) Health, Standard 10/12/2009

Morphology of cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – morphology of cancer, code (ICDO-3) NNNN/N
<i>METeOR identifier:</i>	370023
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour), as represented by a code.
Data Element Concept:	Person with cancer – morphology of cancer

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Diseases for Oncology 3rd edition
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNN/N
<i>Maximum character length:</i>	5

Collection and usage attributes

<i>Guide for use:</i>	<p>ICDO morphology describes histology and behaviour as separate variables, recognising that there are a large number of possible combinations.</p> <p>In ICDO, morphology is a 4-digit number ranging from 8000 to 9989, and behaviour is a single digit which can be 0, 1, 2, 3, 6 or 9.</p> <p>Record morphology codes in accordance with ICDO coding standards. Use the 5th-digit to record behaviour. The 5th-digit behaviour code numbers used in ICDO are listed below:</p> <p>0 Benign</p> <p>1 Uncertain whether benign or malignant</p> <ul style="list-style-type: none">• borderline malignancy• low malignant potential <p>2 Carcinoma in situ</p> <ul style="list-style-type: none">• intraepithelial• non-infiltrating• non-invasive <p>3 Malignant, primary site</p> <p>6 Malignant, metastatic site</p> <ul style="list-style-type: none">• malignant, secondary site <p>9 Malignant, uncertain whether primary or metastatic site</p>
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Source and reference attributes

Origin: International Classification of Diseases for Oncology, Third Edition (ICDO-3)

Data element attributes

Collection and usage attributes

Collection methods: Cancer registry use:
Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.
Morphology information should be obtained from a pathology report or pathology system, and recorded with/on the patient's medical record and/or the hospital's patient administration system. Additional information may also be sought from the patient's attending clinician or medical practitioner.
If the morphology differs on multiple pathology reports for the same tumour, use the value from the most representative tumour specimen examined. For example, if tumour is described as ductal on core biopsy but undifferentiated carcinoma on the excision specimen the morphology would be coded as undifferentiated carcinoma (a lower code) which has a less favourable diagnosis.
Hospital morbidity use:
In hospitals, the morphology code is modified for use with ICD-10-AM. The morphology code consists of histologic type (4 digits) and behaviour code (1 digit) ranging from 8000/0 to 9989/9.

Source and reference attributes

Origin: World Health Organization
New South Wales Health Department
State and Territory Cancer Registries

Reference documents: New South Wales Inpatient Statistics Collection Manual, 2000/2001
Esteban D, Whelan S, Laudico A and Parkin DM editors. International Agency for Research on Cancer World Health Organization and International Association of Cancer Registries: Manual for cancer registry personnel. IARC Technical Report No 10. Lyon: IARC,1995

Relational attributes

Related metadata references: Supersedes [Person with cancer – morphology of cancer, code \(ICDO-3\) NNNN/N](#) Health, Superseded 06/03/2009

Implementation in Data Set Specifications: [Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009
[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009
[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Most common service delivery setting

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – most common service delivery setting, code N
<i>METeOR identifier:</i>	297708
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The setting in which the service provider organisation most commonly delivers services, as represented by a code.
Data Element Concept:	Service provider organisation – most common service delivery setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Mostly community-based setting</td></tr><tr><td>2</td><td>Mostly inpatient setting</td></tr><tr><td>3</td><td>Similar proportion in both settings</td></tr></tbody></table>	Value	Meaning	1	Mostly community-based setting	2	Mostly inpatient setting	3	Similar proportion in both settings
Value	Meaning								
1	Mostly community-based setting								
2	Mostly inpatient setting								
3	Similar proportion in both settings								

Collection and usage attributes

<i>Collection methods:</i>	Record only one code.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Mostly community based setting</p> <p>During the past 12 months, more than 60% of service delivery time was estimated to have been spent on delivering services to, and on behalf of, clients in community settings. This includes residential settings such as private residences (including caravans, mobile homes, houseboats or units in a retirement village), residential aged care facilities, prisons, and community living environments (including group homes); and non-residential settings such as day respite centres or day centres. It includes hospital outreach services and outpatient settings where these are delivered in the community setting.</p> <p>CODE 2 Mostly inpatient setting</p> <p>During the past 12 months, more than 60% of service delivery time was estimated to have been spent on delivering services to,</p>
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and on behalf of, clients in inpatient settings. This includes hospitals, hospices or admitted patient settings. It excludes services delivered in outpatient settings and hospital outreach services delivered in the community setting.

CODE 3 Similar level in both settings

During the past 12 months, a similar proportion of service delivery time (between 40-60%) was estimated to have been spent on delivering services in community and inpatient settings.

Collection methods:

Record only one code.

Source and reference attributes

Submitting organisation:

Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

[Palliative care performance indicators DSS](#) Health, Standard 05/12/2007

Most valid basis of diagnosis of cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – most valid basis of diagnosis of a cancer, code N
<i>METeOR identifier:</i>	270181
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The most valid basis of diagnosis of cancer, as represented by a code.
Data Element Concept:	Person with cancer – most valid basis of diagnosis of a cancer

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Death certificate only: Information provided is from a death certificate</td></tr><tr><td>1</td><td>Clinical: Diagnosis made before death, but without any of the following (codes 2-7)</td></tr><tr><td>2</td><td>Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis</td></tr><tr><td>4</td><td>Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site</td></tr><tr><td>5</td><td>Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates</td></tr><tr><td>6</td><td>Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens</td></tr><tr><td>7</td><td>Histology of a primary tumour: Histological examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour</td></tr><tr><td>8</td><td>Histology: either unknown whether of primary or metastatic site, or not otherwise specified</td></tr><tr><td><i>Supplementary values:</i></td><td>9 Unknown.</td></tr></tbody></table>	Value	Meaning	0	Death certificate only: Information provided is from a death certificate	1	Clinical: Diagnosis made before death, but without any of the following (codes 2-7)	2	Clinical investigation: All diagnostic techniques, including x-ray, endoscopy, imaging, ultrasound, exploratory surgery (e.g. laparotomy), and autopsy, without a tissue diagnosis	4	Specific tumour markers: Including biochemical and/or immunological markers that are specific for a tumour site	5	Cytology: Examination of cells from a primary or secondary site, including fluids aspirated by endoscopy or needle; also includes the microscopic examination of peripheral blood and bone marrow aspirates	6	Histology of metastasis: Histological examination of tissue from a metastasis, including autopsy specimens	7	Histology of a primary tumour: Histological examination of tissue from primary tumour, however obtained, including all cutting techniques and bone marrow biopsies; also includes autopsy specimens of primary tumour	8	Histology: either unknown whether of primary or metastatic site, or not otherwise specified	<i>Supplementary values:</i>	9 Unknown.
Value	Meaning																				
0	Death certificate only: Information provided is from a death certificate																				
1	Clinical: Diagnosis made before death, but without any of the following (codes 2-7)																				
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8	Histology: either unknown whether of primary or metastatic site, or not otherwise specified																				
<i>Supplementary values:</i>	9 Unknown.																				

Collection and usage attributes

Guide for use:

CODES 1 - 4

Non-microscopic.

CODES 5 - 8

Microscopic.

CODE 9

Other.

Comments:

In a hospital setting this metadata item should be collected on the most valid basis of diagnosis at this admission. If more than one diagnosis technique is used during an admission, select the higher code from 1 to 8.

Data element attributes

Collection and usage attributes

Guide for use:

The most valid basis of diagnosis may be the initial histological examination of the primary site, or it may be the post-mortem examination (sometimes corrected even at this point when histological results become available). In a cancer registry setting, this metadata item should be revised if later information allows its upgrading.

When considering the most valid basis of diagnosis, the minimum requirement of a cancer registry is differentiation between neoplasms that are verified microscopically and those that are not. To exclude the latter group means losing valuable information; the making of a morphological (histological) diagnosis is dependent upon a variety of factors, such as age, accessibility of the tumour, availability of medical services, and, last but not least, upon the beliefs of the patient.

A biopsy of the primary tumour should be distinguished from a biopsy of a metastasis, e.g., at laparotomy; a biopsy of cancer of the head of the pancreas versus a biopsy of a metastasis in the mesentery. However, when insufficient information is available, Code 8 should be used for any histological diagnosis. Cytological and histological diagnoses should be distinguished.

Morphological confirmation of the clinical diagnosis of malignancy depends on the successful removal of a piece of tissue that is cancerous. Especially when using endoscopic procedures (bronchoscopy, gastroscopy, laparoscopy, etc.), the clinician may miss the tumour with the biopsy forceps. These cases must be registered on the basis of endoscopic diagnosis and not excluded through lack of a morphological diagnosis.

Care must be taken in the interpretation and subsequent coding of autopsy findings, which may vary as follows:

- a) the post-mortem report includes the post-mortem histological diagnosis (in which case, one of the Histology codes should be recorded instead);
- b) the autopsy is macroscopic only, histological investigations

having been carried out only during life (in which case, one of the Histology codes should be recorded instead);

c) the autopsy findings are not supported by any histological diagnosis.

Source and reference attributes

Origin:

International Agency for Research on Cancer

International Association of Cancer Registries

Relational attributes

Related metadata references:

Supersedes [Most valid basis of diagnosis of cancer, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (47.0 KB)

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Mother's original family name

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – mother's original family name, text [X(40)]
<i>METeOR identifier:</i>	270262
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	The original family name of the person's mother as reported by the person, as represented by text.
Data Element Concept:	Person – mother's original family name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(40)]
<i>Maximum character length:</i>	40

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Mixed case should be used (rather than upper case only).
<i>Collection methods:</i>	See relevant paragraphs in the collection methods section of the metadata item Person (name) – family name, text X[X(39)].

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	National Health Data Committee National Community Services Data Committee Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

<i>Related metadata references:</i>	Supersedes Mother's original family name, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
<i>Implementation in Data Set Specifications:</i>	Health care client identification Health, Superseded 04/05/2005 Health care client identification DSS Health, Superseded 03/12/2008 Health care client identification DSS Health, Standard 03/12/2008

Multi-disciplinary team status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient service event – multi-disciplinary team status, code N
<i>METeOR identifier:</i>	270104
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether a non-admitted patient service event involved a multi-disciplinary team, as represented by a code.
Data Element Concept:	Non-admitted patient service event – multi-disciplinary team status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Non-admitted multi-disciplinary team patient service event</td></tr><tr><td>2</td><td>Other non-admitted patient service event</td></tr></tbody></table>	Value	Meaning	1	Non-admitted multi-disciplinary team patient service event	2	Other non-admitted patient service event
Value	Meaning						
1	Non-admitted multi-disciplinary team patient service event						
2	Other non-admitted patient service event						

Data element attributes

Relational attributes

<i>Related metadata references:</i>	Supersedes Multi-disciplinary team status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)
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Myocardial infarction (history)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – myocardial infarction (history), code N
<i>METeOR identifier:</i>	270285
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether the individual has had a myocardial infarction, as represented by a code.
Data Element Concept:	Person – myocardial infarction

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Myocardial infarction - occurred in the last 12 months</td></tr><tr><td>2</td><td>Myocardial infarction - occurred prior to the last 12 months</td></tr><tr><td>3</td><td>Myocardial infarction - occurred both in and prior to the last 12 months</td></tr><tr><td>4</td><td>No history of myocardial infarction</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Myocardial infarction - occurred in the last 12 months	2	Myocardial infarction - occurred prior to the last 12 months	3	Myocardial infarction - occurred both in and prior to the last 12 months	4	No history of myocardial infarction	9	Not stated/inadequately described
Value	Meaning												
1	Myocardial infarction - occurred in the last 12 months												
2	Myocardial infarction - occurred prior to the last 12 months												
3	Myocardial infarction - occurred both in and prior to the last 12 months												
4	No history of myocardial infarction												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Ask the individual if he/she has had a myocardial infarction. If so determine whether it was within or prior to the last 12 months (or both). Record if evidenced by ECG changes or plasma enzyme changes. Alternatively obtain this information from appropriate documentation.
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Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.
<i>Reference documents:</i>	Long-term Results From the Diabetes and Insulin-Glucose Infusion in Acute Myocardial Infarction (DIGAMI) Study Circulation. 1999;99: 2626-2632.

Relational attributes

Related metadata references:

Supersedes [Myocardial infarction - history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.7 KB)

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Name context flag

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (name) – name conditional use flag, code N
<i>Synonymous names:</i>	Name conditional use flag
<i>METeOR identifier:</i>	287101
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
<i>Definition:</i>	An indicator of specific conditions that may be applied to an individual's name, as represented by a code.
Data Element Concept:	Person (name) – name conditional use flag

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Unreliable information</td></tr><tr><td>2</td><td>Name not for continued use</td></tr><tr><td>3</td><td>Special privacy/security requirement</td></tr></tbody></table>	Value	Meaning	1	Unreliable information	2	Name not for continued use	3	Special privacy/security requirement
Value	Meaning								
1	Unreliable information								
2	Name not for continued use								
3	Special privacy/security requirement								

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A single Person name may have multiple Name conditional use flags associated with it. Record as many as applicable.</p> <p>CODE 1 Unreliable information: should be used where it is known that the name recorded is a fictitious or partial name. These names should not be used for matching client data.</p> <p>CODE 2 Name not for continued use, indicates that this name should NOT be used when referring to this person. The name is retained for identification purposes only. For Aboriginal and Torres Strait Islanders, certain tribal names may become 'not for continued use' due to the death of a relative.</p> <p>CODE 3 Special privacy/security requirements- may apply to names for which episodes are attached that should only be accessible to specified authorised persons. There must be a specific need to implement this additional security level. Local policy should provide guidance to the use of this code.</p>
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Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee
National Community Services Data Committee
Standards Australia 2002. Australian Standard AS5017-2002
Health Care Client Identification. Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

Relational attributes

Related metadata references: Supersedes [Person \(name\) – name context flag, code N](#) Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications: [Health care client identification DSS](#) Health, Superseded 03/12/2008
[Health care client identification DSS](#) Health, Standard 03/12/2008
[Health care provider identification DSS](#) Health, Superseded 04/07/2007
[Health care provider identification DSS](#) Health, Superseded 03/12/2008
[Health care provider identification DSS](#) Health, Standard 03/12/2008

Name suffix

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (name) – name suffix, text [A(12)]
<i>METeOR identifier:</i>	287164
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
<i>Definition:</i>	Additional term following a person's name used to identify a person when addressing them by name, whether by mail, by phone, or in person, as represented by text.
Data Element Concept:	Person (name) – name suffix

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(12)]
<i>Maximum character length:</i>	12

Collection and usage attributes

<i>Guide for use:</i>	Valid abbreviations from the Australian Standard AS4590-1999 Interchange of client information.
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Source and reference attributes

<i>Origin:</i>	Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Mixed case should be used (rather than upper case only). Examples of name suffixes are 'Jr' for Junior and 'MP' for Member of Parliament.
<i>Collection methods:</i>	A person's name may have multiple Name suffixes. For the purpose of positive identification of a person, each Name suffix must have an associated Name suffix sequence number recorded.

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	National Health Data Committee National Community Services Data Committee

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes [Person \(name\) – name suffix, text \[A\(12\)\]](#) Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Name suffix sequence number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (name) – name suffix sequence number, code N
<i>METeOR identifier:</i>	288226
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The numeric order of any additional terms used at the conclusion of a name, as represented by a code.
Data Element Concept:	Person (name) – name suffix sequence number

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>First name suffix</td></tr><tr><td>2</td><td>Second name suffix</td></tr><tr><td>3</td><td>Third name suffix</td></tr><tr><td>4</td><td>Fourth name suffix</td></tr><tr><td>5</td><td>Fifth name suffix</td></tr><tr><td>6</td><td>Sixth name suffix</td></tr><tr><td>7</td><td>Seventh name suffix</td></tr><tr><td>8</td><td>Eighth name suffix</td></tr><tr><td>9</td><td>Ninth and subsequent name suffix</td></tr></tbody></table>	Value	Meaning	1	First name suffix	2	Second name suffix	3	Third name suffix	4	Fourth name suffix	5	Fifth name suffix	6	Sixth name suffix	7	Seventh name suffix	8	Eighth name suffix	9	Ninth and subsequent name suffix
Value	Meaning																				
1	First name suffix																				
2	Second name suffix																				
3	Third name suffix																				
4	Fourth name suffix																				
5	Fifth name suffix																				
6	Sixth name suffix																				
7	Seventh name suffix																				
8	Eighth name suffix																				
9	Ninth and subsequent name suffix																				

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Multiple Name suffixes may be recorded. A Name suffix sequence number must be recorded for each Name suffix. Example: For the name 'John Markham Jr MP', 'Jr' would have a name suffix sequence number of 1 and 'MP' would have a name suffix sequence number of 2.
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Name title

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (name) – name title, text [A(12)]
<i>METeOR identifier:</i>	287166
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
<i>Definition:</i>	An honorific form of address, commencing a name, used when addressing a person by name, whether by mail, by phone, or in person, as represented by text.
Data Element Concept:	Person (name) – name title

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	A(12)
<i>Maximum character length:</i>	12

Collection and usage attributes

<i>Guide for use:</i>	Valid abbreviations from the Australian Standard AS4590-1999 Interchange of client information.
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Source and reference attributes

<i>Origin:</i>	Standards Australia 1999. Australian Standard AS4590-1999 Interchange of Client Information. Sydney: Standards Australia Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Mixed case should be used (rather than upper case only). The Name title for Master should only be used for persons less than 15 years of age. Name titles for Doctor and Professor should only be applicable to persons of greater than 20 years of age. More than one Name title may be recorded e.g. Prof Sir John Markham.
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
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Origin: National Health Data Committee
National Community Services Data Committee
Standards Australia 1999. Australian Standard AS4590-1999
Interchange of Client Information. Sydney: Standards Australia
Standards Australia 2002. Australian Standard AS5017-2002
Health Care Client Identification. Sydney: Standards Australia

Reference documents: AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

Relational attributes

Related metadata references: Supersedes [Person \(name\) – name title, text \[A\(12\)\]](#) Health,
Superseded 04/05/2005, Community services, Superseded
25/08/2005

Implementation in Data Set Specifications: [Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Name title sequence number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (name) – name title sequence number, code N
<i>METeOR identifier:</i>	288263
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The numeric order of an honorific form of address commencing a person's name, as represented by a code.
Data Element Concept:	Person (name) – name title sequence number

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>First name title</td></tr><tr><td>2</td><td>Second name title</td></tr><tr><td>3</td><td>Third name title</td></tr><tr><td>4</td><td>Fourth name title</td></tr><tr><td>5</td><td>Fifth name title</td></tr><tr><td>6</td><td>Sixth name title</td></tr><tr><td>7</td><td>Seventh name title</td></tr><tr><td>8</td><td>Eighth name title</td></tr><tr><td>9</td><td>Ninth and subsequent name title</td></tr></tbody></table>	Value	Meaning	1	First name title	2	Second name title	3	Third name title	4	Fourth name title	5	Fifth name title	6	Sixth name title	7	Seventh name title	8	Eighth name title	9	Ninth and subsequent name title
Value	Meaning																				
1	First name title																				
2	Second name title																				
3	Third name title																				
4	Fourth name title																				
5	Fifth name title																				
6	Sixth name title																				
7	Seventh name title																				
8	Eighth name title																				
9	Ninth and subsequent name title																				

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Multiple Name titles may be recorded. For the purpose of positive identification of a person, each Name title must have a Name title sequence number recorded. Example: Professor Sir John Markham In the example above 'Professor' would have a name title sequence number of 1 and 'Sir' would have a name title sequence number of 2.
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
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Origin:

AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

Relational attributes

*Implementation in Data Set
Specifications:*

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Name type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (name) – name type, code N
<i>METeOR identifier:</i>	287203
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A classification that enables differentiation between recorded names for a person, as represented by a code.
Data Element Concept:	Person (name) – name type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Preferred name</td></tr><tr><td>2</td><td>Medicare name</td></tr><tr><td>3</td><td>Newborn name</td></tr><tr><td>4</td><td>Alias name</td></tr></tbody></table>	Value	Meaning	1	Preferred name	2	Medicare name	3	Newborn name	4	Alias name
Value	Meaning										
1	Preferred name										
2	Medicare name										
3	Newborn name										
4	Alias name										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A person may have more than one name that they use. At least one name must be recorded for each person. Each name recorded must have one or more appropriate Person name type associated with it. Record all that are required.</p> <p>One name is sufficient; however, where the person offers more than one name, clarification should be obtained from the person to ensure accurate identification of the person and recording of the various names. The currently used name, as well as names by which the person has previously been known, should be recorded if these are known.</p> <p>Field value definitions for Person name type codes are:</p> <p>CODE 1 Preferred name is the name by which the person chooses to be identified.</p> <p>There should only be one preferred name recorded for a person. Where the person changes their preferred name, record the previously recorded preferred name as an Alias name. Preferred name is the default name type (i.e. if only one name is recorded it</p>
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should be the person's preferred name). There must be a preferred name recorded except for unnamed newborns where the newborn name is the only name recorded.

Also, if the person is a health care client, record his/her Medicare card name if different to the preferred name, and any known alias names.

CODE 2 Medicare name for a health care client, this is the person's name as it appears on their Medicare card. The name stated on the Medicare card is required for all electronic Medicare claim lodgement. If the preferred name of the person is different to the name on the Medicare card, the Medicare card name should also be recorded. For an individual health care provider, this is the person's name registered by Medicare (Health Insurance Commission).

CODE 3 Newborn name: type is reserved for the identification of unnamed newborn babies.

CODE 4 Alias name is any other name that a person is also known by, or has been known by in the past; that is, all alias names. This includes misspelt names or name variations that are to be retained as they have been used to identify this person. More than one alias name may be recorded for a person.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

National Health Data Committee

National Community Services Data Committee

AS5017 Health Care Client Identification, 2002, Sydney:
Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

In AS5017 and AS4846 alternative alphabetic codes are presented. Refer to the current standard for more details.

Relational attributes

Related metadata references:

Supersedes [Person \(name\) – name type, code A](#) Health,
Superseded 04/05/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Name type (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (name) – name type, code N
<i>METeOR identifier:</i>	288937
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A classification that enables differentiation between recorded names for an establishment, agency or organisation, as represented by a code.
Data Element Concept:	Service provider organisation (name) – name type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	N																		
<i>Maximum character length:</i>	1																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Organisation unit/section/division</td></tr><tr><td>2</td><td>Service location name</td></tr><tr><td>3</td><td>Business name</td></tr><tr><td>4</td><td>Locally used name</td></tr><tr><td>5</td><td>Abbreviated name</td></tr><tr><td>6</td><td>Enterprise name</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Unknown</td></tr></tbody></table>	Value	Meaning	1	Organisation unit/section/division	2	Service location name	3	Business name	4	Locally used name	5	Abbreviated name	6	Enterprise name	8	Other	9	Unknown
Value	Meaning																		
1	Organisation unit/section/division																		
2	Service location name																		
3	Business name																		
4	Locally used name																		
5	Abbreviated name																		
6	Enterprise name																		
8	Other																		
9	Unknown																		
<i>Supplementary values:</i>																			

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Organisation unit/section/division This code is used where a business unit, section or division within an organisation may have its own separate identity.</p> <p>CODE 2 Service location name This code is used where the service location name is an important part of the organisation name and is used for identification purposes, e.g. Mobile Immunisation Unit at Bankstown.</p> <p>CODE 3 Business name Business name used only for trading purposes.</p> <p>CODE 4 Locally used name This code is used where a local name is used, e.g. where a medical practice is known by a name that is different to the company registration name or business name.</p>
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CODE 5 Abbreviated name

A short name or an abbreviated name by which the organisation is known, e.g. HIC.

CODE 6 Enterprise name

Generally, the complete organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name.

CODE 8 Other

This code is used when the organisation name does not fit into any one of the categories listed above.

CODE 9 Unknown

This code is used when the organisation name type is unknown.

Data element attributes

Collection and usage attributes

Guide for use:

At least one organisation name must be recorded for each organisation and each name must have an appropriate Organisation name type.

Relational attributes

Implementation in Data Set Specifications:

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Narrative description of injury event

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Injury event – external cause, text [X(100)]
<i>METeOR identifier:</i>	268946
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A textual description of the environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect.
Data Element Concept:	Injury event – external cause

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(100)]
<i>Maximum character length:</i>	100

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Write a brief description of how the injury occurred. It should indicate what went wrong (the breakdown event); the mechanism by which this event led to injury; and the object(s) or substance(s) most important in the event. The type of place at which the event occurred, and the activity of the person who was injured should be indicated.
<i>Comments:</i>	<p>The narrative of the injury event is very important to injury control workers as it identifies features of the event not revealed by coded data.</p> <p>This is a basic item for injury surveillance. The text description of the injury event is structured to indicate context, place, what went wrong and how the event resulted in injury. Further information on the national injury surveillance program can be obtained from the National Injury Surveillance Unit, Flinders University, Adelaide.</p>

Source and reference attributes

<i>Submitting organisation:</i>	National Injury Surveillance Unit, Flinders University, Adelaide
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Relational attributes

<i>Related metadata references:</i>	Supersedes Narrative description of injury event, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
<i>Implementation in Data Set</i>	Injury surveillance DSS Health, Superseded 05/02/2008

Specifications:

[Injury surveillance DSS](#) Health, Superseded 14/12/2009

[Injury surveillance DSS](#) Health, Standard 14/12/2009

[Injury surveillance NMDS](#) Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Injury surveillance NMDS](#) Health, Superseded 07/12/2005

National standards for mental health services review status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service unit – implementation of National standards for mental health services status, code N
<i>METeOR identifier:</i>	287800
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The extent of progress made by a specialised mental health service unit in implementing the National Standards for Mental Health Services by or at 30 June, as represented by a code.
Data Element Concept:	Specialised mental health service unit – implementation of National standards for mental health services status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>The service unit had been reviewed by an external accreditation agency and was judged to have met the National standards</td></tr><tr><td>2</td><td>The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the National standards</td></tr><tr><td>3</td><td>The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known</td></tr><tr><td>4</td><td>The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review</td></tr><tr><td>5</td><td>The service unit was engaged in self-assessment in relation to the National Standards but did not have a contractual arrangement with an external accreditation agency for review</td></tr><tr><td>6</td><td>The service unit had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future</td></tr><tr><td>7</td><td>It had not been resolved whether the service unit would undertake review by an external accreditation agency under the National standards</td></tr></tbody></table>	Value	Meaning	1	The service unit had been reviewed by an external accreditation agency and was judged to have met the National standards	2	The service unit had been reviewed by an external accreditation agency and was judged to have met some but not all of the National standards	3	The service unit was in the process of being reviewed by an external accreditation agency but the outcomes were not known	4	The service unit was booked for review by an external accreditation agency and was engaged in self-assessment preparation prior to the formal external review	5	The service unit was engaged in self-assessment in relation to the National Standards but did not have a contractual arrangement with an external accreditation agency for review	6	The service unit had not commenced the preparations for review by an external accreditation agency but this was intended to be undertaken in the future	7	It had not been resolved whether the service unit would undertake review by an external accreditation agency under the National standards
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7	It had not been resolved whether the service unit would undertake review by an external accreditation agency under the National standards																

8 The National standards are not applicable to this service unit

Collection and usage attributes

Guide for use:

Code 8 The National standards are not applicable to this service unit

This code should only be used for:

- non-government organisation mental health services and private hospitals (that receive some government funding to provide specialised mental health services) where implementation of National standards for mental health services has not been agreed with the relevant state or territory; or
- those aged care residential services (e.g. psychogeriatric nursing homes) in receipt of funding under the *Aged Care Act* and subject to Commonwealth residential aged care reporting and service standards requirements.

Data element attributes

Collection and usage attributes

Collection methods:

Report the review/accreditation status at 30 June for each service unit for the National standards for mental health services using the standard set of codes shown in the value domain.

For organisations that include more than one service unit the codes relating to each service should be completed. Reporting of progress at the individual service unit level recognises that parts rather than whole organisations may be implementing the standards.

NOTE: for admitted patient setting only, these data need to be disaggregated by specialised mental health service program type and specialised mental health service target population.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Nature of main injury (non-admitted patient)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Injury event – nature of main injury, non-admitted patient code NN{.N}
<i>METeOR identifier:</i>	268947
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The nature of the injury chiefly responsible for the attendance of the non-admitted patient at the health care facility, at represented by a code.
Data Element Concept:	Injury event – nature of main injury

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																				
<i>Data type:</i>	String																																				
<i>Format:</i>	NN{.N}																																				
<i>Maximum character length:</i>	4																																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Superficial (excludes eye injury code 13)</td></tr><tr><td>02</td><td>Open wound (excludes eye injury code 13)</td></tr><tr><td>03</td><td>Fracture (excludes dental injury code 21)</td></tr><tr><td>04</td><td>Dislocation (includes ruptured disc, cartilage, ligament)</td></tr><tr><td>05</td><td>Sprain or strain</td></tr><tr><td>06</td><td>Injury to nerve (includes spinal cord; excludes intracranial injury code 20)</td></tr><tr><td>07</td><td>Injury to blood vessel</td></tr><tr><td>08</td><td>Injury to muscle or tendon</td></tr><tr><td>09</td><td>Crushing injury</td></tr><tr><td>10</td><td>Traumatic amputation (includes partial amputation)</td></tr><tr><td>11</td><td>Injury to internal organ</td></tr><tr><td>12</td><td>Burn or corrosion (excludes eye injury code 13)</td></tr><tr><td>13</td><td>Eye injury (includes burns, excludes foreign body in external eye code 14.1)</td></tr><tr><td>14.1</td><td>Foreign body in external eye</td></tr><tr><td>14.2</td><td>Foreign body in ear canal</td></tr><tr><td>14.3</td><td>Foreign body in nose</td></tr><tr><td>14.4</td><td>Foreign body in respiratory tract (excludes foreign body in nose code 14.3)</td></tr></tbody></table>	Value	Meaning	01	Superficial (excludes eye injury code 13)	02	Open wound (excludes eye injury code 13)	03	Fracture (excludes dental injury code 21)	04	Dislocation (includes ruptured disc, cartilage, ligament)	05	Sprain or strain	06	Injury to nerve (includes spinal cord; excludes intracranial injury code 20)	07	Injury to blood vessel	08	Injury to muscle or tendon	09	Crushing injury	10	Traumatic amputation (includes partial amputation)	11	Injury to internal organ	12	Burn or corrosion (excludes eye injury code 13)	13	Eye injury (includes burns, excludes foreign body in external eye code 14.1)	14.1	Foreign body in external eye	14.2	Foreign body in ear canal	14.3	Foreign body in nose	14.4	Foreign body in respiratory tract (excludes foreign body in nose code 14.3)
Value	Meaning																																				
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14.2	Foreign body in ear canal																																				
14.3	Foreign body in nose																																				
14.4	Foreign body in respiratory tract (excludes foreign body in nose code 14.3)																																				

14.5	Foreign body in alimentary tract
14.6	Foreign body in genitourinary tract
14.7	Foreign body in soft tissue
14.9	Foreign body, other/ unspecified
20	Intracranial injury (includes concussion)
21	Dental injury (includes fractured tooth)
22	Drowning, immersion
23	Asphyxia or other threat to breathing (excludes drowning immersion code 22)
24	Electrical injury
25	Poisoning, toxic effect (excludes effect of venom, or any insect bite code 26)
26	Effect of venom, or any insect bite
27	Other specified nature of injury
28	Injury of unspecified nature
29	Multiple injuries of more than one 'nature'
30	No injury detected

Data element attributes

Collection and usage attributes

Guide for use:

If the full ICD-10-AM code is used to code the injury, this metadata item is not required (see metadata items principal diagnosis and additional diagnosis) When coding to the full ICD-10-AM code is not possible, use this metadata item with the items external cause of injury-non admitted patient, external cause of injury-human intent and bodily location of main injury.

Select the code which best characterises the nature of the injury chiefly responsible for the attendance, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. A major injury, if present, should always be coded rather than a minor injury. If a major injury has been sustained (e.g. a fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general guide, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as 'minor'.

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

Comments:

Injury diagnosis is necessary for purposes including epidemiological research, casemix studies and planning. This metadata item together with the metadata item bodily location of the main injury indicates the diagnosis.

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

Source and reference attributes

Submitting organisation: National Injury Surveillance Unit, Flinders University, Adelaide
National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: See also [Person – bodily location of main injury, code NN](#) Health, Standard 01/03/2005

Supersedes [Nature of main injury - non-admitted patient, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.3 KB)

Implementation in Data Set Specifications:

[Injury surveillance DSS](#) Health, Superseded 05/02/2008

[Injury surveillance DSS](#) Health, Superseded 14/12/2009

[Injury surveillance DSS](#) Health, Standard 14/12/2009

[Injury surveillance NMDS](#) Health, Superseded 03/05/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Injury surveillance NMDS](#) Health, Superseded 07/12/2005

Neo-adjuvant therapy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – neoadjuvant therapy indicator, code N
<i>METeOR identifier:</i>	370014
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	Whether a person with a solid tumour has received neoadjuvant therapy, as represented by a code.
Data Element Concept:	Person with cancer – neoadjuvant therapy indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>To be reported when therapy is received after a diagnosis of cancer and prior to primary surgical treatment.</p> <p>This data item is used to flag cases in which tumour descriptors, for example solid tumour size, may be inaccurate due to shrinkage from neoadjuvant therapy.</p> <p>Yes - indicates that the client has received neo-adjuvant therapy after a diagnosis of cancer and prior to primary surgical treatment</p> <p>No - indicates that the client did not receive neo-adjuvant therapy after a diagnosis of cancer and prior to primary surgical treatment</p> <p>For invasive breast cancer:</p> <p>Information is obtained from</p> <ul style="list-style-type: none">• Clinical notes on pathology report mentions that patient underwent chemotherapy prior to surgery• Microscopy section of pathology report describes tumour changes as a result of neoadjuvant therapy (coder may be alerted to look for this detail by a long interval between biopsy and wider excision)
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- Hospital notification indicates that admission is for chemotherapy only (and admission date is before that for surgery)

Comments:

Preoperative chemotherapy and/or radiotherapy may be received after a diagnosis of cancer but before surgical treatment.

The effects of chemotherapy and/or radiotherapy prior to surgery will shrink the tumour and so the size of the tumour found from the subsequent surgical excision will be smaller than the original size of the tumour at the time of diagnosis. This impacts on the TNM-T and staging classification, and is important to take into account for analysis and research.

Source and reference attributes

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

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

Neonatal morbidity

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Admitted patient (neonate) – neonatal morbidity, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	391332
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	Conditions or diseases of the baby, as represented by an ICD-10-AM code.
Data Element Concept:	Admitted patient (neonate) – neonatal morbidity

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Collection and usage attributes

<i>Guide for use:</i>	Conditions should be coded within chapter of Volume 1, ICD-10-AM.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	There is no arbitrary limit on the number of conditions specified.
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Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Admitted patient (neonate) – neonatal morbidity, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009
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Net capital expenditure (accrual accounting)—buildings and building services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – net capital expenditure (accrual accounting) (buildings and building services) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	269969
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Net capital expenditure, measured in Australian dollars, on buildings and building services (including plant).
<i>Data Element Concept:</i>	Establishment – net capital expenditure (accrual accounting) (buildings and building services)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)— constructions

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment—net capital expenditure (accrual accounting) (constructions) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270531
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Net capital expenditure, measured in Australian dollars, on constructions (other than buildings).
<i>Data Element Concept:</i>	Establishment—net capital expenditure (accrual accounting) (constructions)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health,

Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—equipment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – net capital expenditure (accrual accounting) (equipment) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270534
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Net capital expenditure, measured in Australian dollars, on equipment.
<i>Data Element Concept:</i>	Establishment – net capital expenditure (accrual accounting) (equipment)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—information technology

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – net capital expenditure (accrual accounting) (information technology) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270529
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Net capital expenditure, measured in Australian dollars, on information technology.
Data Element Concept:	Establishment – net capital expenditure (accrual accounting) (information technology)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—intangible assets

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – net capital expenditure (accrual accounting) (intangible assets) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270535
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Net capital expenditure, measured in Australian dollars, on intangible assets.
Data Element Concept:	Establishment – net capital expenditure (accrual accounting) (intangible assets)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—land

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – net capital expenditure (accrual accounting) (land) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270536
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Net capital expenditure, measured in Australian dollars, on land.
<i>Data Element Concept:</i>	Establishment – net capital expenditure (accrual accounting) (land)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—major medical equipment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – net capital expenditure (accrual accounting) (major medical equipment) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270530
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Net capital expenditure, measured in Australian dollars, on major medical equipment.
<i>Data Element Concept:</i>	Establishment – net capital expenditure (accrual accounting) (major medical equipment)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—other equipment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – net capital expenditure (accrual accounting) (other equipment) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270533
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Net capital expenditure, measured in Australian dollars, on other equipment, such as furniture, art objects, professional instruments and containers.
Data Element Concept:	Establishment – net capital expenditure (accrual accounting) (other equipment)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Net capital expenditure (accrual accounting)—transport

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – net capital expenditure (accrual accounting) (transport) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270532
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Net capital expenditure measured in Australian dollars on transport.
Data Element Concept:	Establishment – net capital expenditure (accrual accounting) (transport)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Round to nearest dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Capital expenditure - net (accrual accounting), version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.2 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

New/repeat status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient service event – new/repeat status, code N
<i>METeOR identifier:</i>	270348
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether a non-admitted patient service event is for a new problem not previously addressed at the same clinical service or for a repeat service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event – new/repeat service event status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>New non-admitted patient service event</td></tr><tr><td>2</td><td>Repeat non-admitted patient service event</td></tr></tbody></table>	Value	Meaning	1	New non-admitted patient service event	2	Repeat non-admitted patient service event
Value	Meaning						
1	New non-admitted patient service event						
2	Repeat non-admitted patient service event						

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 New non-admitted patient service event: New service events occur as each type of clinical service makes their full assessment consultation with the patient.</p> <p>CODE 2 Repeat non-admitted patient service event: Repeat visits include completion of an ambulatory procedure e.g. removal of sutures and removal of plaster casts.</p>
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Data element attributes

Relational attributes

<i>Related metadata references:</i>	Supersedes New/repeat status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
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Non-Australian state/province (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – non-Australian state/ province, text [X(40)]
<i>Synonymous names:</i>	International state/ province
<i>METeOR identifier:</i>	288648
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of a person, as represented by text.
Data Element Concept:	Person (address) – non-Australian state/ province

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(40)]
<i>Maximum character length:</i>	40

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The name of the state or territory or province should be recorded using the standard ASCII character set and should be done so in accordance with the official conventions of the country, for example, Hunan rather than Chinese characters.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare Standard Australia
<i>Origin:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Health care client identification DSS Health, Superseded 03/12/2008 Health care client identification DSS Health, Standard 03/12/2008 Health care provider identification DSS Health, Superseded 04/07/2007
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[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Non-Australian state/province (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – non-Australian state/province, text [X(40)]
<i>METeOR identifier:</i>	288636
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country that is associated with the address of an establishment, as represented by text.
Data Element Concept:	Service provider organisation (address) – non-Australian state/province

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(40)]
<i>Maximum character length:</i>	40

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The name of the state or territory or province should be recorded using the standard ASCII character set and should be done so in accordance with the official conventions of the country.
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Non-instrumented bleeding location

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with acute coronary syndrome – bleeding location, non-instrumented code N(N)
<i>Synonymous names:</i>	Non-instrumented bleeding site
<i>METeOR identifier:</i>	372012
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The location of the person's bleeding episode, arising from a non-instrumented site, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome – bleeding location

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	N[N]																		
<i>Maximum character length:</i>	2																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Gastrointestinal site</td></tr><tr><td>2</td><td>Genitourinary site</td></tr><tr><td>3</td><td>Intracranial site</td></tr><tr><td>4</td><td>Pulmonary site</td></tr><tr><td>5</td><td>Pericardial site</td></tr><tr><td>6</td><td>Other site(s)</td></tr><tr><td>7</td><td>Unidentified site</td></tr><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Gastrointestinal site	2	Genitourinary site	3	Intracranial site	4	Pulmonary site	5	Pericardial site	6	Other site(s)	7	Unidentified site	99	Not stated/inadequately described
Value	Meaning																		
1	Gastrointestinal site																		
2	Genitourinary site																		
3	Intracranial site																		
4	Pulmonary site																		
5	Pericardial site																		
6	Other site(s)																		
7	Unidentified site																		
99	Not stated/inadequately described																		
<i>Supplementary values:</i>																			

Collection and usage attributes

<i>Guide for use:</i>	<p>NOTE: Excludes bleeding arising from instrumented sites.</p> <p>CODE 1 Gastrointestinal site Use this code when the person's spontaneous bleeding is originating from the gastrointestinal area.</p> <p>CODE 2 Genitourinary site Use this code when the person's spontaneous bleeding is originating from the genitourinary area.</p> <p>CODE 3 Intracranial site Use this code when the person's spontaneous bleeding is originating from an intracranial site.</p> <p>CODE 4 Pulmonary site Use this code when the person's spontaneous bleeding is originating from a pulmonary site.</p>
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CODE 5 Pericardial site

Use this code when the person's spontaneous bleeding is originating from the pericardium.

CODE 6 Other site(s)

Use this code when the person's spontaneous bleeding is originating from a site not listed in codes 1-5.

CODE 7 Unidentified site

Use this code when the person has a fall in haemoglobin without an identifiable spontaneous site of bleeding.

CODE 99 Not stated/inadequately described

Not for use in primary data collections.

Data element attributes

Collection and usage attributes

Guide for use:

Record the location of all bleeding events that occur. More than one code can be applied.

Relational attributes

Related metadata references:

See also [Person with acute coronary syndrome – bleeding location, instrumented code N\(N\)](#) Health, Standard 01/10/2008

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Number of caesarean sections

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female – number of caesarean sections, total count N[N]
<i>METeOR identifier:</i>	297820
<i>Registration status:</i>	Health, Standard 29/11/2006
<i>Definition:</i>	The total number of previous caesarean sections performed on the woman.
Data Element Concept:	Female – number of caesarean sections

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N]				
<i>Maximum character length:</i>	2				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99</td><td>Not stated/Inadequately described</td></tr></tbody></table>	Value	Meaning	99	Not stated/Inadequately described
Value	Meaning				
99	Not stated/Inadequately described				
<i>Unit of measure:</i>	Caesarean sections				

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	In the case of multiple births, count the number of operations the mother has had, rather than the number of babies born. Exclude the current birth if by caesarean section. Record as 0 if no previous caesarean sections.
<i>Comments:</i>	Previous caesarean sections are associated with a higher risk of obstetric complications, and when used with other indicators provides important information on the quality of obstetric care.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Number of contacts—psychiatric outpatient clinic/day program

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Patient—number of psychiatric outpatient clinic/day program attendances (financial year), total days N[NN]
<i>METeOR identifier:</i>	270121
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Number of days that a patient attended a psychiatric outpatient clinic or a day program during the relevant financial year.
Data Element Concept:	Patient—number of psychiatric outpatient clinic/day program attendances

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	All States and Territories where there are public psychiatric hospitals also collect date of contact, and number of contacts during the financial year can be derived from this. (Collection status for New South Wales is unknown at time of writing.)
<i>Comments:</i>	<p>This metadata item gives a measure of the level of service provided.</p> <p>In December 1998, the National Health Information Management Group decided that the new version of this metadata item (named Person—number of service contact dates, total N[NN]) would be implemented from 1 July 2000 in the Community Mental Health National Minimum Data Set (NMDS). Until then agencies involved in the Community mental health NMDS may report either Patient—number of psychiatric outpatient clinic/day program attendances (financial year), total days N[NN] or Person—number of service contact dates, total N[NN] with the expectation that agencies will make their best efforts to report against the new version of this metadata item (Person—number of service contact dates, total N[NN]) from 1 July 1999.</p>

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Number of contacts \(psychiatric outpatient clinic/day program\), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.4 KB)

Number of coronary artery lesions attempted

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – count of coronary artery lesions attempted, total number N[N]
<i>METeOR identifier:</i>	344404
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A count of number of a person's coronary artery lesions into which an attempt was made to pass a percutaneous coronary intervention (PCI) guidewire.
Data Element Concept:	Person – count of coronary artery lesions attempted

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total	
<i>Data type:</i>	Number	
<i>Format:</i>	N[N]	
<i>Supplementary values:</i>	Value	Meaning
	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the total number of lesions into which an attempt was made to pass a PCI guidewire during a single given PCI procedure, whether they were successful or not. The number of lesions attempted should be reported for each PCI performed. The value '99' is not for use in primary data collections.
<i>Collection methods:</i>	The number of lesions attempted should be recorded from the angioplasty report.

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Coronary artery cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> Record when a percutaneous coronary intervention is performed.
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Number of coronary artery lesions successfully dilated

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – count of coronary artery lesions successfully dilated, total number N[N]
<i>METeOR identifier:</i>	344411
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The number of a person's coronary artery lesions successfully dilated.
Data Element Concept:	Person – count of coronary artery lesions successfully dilated

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total	
<i>Data type:</i>	Number	
<i>Format:</i>	N[N]	
<i>Supplementary values:</i>	Value	Meaning
	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The number of lesions successfully dilated should be recorded for each percutaneous coronary intervention (PCI) performed. Successful dilation is where: <ul style="list-style-type: none">• residual stenosis is less than 10% following coronary stenting; OR• residual stenosis is less than 50% after balloon angioplasty alone. The value '99' is not for use in primary data collections.
<i>Collection methods:</i>	The number of lesions successfully dilated should be recorded from the angioplasty report.

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Coronary artery cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> Record when a percutaneous coronary intervention is performed.
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Number of coronary artery stents

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – count of coronary artery stents, total number N[N]
<i>METeOR identifier:</i>	344417
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The number of stents placed during a person's angioplasty procedure.
Data Element Concept:	Person – count of coronary artery stents

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N]				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	99	Not stated/inadequately described
Value	Meaning				
99	Not stated/inadequately described				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The value '99' is not for use in primary data collections.
<i>Collection methods:</i>	Record the total number of coronary stents placed during the entire angioplasty procedure, regardless of the number of individual lesions.

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Coronary artery cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> Record when a percutaneous coronary intervention with stent implantation (bare metal stent or drug eluting stent) is performed.
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Number of days in special/neonatal intensive care

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – length of stay (special/neonatal intensive care), total days N[NN]
<i>METeOR identifier:</i>	270057
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of days spent by a neonate in a special care or neonatal intensive care nursery (in the hospital of birth).
Data Element Concept:	Episode of admitted patient care – length of stay (special/neonatal intensive care)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The number of days is calculated from the date the baby left the special/neonatal intensive care unit minus the date the baby was admitted to the special/neonatal intensive care unit.
<i>Collection methods:</i>	This item is to be completed if baby has been treated in an intensive care unit or a special care nursery (SCN).
<i>Comments:</i>	<p>An indicator of the requirements for hospital care of high-risk babies in specialised nurseries that add to costs because of extra staffing and facilities.</p> <p>SCN are staffed and equipped to provide a full range of neonatal services for the majority of complicated neonatal problems, including short-term assisted ventilation and intravenous therapy.</p> <p>Neonatal intensive care nurseries (NICN) are staffed and equipped to treat critically ill newborn babies including those requiring prolonged assisted respiratory support, intravenous therapy, and alimentation and treatment of serious infections. Full supportive services are readily available throughout the hospital. These NICN also provide consultative services to other hospitals.</p>

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Number of days in special / neonatal intensive care, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.9 KB)

Number of days of hospital-in-the-home care

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – number of days of hospital-in-the-home care, total {N[NN]}
<i>METeOR identifier:</i>	270305
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The number of hospital-in-the-home days occurring within an episode of care for an admitted patient.
Data Element Concept:	Episode of admitted patient care – number of days of hospital-in-the-home care

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	{N[NN]}
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The rules for calculating the number of hospital-in-the-home days are outlined below:</p> <ul style="list-style-type: none">• The number of hospital-in-the-home days is calculated with reference to the date of admission, date of separation, leave days and any date(s) of change between hospital and home accommodation;• The date of admission is counted if the patient was at home at the end of the day;• The date of change between hospital and home accommodation is counted if the patient was at home at the end of the day;• The date of separation is not counted, even if the patient was at home at the end of the day;• The normal rules for calculation of patient days apply, for example in relation to leave and same day patients.
<i>Comments:</i>	<p>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.</p>

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Number of days of hospital-in-the-home care, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.0 KB)

Implementation in Data Set Specifications: [Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Number of episodes of angina in last 24 hours

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – angina episodes count (24 hours preceding hospital presentation), total number NN[N]
<i>METeOR identifier:</i>	338293
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The number of angina episodes experienced by a person in the 24 hours preceding presentation to the hospital, including the current episode.
Data Element Concept:	Person – count of angina episodes

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total	
<i>Data type:</i>	Number	
<i>Format:</i>	NN[N]	
<i>Maximum character length:</i>	3	
<i>Supplementary values:</i>	Value	Meaning
	999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Is the total number of distinct episodes of anginal pain that occurred in the 24 hours preceding presentation to the hospital, including the current episode for which the person presented to hospital. An episode of angina may include chest pain (which may spread to either or both shoulders, the back, neck, jaws or down the arm) or overwhelming shortness of breath.
<i>Collection methods:</i>	Ask the individual how many distinct episodes of anginal pain he/she experienced in the 24 hours preceding presentation to hospital, including the current episode. Alternatively, if available, obtain this information from appropriate documentation.

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Number of episodes of residential care

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of residential care – number of episodes of residential care, total N[NNN]
<i>METeOR identifier:</i>	287957
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The total number of episodes of completed residential care occurring during the reference period (between 1 July and 30 June each year). This includes both formal and statistical episodes of residential care.
Data Element Concept:	Episode of residential care – number of episodes of residential care

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN]
<i>Maximum character length:</i>	4

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The sum of the number of episodes of residential care where the Episode of residential care end date has a value: <ul style="list-style-type: none">• Equal to or greater than the beginning of the reference period (01 July each year); and• Less than or equal to the end of the reference period (30 June each year at midnight).
<i>Collection methods:</i>	To be reported for all specialised residential mental health care services, including non-government residential mental health care services and

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006
	Mental health establishments NMDS 2006-2007 Health,

Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Number of group sessions

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of group sessions, total N[NNNNN]
<i>Synonymous names:</i>	Group occasions of service
<i>METeOR identifier:</i>	336900
<i>Registration status:</i>	Health, Standard 04/07/2007
<i>Definition:</i>	The total number of groups of patients receiving services. Each group is to be counted once, irrespective of the size of the group of patients or the number of staff providing services.
Data Element Concept:	Establishment – number of group sessions

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Group session

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A group is defined as two or more patients receiving the same services at the same time from the same hospital staff at the same clinics.</p> <p>The following guides for use apply:</p> <ul style="list-style-type: none">• a group session is counted only for two or more patients attending in the capacity of patients in their own right, even if other non-patient persons are present for the service.• Spouses, parents or carers attending the session are counted for the group session only if they are also participating in the service as a patient.• A group session is counted for staff attending clinics only if they are attending as a patient in their own right. Staff training and education is excluded.• A group session may be delivered by more than one provider. A group session is counted for two or more patients receiving the same services, even if more than one provider delivers that service simultaneously.• Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or
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dialysis clinics are counted as group sessions, if two or more people are receiving the same services at the same time.

Collection methods:

Where a patient receives multidisciplinary care within one booked clinic appointment as part of a group, one group session shall be recorded, regardless of the number of providers involved. For example, if a group session is jointly delivered by a physiotherapist and an occupational therapist, one group session is counted for the patients attending that session.

Source and reference attributes

Submitting organisation:

Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references:

Supersedes [Establishment – number of group sessions, total N\[NNNNN\]](#) Health, Superseded 04/07/2007

Implementation in Data Set Specifications:

[Outpatient care NMDS](#) Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Number of leave periods

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – number of leave periods, total N[N]
<i>METeOR identifier:</i>	270058
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Number of leave periods in a hospital stay (excluding one-day leave periods for admitted patients).
Data Element Concept:	Episode of admitted patient care – number of leave periods

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[N]
<i>Maximum character length:</i>	2
<i>Unit of measure:</i>	Period

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	If the period of leave is greater than seven days or the patient fails to return from leave, the patient is discharged.
<i>Comments:</i>	<p>Recording of leave periods allows for the calculation of patient days excluding leave. This is important for analysis of costs per patient and for planning. The maximum limit allowed for leave affects admission and separation rates, particularly for long-stay patients who may have several leave periods.</p> <p>This data element was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients at the instigation of the National Mental Health Strategy Committee.</p>

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	<p>Supersedes Number of leave periods, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)</p> <p>Is used in the formation of Episode of admitted patient care – length of stay (excluding leave days), total N[NN] Health, Standard 01/03/2005</p>
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Number of occasions of service

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of occasions of service, total N[NNNNNN]
<i>Synonymous names:</i>	Individual occasions of service
<i>METeOR identifier:</i>	336947
<i>Registration status:</i>	Health, Standard 04/07/2007
<i>Definition:</i>	The total number of occasions of examination, consultation, treatment or other service provided to a patient.
Data Element Concept:	Establishment – number of occasions of service

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The following guides for use apply: <ul style="list-style-type: none">• an occasion of service is counted for each person attending in the capacity of a patient in their own right, even if other non-patient persons are present for the service.• spouses, parents or carers attending the session are only counted if they are also participating in the service as a patient.• in the instance of a dependent child presenting to a clinic, the session is counted as a single Occasion of Service provided to the individual child for whom an event history is being recorded. Where parents/carers also attend in the capacity of patients themselves within a booked appointment, and receive the same services at the same time, the child and parent/carer can be counted as a group. In this instance a Group Session count would be recorded.• An occasion of service is counted for staff attending clinics of public hospitals only if they are attending as patients in their own right. Staff education and training is excluded.• Patients attending for treatment at a dialysis or a chemotherapy clinic are receiving individual services. Patients attending education sessions at chemotherapy or
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Collection methods:

dialysis clinics are counted as group sessions, if two or more people receiving the same services at the same time.

- Where a patient receives the occasion of service is counted at the clinic of the public hospital where the patient is booked.
- Where a patient receives multidisciplinary care, within one booked clinic appointment by themselves, one occasion of service shall be recorded, regardless of the number of providers involved.
- Where patients have received more than one booked appointment, each appointment will be counted as one occasion of service. (Example: three booked appointments with all services provided on a single day will be counted as three occasions of service).
- The occasion of service count should be attributed to the clinic type associated with the booked appointment.
- Services to individual patients should be counted separately from services to groups of patients. An occasion of service is counted only for a service provided to an individual. Group sessions are reported separately under 'Establishment - number of group sessions total N[NNNNNN]'.

Source and reference attributes

Submitting organisation:

Non-admitted patient NMDS Development Working Party, 2006

Relational attributes

Related metadata references:

See also [Establishment – outpatient clinic type, code N\[N\]](#) Health, Standard 04/07/2007

Supersedes [Establishment – number of occasions of service, total N\[NNNNNN\]](#) Health, Superseded 04/07/2007

Implementation in Data Set Specifications:

[Outpatient care NMDS](#) Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Number of positive sentinel lymph nodes

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – number of positive sentinel lymph nodes, total code N[N]
<i>METeOR identifier:</i>	370549
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The total number of sentinel lymph nodes reported as containing tumour after examination by a pathologist.
Data Element Concept:	Person with cancer – number of positive sentinel lymph nodes

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total	
<i>Data type:</i>	Number	
<i>Format:</i>	N[N]	
<i>Maximum character length:</i>	3	
<i>Supplementary values:</i>	Value	Meaning
	997	Number of lymph nodes unknown

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	For cancer registries: Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.
<i>Comments:</i>	Sentinel lymph nodes are the first nodes that filter fluid draining away from the area of cancer. The number of lymph nodes with metastasis is important for cancer staging

Source and reference attributes

<i>Origin:</i>	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
<i>Reference documents:</i>	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

<i>Implementation in Data Set Specifications:</i>	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009
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Number of qualified days for newborns

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care (newborn) – number of qualified days, total N[NNNN]
<i>METeOR identifier:</i>	270033
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The number of qualified newborn days occurring within a newborn episode of care.
Data Element Concept:	Episode of admitted patient care (newborn) – number of qualified days

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNN]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The rules for calculating the number of qualified newborn days are outlined below. The number of qualified days is calculated with reference to the Episode of admitted patient care – admission date, DDMMYYYY, Episode of admitted patient care – separation date, DDMMYYYY and any Episode of admitted patient care (newborn) – date of change to qualification status, DDMMYYYY:</p> <ul style="list-style-type: none">• the date of admission is counted if the patient was qualified at the end of the day• the date of change to qualification status is counted if the patient was qualified at the end of the day• the date of separation is not counted, even if the patient was qualified on that day• the normal rules for calculation of patient days apply, for example in relation to leave and same day patients <p>The length of stay for a newborn episode of care is equal to the sum of the qualified and unqualified days.</p>
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Relational attributes

<i>Related metadata references:</i>	Supersedes Number of qualified days for newborns, version 2,
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Implementation in Data Set Specifications:

[DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.5 KB)

Is formed using [Episode of admitted patient care \(newborn\) – date of change to qualification status, DDMMYYYY](#) Health, Standard 01/03/2005

Is used in the formation of [Establishment – number of patient days, total N\[N\(7\)\]](#) Health, Standard 01/03/2005

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Number of regional lymph nodes examined

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – number of regional lymph nodes examined, total code N[N]
<i>METeOR identifier:</i>	370032
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The total number of a person's regional lymph nodes examined by the pathologist.
Data Element Concept:	Person with cancer – number of regional lymph nodes examined

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total	
<i>Data type:</i>	Number	
<i>Format:</i>	N[N]	
<i>Maximum character length:</i>	3	
<i>Supplementary values:</i>	Value	Meaning
	997	Number of lymph nodes unknown

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A list of which lymph nodes are defined as regional lymph nodes for each cancer site may be found in the TNM Classification of Tumours, 6th Edition, UICC.</p> <p>The number includes all nodes examined regardless of whether removed/examined at a single or multiple procedures e.g. for breast cancer, record the sum of regional lymph nodes examined from node sampling/sentinel node biopsy and axillary clearance.</p> <p>The number of regional lymph nodes is cumulative from all procedures that removed lymph nodes through the completion of surgeries for the treatment of the cancer.</p> <p>Breast cancer:</p> <p>Regional lymph nodes include all ipsilateral axillary, ipsilateral infraclavicular/subclavicular, ipsilateral internal mammary and ipsilateral supraclavicular nodes. All other nodes (including contralateral internal mammary nodes) are considered to be distant metastases and should not be recorded in this data item. Definitions from UICC TNM Classification of Malignant Tumours 6th Edition.</p>
<i>Collection methods:</i>	For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

Source and reference attributes

Origin:

Australian Cancer Network

Commission on Cancer American College of Surgeons

Reference documents:

Australian Cancer Network The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)

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

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:

See also [Person with cancer – number of positive regional lymph nodes, total N\[N\]](#) Health, Superseded 06/03/2009

Supersedes [Person with cancer – number of regional lymph nodes examined, total N\[N\]](#) Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Number of sentinel lymph nodes examined

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – number of sentinel lymph nodes examined, total code N[N]
<i>METeOR identifier:</i>	370558
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The total number of a person's sentinel lymph nodes examined by the pathologist.
Data Element Concept:	Person with cancer – number of sentinel lymph nodes examined

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total	
<i>Data type:</i>	Number	
<i>Format:</i>	N[N]	
<i>Maximum character length:</i>	3	
<i>Supplementary values:</i>	Value	Meaning
	997	Number of lymph nodes unknown

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	For cancer registries, collection of this data item should only be from pathology reports relating to initial diagnosis and not for recurrent or metastatic tumour.
<i>Comments:</i>	Sentinel lymph nodes are the first nodes that filter fluid draining away from the area of cancer. The presence of cancer cells in the lymph nodes indicates that cancer cells have already spread outside the primary site and may have spread to other areas of the body. This is important for cancer staging and treatment options.

Source and reference attributes

<i>Origin:</i>	National Breast and Ovarian Cancer Centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
<i>Reference documents:</i>	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

<i>Implementation in Data Set Specifications:</i>	Breast cancer (Cancer registries) DSS Health, Standard 06/03/2009
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Number of service contact dates

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – number of service contact dates, total N[NN]
<i>METeOR identifier:</i>	270231
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of dates where a service contact was recorded for the patient/client.
Data Element Concept:	Person – number of service contact dates

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Service contact date

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item is a count of service contact dates recorded on a patient or client record. Where multiple service contacts occur on the same date, the date is counted only once.</p> <p>For collection from community-based (ambulatory and non-residential) agencies. Includes mental health day programs and psychiatric outpatients.</p>
<i>Comments:</i>	This metadata item gives a measure of the level of service provided to a patient/client.

Source and reference attributes

<i>Submitting organisation:</i>	National Mental Health Information Strategy Committee
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Relational attributes

<i>Related metadata references:</i>	<p>Is formed using Service contact – service contact date, DDMMYYYY Health, Standard 01/03/2005</p> <p>Supersedes Number of service contact dates, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)</p>
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Number of service contacts within a treatment episode for alcohol and other drug

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – number of service contacts, total N[NN]
<i>METeOR identifier:</i>	270117
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of service contacts recorded between a client and the service provider within a treatment episode for the purpose of providing alcohol and other drug treatment.
Data Element Concept:	Episode of treatment for alcohol and other drugs – number of service contacts

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Service contact

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item is a count of service contacts related to treatment that are recorded on a client record. Any client contact that does not constitute part of a treatment should not be considered a service contact. Contact with the client for administrative purposes, such as arranging an appointment, should not be included.</p> <p>This item is not collected for residential clients.</p> <p>Where multiple service provider staff have contact with the client at the same time, on the same occasion of service, the contact is counted only once.</p> <p>When multiple service contacts are recorded on the same day, each independent contact should be counted separately.</p>
<i>Collection methods:</i>	To be collated at the close of a treatment episode.
<i>Comments:</i>	This metadata item provides a measure of the frequency of client contact and service utilisation within a treatment episode.

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes [Number of service contacts within a treatment episode for alcohol and other drug, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.6 KB)

Number of service events (non-admitted patient)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of non-admitted patient service events, total N[NNNNNNN]
<i>Synonymous names:</i>	Non-admitted patient service event count
<i>METeOR identifier:</i>	270108
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of service events provided to non-admitted patients in the reference period, for each of the clinical service types in the hospital.
Data Element Concept:	Establishment – number of non-admitted patient service events

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNNNN]
<i>Maximum character length:</i>	7
<i>Unit of measure:</i>	Service event

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Count of non-admitted patient service events for each of the clinical service types listed in the value domain of the metadata item Non-admitted patient service event – service event type (clinical), code N[N].</p> <p>For each Non-admitted patient service event count, specify the</p> <ul style="list-style-type: none">• Non-admitted patient service event – service event type (clinical), code N[N]• Non-admitted patient service event – multi-disciplinary team status, code N• Service contact – group session status, individual/group session indicator code ANN.N• Non-admitted patient service event – patient present status, code N• Non-admitted patient service event – service mode, hospital code N{N}
<i>Comments:</i>	Public patients are defined in accordance with the 1998-2003 Australian Health Care Agreements.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Non-admitted patient service event count, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.5 KB)

Number of tobacco cigarettes smoked per day after 20 weeks of pregnancy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female (pregnant) – number of cigarettes smoked (per day after 20 weeks of pregnancy), number N[NN]
<i>METeOR identifier:</i>	365445
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The self-reported number of cigarettes usually smoked daily by a pregnant woman after the first 20 weeks of pregnancy until the birth
<i>Context:</i>	Perinatal Statistics
<i>Data Element Concept:</i>	Female (pregnant) – number of cigarettes smoked (after 20 weeks of pregnancy)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Quantity						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NN]						
<i>Maximum character length:</i>	3						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>998</td><td>Occasional smoking (less than one)</td></tr><tr><td>999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	998	Occasional smoking (less than one)	999	Not stated/inadequately described
Value	Meaning						
998	Occasional smoking (less than one)						
999	Not stated/inadequately described						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Data should be collected after the birth. 'After 20 weeks' is defined as greater than or equal to 20 completed weeks' gestation (≥ 20 weeks + 0 days). 'Usually' is defined as 'according to established, or frequent usage; commonly, ordinarily; as a rule'. If a woman reports having quit smoking at some point between 20 weeks of pregnancy and the birth, the value recorded should be the number of cigarettes usually smoked daily prior to quitting.
<i>Collection methods:</i>	Recommended question: 'How many tobacco cigarettes did the woman usually smoke each day after 20 weeks of pregnancy?', where after 20 weeks of pregnancy is defined as greater than or equal to 20 weeks + 0 days. If a woman did not smoke tobacco cigarettes at any time after 20 weeks of pregnancy, a value of 000 should be recorded.

Occasional smoking
Women who report that they usually smoked less than one tobacco cigarette per day should have a value recorded of 998.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also [Female \(pregnant\) – tobacco smoking indicator \(first twenty weeks of pregnancy\), yes/no code N](#) Health, Standard 03/12/2008

Implementation in Data Set Specifications: [Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Conditional obligation:

Record if answer to female (pregnant)-tobacco smoking indicator (after twenty weeks of pregnancy), yes/no code N is Yes

Number of tobacco cigarettes smoked per day first 20 weeks of pregnancy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female (pregnant) – number of cigarettes smoked (per day first 20 weeks of pregnancy), number N[NN]
<i>METeOR identifier:</i>	365441
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The self-reported number of cigarettes usually smoked daily by a woman during the first 20 weeks of pregnancy
<i>Context:</i>	Perinatal Statistics
<i>Data Element Concept:</i>	Female (pregnant) – number of cigarettes smoked (first 20 weeks of pregnancy)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Quantity						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NN]						
<i>Maximum character length:</i>	3						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>998</td><td>Occasional smoking (less than one)</td></tr><tr><td>999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	998	Occasional smoking (less than one)	999	Not stated/inadequately described
Value	Meaning						
998	Occasional smoking (less than one)						
999	Not stated/inadequately described						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Data should be collected after the first 20 weeks of pregnancy; e.g. the next antenatal visit after the first 20 weeks would be an ideal time.</p> <p>'The first 20 weeks of pregnancy' is defined as less than or equal to 19 weeks + 6 days.</p> <p>'Usually' is defined as 'according to established, or frequent usage; commonly, ordinarily; as a rule'. If a woman reports having quit smoking at some point during the first 20 weeks of pregnancy, the value recorded should be the number of cigarettes usually smoked daily prior to quitting.</p>
<i>Collection methods:</i>	<p>Recommended question: 'How many tobacco cigarettes did the woman usually smoke during the first 20 weeks of pregnancy?', where the first 20 weeks of pregnancy is defined as less than or equal to 19 weeks + 6 days.</p> <p>If a woman did not smoke tobacco cigarettes at any time during the first 20 weeks of pregnancy, a value of 000 should be recorded.</p>

Occasional smoking

Women who report that they usually smoked less than one tobacco cigarette per day should have a value recorded of 998.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Nursing diagnosis—other

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – nursing diagnosis (other), code (NANDA 1997-98) N.N[{{.N}}{.N}{.N}{.N}]
<i>METeOR identifier:</i>	270466
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The nursing diagnosis other than the principal nursing diagnosis, as represented by a code.
Data Element Concept:	Episode of care – nursing diagnosis

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	N.N[{{.N}}{.N}{.N}{.N}]
<i>Maximum character length:</i>	6

Collection and usage attributes

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

Collection and usage attributes

<i>Guide for use:</i>	Up to seven nursing diagnoses may be nominated, according to the following: <ol style="list-style-type: none">1. Nursing diagnosis most related to the principal reason for admission (one only)2-6. Other nursing diagnoses or relevance to the current episode.
<i>Collection methods:</i>	In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place. Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the codeset or automated mapping to it when

the information is at a more detailed level are equally valid and viable options.

Comments:

The Community Nursing Minimum Data Set - Australia (CNMDSA) Steering Committee considered information from users of the data in relation to this metadata item. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain North American Nursing Diagnosis Association (NANDA). The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a United States of America project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Relational attributes

Related metadata references:

Supersedes [Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.4 KB)

Nursing diagnosis—principal

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – nursing diagnosis (principal), code (NANDA 1997-98) N.N[{{.N}}{.N}}{.N}}{.N}}]
<i>METeOR identifier:</i>	270220
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The principal nursing diagnosis, as represented by a code.
<i>Data Element Concept:</i>	Episode of care – nursing diagnosis

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	North American Nursing Diagnosis Association (NANDA) Taxonomy 1997-1998
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	N.N[{{.N}}{.N}}{.N}}{.N}}]
<i>Maximum character length:</i>	6

Collection and usage attributes

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

Collection and usage attributes

<i>Guide for use:</i>	Up to seven nursing diagnoses may be nominated, according to the following: <ol style="list-style-type: none">1. Nursing diagnosis most related to the principal reason for admission (one only)2-6. Other nursing diagnoses of relevance to the current episode.
<i>Collection methods:</i>	In considering how nursing diagnosis could be implemented, agencies may opt to introduce systems transparent to the clinician if there is confidence that a direct and reliable transfer to NANDA codes can be made from information already in place. Agencies implementing new information systems should consider the extent to which these can facilitate practice and at the same time lighten the burden of documentation. Direct incorporation of the code set or automated mapping to it when the information is at a more detailed level are equally valid and viable options.

Comments:

The Community Nursing Minimum Data Set - Australia (CNMDSA) Steering Committee considered information from users of the data in relation to this metadata item. Many users have found the taxonomy wanting in its ability to describe the full range of persons and conditions seen by community nurses in the Australian setting. In the absence of an alternative taxonomy with wide acceptance, the CNMDSA Steering Committee has decided to retain North American Nursing Diagnosis Association (NANDA). The University of Iowa has a written agreement with NANDA to expand the relevance of NANDA. The Australian Council of Community Nursing Services (ACCNS) has sought collaboration with a United States of America project at the University of Iowa which is seeking to refine, extend, validate and classify the NANDA taxonomy.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Relational attributes

Related metadata references:

Supersedes [Nursing diagnosis, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.4 KB)

Nursing interventions

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Community nursing service episode – nursing intervention, code N
<i>METeOR identifier:</i>	270223
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The nursing action intended to relieve or alter a person's responses to actual or potential health problems, as represented by a code.
Data Element Concept:	Community nursing service episode – nursing intervention

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Coordination and collaboration of care</td></tr><tr><td>2</td><td>Supporting informal carers</td></tr><tr><td>3</td><td>General nursing care</td></tr><tr><td>4</td><td>Technical nursing treatment or procedure</td></tr><tr><td>5</td><td>Counselling and emotional support</td></tr><tr><td>6</td><td>Teaching/education</td></tr><tr><td>7</td><td>Monitoring and surveillance</td></tr><tr><td>8</td><td>Formal case management</td></tr><tr><td>9</td><td>Service needs assessment only</td></tr></tbody></table>	Value	Meaning	1	Coordination and collaboration of care	2	Supporting informal carers	3	General nursing care	4	Technical nursing treatment or procedure	5	Counselling and emotional support	6	Teaching/education	7	Monitoring and surveillance	8	Formal case management	9	Service needs assessment only
Value	Meaning																				
1	Coordination and collaboration of care																				
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7	Monitoring and surveillance																				
8	Formal case management																				
9	Service needs assessment only																				

Collection and usage attributes

<i>Guide for use:</i>	<p>The following definitions are to assist in coding:</p> <p>CODE 1 Coordination and collaboration of care</p> <p>This code occurs when there are multiple care deliverers. The goal of coordination and collaboration is the efficient, appropriate integrated delivery of care to the person. Tasks which may be involved include: liaison, advocacy, planning, referral, information and supportive discussion and/or education. Although similar in nature to formal case management this intervention is not the one formally recognised by specific funding (see Code 8).</p> <p>CODE 2 Supporting information carers</p> <p>This code includes activities, which the nurse undertakes to assist</p>
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the carer in the delivery of the carer's role. This does not include care given directly to the person. Examples of tasks involved in supporting the carer include: counselling, teaching, informing, advocacy, coordinating, and grief or bereavement support.

CODE 3 General nursing care

This code includes a broad range of activities, which the nurse performs to directly assist the person; in many cases, this assistance will focus on activities of daily living. This assistance will help a person whose health status, level of dependency, and/or therapeutic needs are such that nursing skills are required. Examples of tasks include: assistance with washing, grooming and maintaining hygiene, dressing, pressure area care, assistance with toileting, bladder and bowel care, assistance with mobility and therapeutic exercise, attention to physical comfort and maintaining a therapeutic environment.

CODE 4 Technical nursing treatment or procedure

This code refers to technical tasks and procedures for which nurses receive specific training and which require nursing knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions related to each. Some examples of technical care activities are: medication administration (including injections), dressings and other procedures, venipuncture, monitoring of dialysis, and implementation of pain management technology.

CODE 5 Counselling and emotional support

This code focuses on non-physical care given to the person, which aims to address the affective, psychological and/or social needs. Examples of these include: bereavement, well being, decision-making support and values-clarification.

CODE 6 Teaching/education

This code refers to providing information and/or instruction about a specific body of knowledge and/or procedure, which is relevant to the person's situation. Examples of teaching areas include: disease process, technical procedure, health maintenance, health promotion and techniques for coping with a disability.

CODE 7 Monitoring and surveillance

This code refers to any action by which the nurse evaluates and monitors physical, behavioural, social and emotional responses to disease, injury, and nursing or medical interventions.

CODE 8 Formal case management

This code refers to the specific formal service, which is funded to provide case management for a person. Note that coordination and collaboration of care (Code 1) is not the same as formal case management.

CODE 9 Service needs assessment only

This code is for assessment of the person when this is the only activity carried out and no further nursing care is given; for example, assessment for ongoing care and/or inappropriate referrals. Selection of this option means that no other intervention

may be nominated. Thus, if an assessment for the domiciliary care benefit is the reason for a visit, but other interventions such as, counselling and support; coordination/collaboration of care are carried out, then the assessment only is not an appropriate code.

Data element attributes

Collection and usage attributes

Guide for use:

Up to eight codes may be selected. If Code 9 is selected no other nursing interventions are collected. If Code 9 is selected then code 07 in Community nursing service episode – goal of care, code NN must also be selected.

Collection methods:

Collect on continuing basis throughout the episode in the event of data collection that occurs prior to discharge. Up to eight codes may be collected. Within a computerised information system the detailed activities can be mapped to the Community Nursing Minimum Data Set Australia (CNMDSA) interventions enabling the option of a rich level of detail of activities or summarised information.

Comments:

For the purposes of the CNMDSA, the interventions are not necessarily linked to each nursing problem, nor are they specific tasks, but rather, broader-level intervention categories focusing on the major areas of a person's need. These summary categories subsume a range of specific actions or tasks.

The CNMDSA nursing interventions are summary information overlying the detailed nursing activity usually included in an agency data collection. They are not intended as a description of nursing activities in the CNMDSA. For instance, 'technical nursing treatment' or 'procedure' is the generic term for a broad range of nursing activities such as medication administration and wound care management.

Collection of this information at discharge carries with it the expectation that nursing records will lend themselves to this level of summarisation of the care episode. The selection of eight interventions if more are specified is a potentially subjective task unless the nursing record is structured and clear enough to enable such a selection against the reasons for admission to care, and the major focus of care delivery. Clearly, the task is easier if ongoing automated recording of interventions within an agency information system enables discharge reporting of all interventions and their frequency, over a care episode.

Those agencies providing allied health services may wish to use the Physiotherapy and Occupational Therapy Interventions developed in conjunction with the National Centre for Classification in Health in addition to the CNMDSA data element Nursing interventions or other more relevant code sets.

To enable analysis of the interventions within an episode of care, in relation to the outcome of this care, especially when linked with information on the diagnosis and goals. The recording of nursing interventions is critical information for health service

monitoring and planning. It is a major descriptor of the care provided throughout an episode.

Source and reference attributes

Submitting organisation:

Australian Council of Community Nursing Services

Origin:

Australian Council of Community Nursing Services 1997.
Community Nursing Minimum Data Set Australia (CNMDSA),
version 2.0: data dictionary and guidelines. Melbourne: ACCNS

Relational attributes

Related metadata references:

Supersedes [Nursing interventions, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (24.2 KB)

Occasions of service (residential aged care services)— outreach/community

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment (residential aged care service)— number of occasions of service (outreach/community), total N[NN]
<i>METeOR identifier:</i>	270308
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of occasions of service delivered by a residential aged care service employees to the patient in the home, place of work or other non-establishment site.
Data Element Concept:	Establishment (residential aged care service)— number of occasions of service

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Comments:</i>	Required to adequately describe the services provided to non-admitted patients. Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)
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Occasions of service (residential aged care services)—outpatient

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment (residential aged care service)— number of occasions of service (outpatient), total N[NN]
<i>METeOR identifier:</i>	270290
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>The number of occasions of service delivered by residential aged care service employees.</p> <p>Outpatients are patients who receive non-admitted care. Non-admitted care is care provided to a patient who is not formally admitted but receives direct care from a designated clinic within the residential aged care service.</p>
Data Element Concept:	Establishment (residential aged care service)— number of occasions of service

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Occasion of service

Data element attributes

Collection and usage attributes

<i>Comments:</i>	<p>Required to adequately describe the services provided to non-admitted patients.</p> <p>Apart from acute hospitals, establishments generally provide a much more limited range of services for non-admitted patients and outreach/community patients/clients. Therefore disaggregation by type of episode is not as necessary as in acute hospitals.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Type of non-admitted patient care (residential aged care services), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)
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Oestrogen receptor assay result

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – oestrogen receptor assay result, code N
<i>METeOR identifier:</i>	370036
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The result of oestrogen receptor assay at the time of diagnosis of the primary breast tumour, as represented by a code.
Data Element Concept:	Person with cancer – oestrogen receptor assay result

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Positive</td></tr><tr><td>2</td><td>Negative</td></tr><tr><td>3</td><td>Equivocal</td></tr></tbody></table>	Value	Meaning	1	Positive	2	Negative	3	Equivocal
Value	Meaning								
1	Positive								
2	Negative								
3	Equivocal								
<i>Supplementary values:</i>	<table><tbody><tr><td>7</td><td>Unknown (test results not available)</td></tr><tr><td>8</td><td>Not applicable (test not done)</td></tr></tbody></table>	7	Unknown (test results not available)	8	Not applicable (test not done)				
7	Unknown (test results not available)								
8	Not applicable (test not done)								

Collection and usage attributes

<i>Guide for use:</i>	Supplementary codes CODE 7 Unknown (test results not available) Use this code when the test has been performed but the results are not yet available for analysis. CODE 8 Not applicable (test not done) This code is used as a validation measure, to show that the reason for the lack of results is due to the test not being performed.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the pathologist has stated the test result in the conclusion of the pathology report as being positive, negative or equivocal this value should be coded. If the report does not specifically state the test result, this should be interpreted from the reported % nuclei stained positive. If => 1% of nuclei are reported as stained regardless of stain intensity (weak, intermediate or high/strong) the result is positive. If % nuclei stained is <1% the
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result is negative. Definitions from NBOCC & ACN Pathology Reporting Guidelines.

Collection methods:

For cancer registries:

Collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or subsequent metastatic disease.

Where there are multiple reports relating to the primary breast tumour (from different specimens), the 'most positive' value is chosen according to the following hierarchy: Positive > Equivocal > Negative > Test done but results not known > Test not done.

If oestrogen receptor assay tests are completed for invasive tumours with an in situ component, use the values from the invasive tumour.

Do not record oestrogen receptor values for in situ tumours.

For multifocal tumours, use the oestrogen receptor value from the largest focus or from a metastatic deposit, e.g. Lymph node metastasis. A smaller focus that is ER positive may in fact be the source of a metastasis and in this setting the patient would derive benefit from the therapy offered as a result of hormone receptor positive status.

Comments:

Hormone receptor status is an important prognostic indicator for breast cancer.

The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include

- the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high) and
- a conclusion as to whether the assay is positive or negative.

Source and reference attributes

Origin:

Royal College of Pathologists of Australasia
Australian Cancer Network

Reference documents:

Commission on Cancer American College of Surgeons
Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)
Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)
Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:

Supersedes [Person with cancer – oestrogen receptor assay results, code N](#) Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Onset of labour

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – labour onset type, code N
<i>METeOR identifier:</i>	269942
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The manner in which labour started in a birth event, as represented by a code.
Data Element Concept:	Birth event – labour onset type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Spontaneous</td></tr><tr><td>2</td><td>Induced</td></tr><tr><td>3</td><td>No labour</td></tr></tbody></table>	Value	Meaning	1	Spontaneous	2	Induced	3	No labour
Value	Meaning								
1	Spontaneous								
2	Induced								
3	No labour								
<i>Supplementary values:</i>	<table><tbody><tr><td>4</td><td>Not stated</td></tr></tbody></table>	4	Not stated						
4	Not stated								

Collection and usage attributes

<i>Guide for use:</i>	<p>Labour commences at the onset of regular uterine contractions, which act to produce progressive cervical dilatation, and is distinct from spurious labour or pre-labour rupture of membranes.</p> <p>If prostaglandins were given to induce labour and there is no resulting labour until after 24 hours, then code the onset of labour as spontaneous.</p> <p>CODE 3 No labour Can only be associated with a caesarean section.</p>
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Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Onset of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)
<i>Implementation in Data Set Specifications:</i>	Perinatal NMDS Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS Health](#), Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Ophthalmological assessment—outcome (left retina)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – ophthalmological assessment outcome (left retina) (last 12 months), code N
<i>METeOR identifier:</i>	270472
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The result of an ophthalmological assessment for the left retina during the last 12 months, as represented by a code.
Data Element Concept:	Person – ophthalmological assessment outcome

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Normal</td></tr><tr><td>2</td><td>Diabetes abnormality</td></tr><tr><td>3</td><td>Non-diabetes abnormality</td></tr><tr><td>4</td><td>Not visualised</td></tr></tbody></table>	Value	Meaning	1	Normal	2	Diabetes abnormality	3	Non-diabetes abnormality	4	Not visualised
Value	Meaning										
1	Normal										
2	Diabetes abnormality										
3	Non-diabetes abnormality										
4	Not visualised										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This is a repeating record of both eyes.</p> <p>1st field - Right retina</p> <p>2nd field - Left retina</p> <p>Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/ or Not visualised.</p> <p>Example:</p> <ul style="list-style-type: none">code 12 for right retina Normal and left retina Diabetes abnormalitycode 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality <p>Only the result of an assessment carried out in the last 12 months should be recorded.</p>
<i>Collection methods:</i>	Ophthalmological assessment should be performed by an

ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;
- Examination of fundi with pupils dilated.

Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

See also [Person – ophthalmological assessment outcome \(right retina\) \(last 12 months\), code N](#) Health, Standard 01/03/2005

Supersedes [Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (18.5 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Ophthalmological assessment—outcome (right retina)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – ophthalmological assessment outcome (right retina) (last 12 months), code N
<i>METeOR identifier:</i>	270363
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The result of an ophthalmological assessment for the right retina during the last 12 months, as represented by a code.
Data Element Concept:	Person – ophthalmological assessment outcome

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Normal</td></tr><tr><td>2</td><td>Diabetes abnormality</td></tr><tr><td>3</td><td>Non-diabetes abnormality</td></tr><tr><td>4</td><td>Not visualised</td></tr></tbody></table>	Value	Meaning	1	Normal	2	Diabetes abnormality	3	Non-diabetes abnormality	4	Not visualised
Value	Meaning										
1	Normal										
2	Diabetes abnormality										
3	Non-diabetes abnormality										
4	Not visualised										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This is a repeating record of both eyes.</p> <p>1st field - Right retina</p> <p>2nd field - Left retina</p> <p>Record the result of the fundus examination for each eye as: Normal/ Diabetes abnormality/ Non-diabetes abnormality/ or Not visualised.</p> <p>Example:</p> <ul style="list-style-type: none">code 12 for right retina Normal and left retina Diabetes abnormalitycode 32 for right retina Non-diabetes abnormality and left retina Diabetes abnormality <p>Only the result of an assessment carried out in the last 12 months should be recorded.</p>
<i>Collection methods:</i>	Ophthalmological assessment should be performed by an

ophthalmologist or a suitably trained clinician.

A comprehensive ophthalmological examination includes:

- Checking visual acuity with Snellen chart - correct with pinhole if indicated;
- Examination for cataract;
- Examination of fundi with pupils dilated.

Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

See also [Person – ophthalmological assessment outcome \(left retina\) \(last 12 months\), code N](#) Health, Standard 01/03/2005
Supersedes [Ophthalmological assessment - outcome, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (18.5 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005
[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Ophthalmoscopy performed indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – ophthalmoscopy performed indicator (last 12 months), code N
<i>METeOR identifier:</i>	302821
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether or not an examination of the fundus of the eye by an ophthalmologist or optometrist, as a part of the ophthalmological assessment, has been undertaken in the last 12 months, as represented by a code.
Data Element Concept:	Person – ophthalmoscopy performed indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if a fundus examination of eye has occurred. CODE 2 No: Record if a fundus examination of eye has not occurred.
<i>Collection methods:</i>	Ask the individual if he/she has undertaken an eye check, including examination of fundi with pupils dilated. Pupil dilatation and an adequate magnified view of the fundus is essential, using either detailed direct or indirect ophthalmoscopy or fundus camera. This will usually necessitate referral to an ophthalmologist.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
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Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes [Person – ophthalmoscopy performed status \(previous 12 months\), code N](#) Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Organisation end date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – organisation end date, DDMMYYYY
<i>METeOR identifier:</i>	288733
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The date on which an establishment, agency or organisation stopped or concluded operations or practice.
Data Element Concept:	Service provider organisation – organisation end date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Organisation expenses, total Australian currency

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Organisation—expenses, total Australian currency NNNNN.N
<i>METeOR identifier:</i>	359963
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Expenses of an organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, workers compensation premiums and payouts, purchases of goods and services and consumption of fixed capital (depreciation), in Australian currency.
Data Element Concept:	Organisation—expenses

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Currency
<i>Format:</i>	NNNNN.N
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Australian currency (AU\$)

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.</p> <p>Expenses are to be reported in millions to the nearest 100,000 e.g. \$4,064,000 should be reported as \$4.1 million.</p> <p>When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).</p> <p>Includes:</p> <ul style="list-style-type: none">• Salaries, wages and supplements• Superannuation employer contributions• Workers compensation premiums and payments• Consumption of fixed capital (depreciation).• Administrative expenses (excluding workers compensation premiums and payouts)• Domestic services
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- Drug supplies
- Food supplies
- Grants
- Medical and surgical supplies
- Patient transport
- Payments to visiting medical officers
- Repairs and maintenance
- Social benefits
- Subsidy expenses
- Other expenses

Collection methods:

Expenses are to be reported for the *Health industry relevant organisation type* and *Type of health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303–305; 307; 499; 503–504; 599; 601–603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, reference: <http://www.aasb.com.au/>

Relational attributes

Related metadata references:

Is formed using [Organisation – employee related expenses, total Australian currency NNNNN.N](#) Health, Standard 05/12/2007

Is formed using [Organisation – purchase of goods and services, total Australian currency NNNNN.N](#) Health, Standard 05/12/2007

Is formed using [Organisation – capital consumption expenses, total Australian currency NNNNN.N](#) Health, Standard 01/04/2009

Implementation in Data Set

[Government health expenditure organisation expenditure data](#)

Specifications:

[cluster](#) Health, Superseded 03/12/2008

[Government health expenditure organisation expenditure data element cluster](#) Health, Superseded 01/04/2009

[Government health expenditure organisation expenditure data element cluster](#) Health, Standard 01/04/2009

Organisation name

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (name) – organisation name, text [X(200)]
<i>METeOR identifier:</i>	288917
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The appellation by which an establishment, agency or organisation is known or called, as represented by text.
Data Element Concept:	Service provider organisation (name) – organisation name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(200)]
<i>Maximum character length:</i>	200

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Generally, the complete establishment, agency or organisation name should be used to avoid any ambiguity in identification. This should usually be the same as company registration name. However, in certain circumstances (e.g. internal use), a short name (i.e. an abbreviated name by which the organisation is known) or a locally used name (e.g. where a medical practice is known by a name that is different to the company registration name) can be used. Further, a business unit within an organisation may have its own separate identity; this should be captured (as the unit name – see Organisation name type).</p> <p>More than one name can be recorded for an organisation. That is, this field is a multiple occurring field. At least one organisation name must be recorded for each organisation and each name must have an appropriate Organisation name type.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

<i>Implementation in Data Set</i>	Health care provider identification DSS Health, Superseded
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Specifications:

04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Organisation revenues

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Organisation—revenue, total Australian currency NNNNN.N
<i>METeOR identifier:</i>	357510
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Revenues of an organisation relating to patient fees, recoveries, and other revenue in Australian currency.
Data Element Concept:	Organisation—revenue

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Currency
<i>Format:</i>	NNNNN.N
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Australian currency (AU\$)

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Revenues are to be reported in millions to the nearest 100,000 e.g. \$4,064,000 should be reported as \$4.1 million.</p> <p>Revenue arises from:</p> <ul style="list-style-type: none">• the sale of goods,• the rendering of services, and• the use by others of entity assets yielding interest, royalties and dividends. <p>Goods includes goods produced by the entity for the purpose of sale and goods purchased for resale, such as merchandise purchased by a retailer or land and other property held for resale.</p> <p>The rendering of services typically involves the performance by the entity of a contractually agreed task over an agreed period of time. The services may be rendered within a single period or over more than one period. Some contracts for the rendering of services are directly related to construction contracts, for example, those for the services of project managers and architects. Revenue arising from these contracts is not dealt with in this Standard but is dealt with in accordance with the requirements for construction contracts as specified in AASB 111</p>
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Construction Contracts.

The use by others of entity assets gives rise to revenue in the form of:

- (a) interest – charges for the use of cash or cash equivalents or amounts due to the entity;
- (b) royalties – charges for the use of long-term assets of the entity, for example, patents, trademarks, copyrights and computer software; and
- (c) dividends – distributions of profits to holders of equity investments in proportion to their holdings of a particular class of capital.

Revenue is the gross inflow of economic benefits during the period arising in the course of the ordinary activities of an entity when those inflows result in increases in equity, other than increases relating to contributions from equity participants.

Revenue includes only the gross inflows of economic benefits received and receivable by the entity on its own account.

Amounts collected on behalf of third parties such as sales taxes, goods and services taxes and value added taxes are not economic benefits which flow to the entity and do not result in increases in equity. Therefore, they are excluded from revenue. Similarly, in an agency relationship, the gross inflows of economic benefits include amounts collected on behalf of the principal and which do not result in increases in equity for the entity. The amounts collected on behalf of the principal are not revenue. Instead, revenue is the amount of commission.

Collection methods:

Revenues are to be reported for the *Source of public and private revenue* and *Health industry relevant organisation type* data elements.

Source of public and private revenue

State and territory health authorities are NOT to report the following codes:

Codes 101–103; 204; 207; 301

Health industry relevant organisation type

State and territory health authorities are NOT to report the following codes:

Codes 106–109; 111; 115–119; 123; 201 and 203

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Reference documents:

ABS 2003. Australian System of Government Finance Statistics: Concepts, Sources and Methods (Cat. no. 5514.0.55.001) 10/10/2003.

Australian Accounting Standards Board 118, July 2007, <www.aasb.com.au>.

Relational attributes

Implementation in Data Set

[Government health expenditure function revenue data cluster](#)

Specifications:

Health, Superseded 03/12/2008

[Government health expenditure function revenue data element cluster](#) Health, Standard 03/12/2008

[Government health expenditure organisation revenue data element cluster](#) Health, Superseded 03/12/2008

[Government health expenditure organisation revenue data element cluster](#) Health, Superseded 01/04/2009

[Government health expenditure organisation revenue data element cluster](#) Health, Standard 01/04/2009

Organisation start date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – organisation start date, DDMMYYYY
<i>METeOR identifier:</i>	288963
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The date on which an establishment, agency or organisation started or commenced operations or service.
Data Element Concept:	Service provider organisation – organisation start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This field must – <ul style="list-style-type: none">• be a valid date;• be less than or equal to the Organisation end date.
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Other drug of concern

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – drug of concern (other), code (ASCDC 2000 extended) NNNN
<i>METeOR identifier:</i>	270110
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A drug apart from the principal drug of concern which the client states as being a concern, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs – drug of concern

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Australian Standard Classification of Drugs of Concern 2000	
<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	NNNN	
<i>Maximum character length:</i>	4	
<i>Supplementary values:</i>	Value	Meaning
	0005	Opioid analgesics not further defined
	0006	Psychostimulants not further defined

Collection and usage attributes

<i>Guide for use:</i>	<p>The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC e.g. 0000 = inadequately described.</p> <p>Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:</p> <p>CODE 0005 Opioid analgesics not further defined</p> <p>This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.</p> <p>CODE 0006 Psychostimulants not further defined</p> <p>This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which type. The existing code 3000 combines stimulants and</p>
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hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499 categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record each additional drug of concern (according to the client) relevant to the treatment episode. The other drug of concern does not need to be linked to a specific treatment type. More than one drug may be selected. There should be no duplication with the principal drug of concern.
<i>Collection methods:</i>	Any other drug of concern for the client should be recorded upon commencement of a treatment episode. For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.
<i>Comments:</i>	This item complements principal drug of concern. The existence of other drugs of concern may have a role in determining the types of treatment required and may also influence treatment outcomes.

Source and reference attributes

<i>Submitting organisation:</i>	Intergovernmental Committee on Drugs National Minimum Data Set Working Group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Other drug of concern, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.4 KB)
<i>Implementation in Data Set Specifications:</i>	Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008 Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009 <i>Implementation start date:</i> 01/07/2008 <i>Implementation end date:</i> 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011
Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Other treatment type for alcohol and other drugs

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – treatment type (other), code [N]
<i>METeOR identifier:</i>	270076
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	All other forms of treatment provided to the client in addition to the main treatment type for alcohol and other drugs, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs – treatment type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	[N]												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Withdrawal management (detoxification)</td></tr><tr><td>2</td><td>Counselling</td></tr><tr><td>3</td><td>Rehabilitation</td></tr><tr><td>4</td><td>Pharmacotherapy</td></tr><tr><td>5</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Withdrawal management (detoxification)	2	Counselling	3	Rehabilitation	4	Pharmacotherapy	5	Other
Value	Meaning												
1	Withdrawal management (detoxification)												
2	Counselling												
3	Rehabilitation												
4	Pharmacotherapy												
5	Other												

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Withdrawal management (detoxification) Refers to any form of withdrawal management, including medicated and non-medicated.</p> <p>CODE 2 Counselling Refers to any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency. This selection excludes counselling activity that is part of a rehabilitation program as defined in Code 3.</p> <p>CODE 3 Rehabilitation Refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer-term duration. Rehabilitation activities can occur in residential or non-residential settings. Counselling that is</p>
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included within an overall rehabilitation program should be coded to Code 3 for Rehabilitation, not to Code 2 as a separate treatment episode for counselling.

CODE 4 Pharmacotherapy

Refers to pharmacotherapies that include those used as maintenance therapies (e.g. naltrexone, buprenorphine, and methadone treatment) and those used as relapse prevention. Use Code 1 (withdrawal management) where a pharmacotherapy is used solely for withdrawal. Note collection exclusions: excludes clients who are on an opioid pharmacotherapy maintenance program and are not receiving any other form of treatment.

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To be completed at cessation of treatment episode. Only report treatment recorded in the client's file that is in addition to, and not a component of, the main treatment type for alcohol and other drugs. Treatment activity reported here is not necessarily for principal drug of concern in that it may be treatment for other drugs of concern. More than one code may be selected.
<i>Collection methods:</i>	This field should be left blank if there are no other treatment types for the episode.
<i>Comments:</i>	Information about treatment provided is of fundamental importance to service delivery and planning.

Source and reference attributes

<i>Submitting organisation:</i>	Intergovernmental Committee on Drugs National Minimum Data Set Working Group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Other treatment type for alcohol and other drugs, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.7 KB)
<i>Implementation in Data Set Specifications:</i>	Alcohol and other drug treatment services NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Alcohol and other drug treatment services NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Alcohol and other drug treatment services NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

Alcohol and other drug treatment services NMDS 2008-2010

Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

Alcohol and other drug treatment services NMDS 2010-2011

Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Other/Underlying cause of acute coronary syndrome

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with acute coronary syndrome – underlying cause of acute coronary syndrome, code N
<i>Synonymous names:</i>	Secondary cause of ACS
<i>METeOR identifier:</i>	338310
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The condition or event, other than the usual risk factors, which has caused a person's acute coronary syndrome symptoms, as represented by a code
Data Element Concept:	Person – underlying cause of acute coronary syndrome

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N[N]																				
<i>Maximum character length:</i>	9																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Anaemia</td></tr><tr><td>2</td><td>Severe valvular disease</td></tr><tr><td>3</td><td>Thyrotoxicosis</td></tr><tr><td>4</td><td>Fever</td></tr><tr><td>5</td><td>Hypoxaemia</td></tr><tr><td>6</td><td>Trauma</td></tr><tr><td>7</td><td>Surgery</td></tr><tr><td>88</td><td>Other</td></tr><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Anaemia	2	Severe valvular disease	3	Thyrotoxicosis	4	Fever	5	Hypoxaemia	6	Trauma	7	Surgery	88	Other	99	Not stated/inadequately described
Value	Meaning																				
1	Anaemia																				
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3	Thyrotoxicosis																				
4	Fever																				
5	Hypoxaemia																				
6	Trauma																				
7	Surgery																				
88	Other																				
99	Not stated/inadequately described																				
<i>Supplementary values:</i>																					

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	This is to be recorded by the clinician.
<i>Comments:</i>	<p>This identifies whether the person experiencing acute coronary syndrome (ACS) symptoms is doing so due to another condition or event and where the treatment would be primarily targeted at managing that condition.</p> <p>The presence of one of these conditions or events has a significant impact on the appropriate treatment modalities for ACS. Therefore, the person's treatment may be different from those recommended for ACS.</p>

Relational attributes

*Implementation in Data Set
Specifications:*

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard
01/10/2008

Outcome of initial treatment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – outcome of treatment, code N.N
<i>METeOR identifier:</i>	289304
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The response of the tumour at the completion of the initial treatment modalities, as represented by a code.
Data Element Concept:	Cancer treatment – outcome of treatment

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N.N												
<i>Maximum character length:</i>	2												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1.0</td><td>Complete response</td></tr><tr><td>2.1</td><td>Partial response</td></tr><tr><td>2.2</td><td>Stable or static disease</td></tr><tr><td>2.3</td><td>Progressive disease</td></tr><tr><td>2.9</td><td>Incomplete response</td></tr></tbody></table>	Value	Meaning	1.0	Complete response	2.1	Partial response	2.2	Stable or static disease	2.3	Progressive disease	2.9	Incomplete response
Value	Meaning												
1.0	Complete response												
2.1	Partial response												
2.2	Stable or static disease												
2.3	Progressive disease												
2.9	Incomplete response												
<i>Supplementary values:</i>	9.0 Not assessed or unable to be assessed												

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1.0 Complete response</p> <p>Complete disappearance of all measurable disease, including tumour markers, for at least four weeks. No new lesions or new evidence of disease.</p> <p>CODE 2.1 Partial response</p> <p>A decrease by at least 50% of the sum of the products of the maximum diameter and perpendicular diameter of all measurable lesions, for at least four weeks. No new lesions or worsening of disease.</p> <p>CODE 2.2 Stable or static disease</p> <p>No change in measurable lesions qualifying as partial response or progression and no evidence of new lesions.</p> <p>CODE 2.3 Progressive disease</p> <p>An increase by at least 25% of the sum of the products of the maximum diameter and a perpendicular diameter of any measurable lesion, or the appearance of new lesions.</p>
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Data element attributes

Source and reference attributes

Origin: New South Wales Health Department

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

Relational attributes

Related metadata references: Supersedes [Outcome of initial treatment, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.8 KB)

Implementation in Data Set Specifications: [Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Outcome of last previous pregnancy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Pregnancy (last previous) – pregnancy outcome, code N
<i>METeOR identifier:</i>	270006
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Outcome of the most recent pregnancy preceding this pregnancy, as represented by a code.
Data Element Concept:	Pregnancy (last previous) – pregnancy outcome

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	Number																		
<i>Format:</i>	N																		
<i>Maximum character length:</i>	1																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Single live birth - survived at least 28 days</td></tr><tr><td>2</td><td>Single live birth - neonatal death (within 28 days)</td></tr><tr><td>3</td><td>Single stillbirth</td></tr><tr><td>4</td><td>Spontaneous abortion</td></tr><tr><td>5</td><td>Induced abortion</td></tr><tr><td>6</td><td>Ectopic pregnancy</td></tr><tr><td>7</td><td>Multiple live birth - all survived at least 28 days</td></tr><tr><td>8</td><td>Multiple birth - one or more neonatal deaths (within 28 days) or stillbirths</td></tr></tbody></table>	Value	Meaning	1	Single live birth - survived at least 28 days	2	Single live birth - neonatal death (within 28 days)	3	Single stillbirth	4	Spontaneous abortion	5	Induced abortion	6	Ectopic pregnancy	7	Multiple live birth - all survived at least 28 days	8	Multiple birth - one or more neonatal deaths (within 28 days) or stillbirths
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	In the case of multiple pregnancy with fetal loss before 20 weeks, code on outcome of surviving fetus(es) beyond 20 weeks.
<i>Comments:</i>	This data item is recommended by the World Health Organization. It is collected in some states and territories. Adverse outcome in previous pregnancy is an important risk factor for subsequent pregnancy.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Outcome of last previous pregnancy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)
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Outpatient clinic type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – outpatient clinic type, code N[N]
<i>METeOR identifier:</i>	336952
<i>Registration status:</i>	Health, Standard 04/07/2007
<i>Definition:</i>	The organisational unit or organisational arrangement through which a hospital provides healthcare services in an outpatient setting, as represented by a code.
Data Element Concept:	Establishment – outpatient clinic type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																														
<i>Data type:</i>	Number																																														
<i>Format:</i>	N[N]																																														
<i>Maximum character length:</i>	2																																														
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8	Respiratory																																														
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22	Surgery																																														

23	Paediatric surgery
24	Renal medical

Collection and usage attributes

Guide for use:

The rules for allocating (mapping) clinic services to the clinic codes structure is the responsibility of each State and Territory and these rules need to be applied consistently within each State and Territory.

In most cases, reference to the code guide of permissible values will be adequate to map a hospital's clinics to the data domain. If not, general principles for mapping existing clinics to the data domain should take account of (a) the nature of the specialty, (b) patient characteristics, e.g. age, and (c) the field of practice of the service provider.

Where the patient characteristics have determined that a paediatric clinic type is appropriate, then further differentiation between surgical and medical is determined by (a) the nature of the specialty, and (b) the field of practice of the service provider. That is, paediatric medical would include any investigations, treatment(s) or services provided to a child which do not pertain to the surgical care of diseases or injuries.

In paediatric hospitals, the full range of clinic types should be used.

A guide for the permissible values of codes for the outpatient clinic types is as follows:

CODE 1 Allied Health

- Audiology.
- Clinical Pharmacology.
- Neuropsychology.
- Dietetics.
- Occupational therapy.
- Optometry.
- Orthoptics.
- Orthotics.
- Physiotherapy.
- Podiatry.
- Prosthetics.
- Psychology.
- Social work.
- Speech pathology.

Includes clinics specified in mapping list above run solely by these Allied Health (AH) professionals. Example: A speech Pathologist conducting a clinic with booked patients for speech pathology services.

Excludes services provided by AH professionals in clinics classified in codes 2-23. Example: a physiotherapist running a

cardiac rehabilitation clinic is classified to the Cardiology Clinic (see code 5).

CODE 2 Dental

- Dental.

CODE 3 Gynaecology

- Gynaecology.
- Gynaecological oncology (excluding chemotherapy).
- Menopause.
- Assisted reproduction, infertility.
- Family planning.

CODE 4 Obstetrics

- Obstetrics.
- Childbirth education.
- Antenatal.
- Postnatal.

Excludes gestational diabetes (see code 6).

CODE 5 Cardiology

- Cardiac rehabilitation.
- ECG.
- Doppler.
- Cardiac stress test.
- Hypertension.
- Pacemaker.

Excludes cardiac catheterisation (see code 22).

CODE 6 Endocrinology

- Endocrine.
- Gestational diabetes.
- Thyroid.
- Metabolic.
- Diabetes.
- Diabetes education.

CODE 7 Oncology

- Oncology.
- Lymphoedema.
- Radiation oncology.

Excludes chemotherapy (see code 20).

Excludes gynaecological oncology (see code 3).

CODE 8 Respiratory

- Asthma.
- Asthma education.
- Respiratory; excludes tuberculosis (see code 10).

- Cystic Fibrosis.
- Sleep.
- Pulmonary.

CODE 9 Gastroenterology

- Gastroenterology.

Excludes endoscopy (see code 13).

CODE 10 Medical

- Aged care, geriatric, gerontology.
- Allergy.
- Anti-coagulant.
- Clinical Measurement; include with relevant specialty clinic type where clinical measurement services are specific to a specialty (see codes 1-23) e.g. urodynamic analysis is counted with Urology (see code 15).
- Dementia.
- Dermatology.
- Development disability.
- Epilepsy.
- Falls.
- General medicine.
- Genetic.
- Haematology, haemophilia.
- Hepatobiliary.
- Hyperbaric medicine.
- Immunology, HIV.
- Infectious diseases; Communicable diseases; Hep B, C; includes tuberculosis.
- Men's Health.
- Metabolic bone.
- Excludes Nephrology (see code 24); excludes renal (see code 24); excludes dialysis (see code 21).
- Neurology, neurophysiology.
- Occupational medicine.
- Other.
- Pain management
- Palliative.
- Refugee clinic.
- Rehabilitation; excludes cardiac rehabilitation (see code 5).
- Rheumatology.
- Sexual Health.
- Spinal.

- Stoma therapy.
- Transplants (excludes kidney transplants see code 24).
- Wound, Dressing clinic.

CODE 11 General practice/primary care

- General Practice, Primary Care.

Excludes Medicare billable patients; defined specialty general practice clinics only.

CODE 12 Paediatric Medical

- Adolescent health.
- Neonatology.
- Paediatric medicine.

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 13 Endoscopy

Includes all occasions of service for endoscopy including cystoscopy, gastroscopy, oesophagoscopy, duodenoscopy, colonoscopy, bronchoscopy, laryngoscopy and sigmoidoscopy.

Care must be taken to ensure procedures for admitted patients are excluded from this category.

CODE 14 Plastic surgery

- Craniofacial.
- Melanoma.
- Plastic surgery.

CODE 15 Urology

- Urology.

Includes urodynamic measurement and IVPs.

CODE 16 Orthopaedic surgery

- Fracture.
- Hand.
- Orthopaedics Surgery.
- Other.
- Scoliosis.
- Neck of femur.

CODE 17 Ophthalmology

- Ophthalmology.
- Cataract extraction.
- Lens insertion.

CODE 18 Ear, nose and throat

- Ear, nose and throat.
- Otitis media.
- Oral.

CODE 19 Pre-admission and pre-anaesthesia

- Pre-admission.
- Pre-anaesthesia.

CODE 20 Chemotherapy

Includes all forms of chemotherapy.

CODE 21 Dialysis

Dialysis and includes renal dialysis education. See code 24 for Renal medicine

CODE 22 Surgery

- Cardiac.
- Vascular.
- Cardiac catheterisation.
- Colorectal.
- Upper GI surgery.
- General surgery.
- Neurosurgery.
- Other surgery.
- Thoracic surgery.

CODE 23 Paediatric surgery

In paediatric hospitals the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgery should be reported as surgery.

CODE 24 Renal Medical

- Renal Medicine.
- Nephrology.
- Includes pre and post transplant treatment, support and education.
- Excludes dialysis and renal dialysis education. See code 21.

Source and reference attributes

Origin: National Centre for Classification in Health consultant's report to Outpatients National Minimum Data Set Development Working Group, September 2004.

Data element attributes

Collection and usage attributes

Guide for use: Does not include services provided through community health settings (such as community and child health centres).

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Group, 2006

Relational attributes

Related metadata references:

See also [Establishment – number of occasions of service, total N\[NNNNNN\]](#) Health, Standard 04/07/2007

Supersedes [Establishment – outpatient clinic type, code N\[N\]](#) Health, Superseded 04/07/2007

Implementation in Data Set Specifications:

[Outpatient care NMDS](#) Health, Standard 04/07/2007

Implementation start date: 01/07/2007

Overdue patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – overdue patient status, code N
<i>METeOR identifier:</i>	270009
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a patient is an overdue patient, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode – overdue patient status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Overdue patient</td></tr><tr><td>2</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Overdue patient	2	Other
Value	Meaning						
1	Overdue patient						
2	Other						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item is only required for patients in Elective surgery waiting list episode – clinical urgency, code N categories with specified maximum desirable waiting times. Overdue patients are those for whom the hospital system has failed to provide timely care and whose wait may have an adverse effect on the outcome of their care. They are identified by a comparison of Elective surgery waiting list episode – waiting time (at removal), total days N[NNN] or Elective surgery waiting list episode – waiting time (at a census date), total days N[NNN] and the maximum desirable time limit for the Elective surgery waiting list episode – clinical urgency, code N classification.</p> <p>A patient is classified as overdue if ready for care and waiting time at admission or waiting time at a census date is longer than 30 days for patients in Elective surgery waiting list episode – clinical urgency, code N category 1 or 90 days for patients in Elective surgery waiting list episode – clinical urgency, code N category 2.</p>
<i>Comments:</i>	<p>This metadata item is not used for patients in Elective surgery waiting list episode – clinical urgency, code N category 3 as there is no specified timeframe within which it is desirable that they</p>

are admitted. The metadata item Elective surgery waiting list episode—extended wait patient indicator, status code N identifies patients in Elective surgery waiting list episode—clinical urgency, code N category 3 who have waited longer than one year at admission or at the time of a census.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

See also [Elective surgery waiting list episode—clinical urgency, code N](#) Health, Standard 01/03/2005

Is formed using [Elective surgery waiting list episode—waiting time \(at a census date\), total days N\[NNN\]](#) Health, Standard 01/03/2005

Is formed using [Elective surgery waiting list episode—waiting time \(at removal\), total days N\[NNN\]](#) Health, Standard 01/03/2005

Supersedes [Overdue patient, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.4 KB)

Implementation in Data Set Specifications:

[Elective surgery waiting times \(census data\) NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(census data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

[Elective surgery waiting times \(census data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(removals data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Palliative care agency service delivery setting

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – service delivery setting, palliative care agency code N
<i>METeOR identifier:</i>	297661
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The setting in which a palliative care agency delivers palliative care services, as represented by a code.
Data Element Concept:	Service provider organisation – service delivery setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Private residence</td></tr><tr><td>2</td><td>Residential - aged care setting</td></tr><tr><td>3</td><td>Residential - other setting</td></tr><tr><td>4</td><td>Non-residential setting</td></tr><tr><td>5</td><td>Inpatient - designated palliative care unit or hospice</td></tr><tr><td>6</td><td>Inpatient - other than a designated palliative care unit</td></tr><tr><td>7</td><td>Outpatient - in a hospital/hospice</td></tr></tbody></table>	Value	Meaning	1	Private residence	2	Residential - aged care setting	3	Residential - other setting	4	Non-residential setting	5	Inpatient - designated palliative care unit or hospice	6	Inpatient - other than a designated palliative care unit	7	Outpatient - in a hospital/hospice
Value	Meaning																
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4	Non-residential setting																
5	Inpatient - designated palliative care unit or hospice																
6	Inpatient - other than a designated palliative care unit																
7	Outpatient - in a hospital/hospice																

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Private residence This may include a caravan, a mobile home, a houseboat or a unit in a retirement village.</p> <p>CODE 2 Residential - aged care setting Includes high and low care residential aged care facilities. Does not include units in a retirement village.</p> <p>CODE 3 Residential - other setting Includes a residential facility other than an aged care facility; a prison; or a community living environment including a group home. This code does not include inpatient settings e.g. hospitals and hospices.</p>
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CODE 4 Non-residential setting

Includes day respite centres and day centres. It does not include hospital outpatient departments.

CODE 5 Inpatient - designated palliative care unit or hospice

A dedicated ward or unit that receives identified funding for palliative care and/or primarily delivers palliative care. The unit may be a standalone unit (i.e. a hospice).

CODE 6 Inpatient - other than designated palliative care unit

Includes all beds not in a unit designated for palliative care. These are usually located in acute hospital wards. Excludes designated palliative care units.

CODE 7 Outpatient - in a hospital/hospice

Includes palliative care services provided at a hospital/hospice in an outpatient setting. Excludes all inpatient settings.

Collection methods:

More than one code can be recorded.

Source and reference attributes

Submitting organisation:

Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

[Palliative care performance indicators DSS](#) Health, Standard 05/12/2007

Parity

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female – parity, total N[N]
<i>METeOR identifier:</i>	302013
<i>Registration status:</i>	Health, Standard 29/11/2006
<i>Definition:</i>	The total number of previous pregnancies experienced by the woman that have resulted in a live birth or a stillbirth.
Data Element Concept:	Female – parity

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N]				
<i>Maximum character length:</i>	2				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	99	Not stated
Value	Meaning				
99	Not stated				
<i>Unit of measure:</i>	Pregnancy				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This is to be recorded for each pregnancy.</p> <p>This data element includes live births and stillbirths of 20 weeks gestation or 400 grams birthweight.</p> <p>This data element excludes:</p> <ul style="list-style-type: none">• the current pregnancy;• pregnancies resulting in spontaneous or induced abortions before 20 weeks gestation; and• ectopic pregnancies. <p>A primigravida (a woman pregnant for the first time) has a parity of 0.</p>
<i>Collection methods:</i>	A pregnancy with multiple fetuses is counted as one pregnancy.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Partner organisation type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – partner organisation type, palliative care code N[N]
<i>METeOR identifier:</i>	290715
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The type of organisation with which a palliative care service provider organisation has formal working partnership(s) in place, as represented by a code.
Data Element Concept:	Service provider organisation – partner organisation type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																								
<i>Data type:</i>	Number																								
<i>Format:</i>	N[N]																								
<i>Maximum character length:</i>	2																								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Palliative care services</td></tr><tr><td>2</td><td>Hospitals</td></tr><tr><td>3</td><td>Community nursing agencies</td></tr><tr><td>4</td><td>Residential aged care facilities</td></tr><tr><td>5</td><td>Allied health services</td></tr><tr><td>6</td><td>Aboriginal health services</td></tr><tr><td>7</td><td>Medical practices</td></tr><tr><td>8</td><td>Integrated health centres</td></tr><tr><td>9</td><td>Universities/research centres</td></tr><tr><td>10</td><td>Volunteer support services</td></tr><tr><td>99</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Palliative care services	2	Hospitals	3	Community nursing agencies	4	Residential aged care facilities	5	Allied health services	6	Aboriginal health services	7	Medical practices	8	Integrated health centres	9	Universities/research centres	10	Volunteer support services	99	Other
Value	Meaning																								
1	Palliative care services																								
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10	Volunteer support services																								
99	Other																								

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A formal working partnership involves arrangements between a service provider organisation and other service providers and organisations, aimed at providing integrated and seamless care, so that clients are able to move smoothly between services and service settings.</p> <p>A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes of the agreement.</p>
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Key elements of a formal working partnership are that it is organised, routine, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships include the existence of: written service agreements; formal liaison; referral and discharge planning processes; formal and routine consultation; protocols; partnership working groups; memoranda of understanding with other providers; and case conferencing.

Where partnerships exist for case conferencing purposes, record all partners involved.

CODE 1 Palliative care services

Includes services whose substantive work is with patients who have a life-limiting illness. These palliative care services may provide services in the community and/or in admitted patient settings (including hospices).

CODE 2 Hospitals

Includes emergency departments. Excludes hospices/designated palliative care units in a hospital, and other palliative care agencies as defined under Code 1. Also excludes hospital-based allied health services and individual medical practitioners.

CODE 7 Medical practices

Includes practices of general practitioners and individual specialist physicians such as specialists in palliative care, oncologists, urologists and neurologists.

CODE 8 Integrated health centres

Includes multipurpose centres, aged care centres and specialist care centres such as cancer centres.

CODE 9 Universities/research centres

Includes universities that may undertake research and development projects.

CODE 99 Other

Includes organisations based in the community such as schools, clubs, workplaces, organisations that provide respite care or pastoral care and 'Meals on wheels'.

Collection methods:

More than one code can be recorded.

Source and reference attributes

Submitting organisation:

Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

[Palliative care performance indicators DSS](#) Health, Standard 05/12/2007

Conditional obligation:

Recorded when the data element *Service provider organisation – working partnerships indicator, yes/no code N* is 'yes' (code 1).

Patient days

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of patient days, total N[N(7)]
<i>METeOR identifier:</i>	270045
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of days for all patients who were admitted for an episode of care and who separated during a specified reference period.
Data Element Concept:	Establishment – number of patient days

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[N(7)]
<i>Maximum character length:</i>	8
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A day is measured from midnight to 2359 hours.</p> <p>The following basic rules are used to calculate the number of patient days for overnight stay patients:</p> <ul style="list-style-type: none">• The day the patient is admitted is a patient day• If the patient remains in hospital from midnight to 2359 hours count as a patient day• The day a patient goes on leave is counted as a leave day• If the patient is on leave from midnight to 2359 hours count as a leave day• The day the patient returns from leave is counted as a patient day• The day the patient is separated is not counted as a patient day. <p>The following additional rules cover special circumstances and in such cases, override the basic rules:</p> <ul style="list-style-type: none">• Patients admitted and separated on the same date (same-day patients) are to be given a count of one patient day• If the patient is admitted and goes on leave on the same day, count as a patient day• If the patient returns from leave and goes on leave on the same date, count as a leave day.
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- If the patient returns from leave and is separated, it is not counted as either a patient day or a leave day.
- If a patient goes on leave the day they are admitted and does not return from leave until the day they are discharged, count as one patient day (the day of admission is counted as a patient day, the day of separation is not counted as a patient day).

When calculating total patient days for a specified period:

- Count the total patient days of those patients separated during the specified period including those admitted before the specified period
- Do not count the patient days of those patients admitted during the specified period who did not separate until the following reference period
- Contract patient days are included in the count of total patient days. If it is a requirement to distinguish contract patient days from other patient days, they can be calculated by using the rules contained in the data element: total contract patient days.

Source and reference attributes

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Is formed using [Episode of admitted patient care \(newborn\)—number of qualified days, total N\[NNNN\]](#) Health, Standard 01/03/2005

Supersedes [Patient days, version 3, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.2 KB)

Patient listing status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – patient listing status, readiness for care code N
<i>METeOR identifier:</i>	269996
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	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

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Ready for care</td></tr><tr><td>2</td><td>Not ready for care</td></tr></tbody></table>	Value	Meaning	1	Ready for care	2	Not ready for care
Value	Meaning						
1	Ready for care						
2	Not ready for care						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>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:</p> <ul style="list-style-type: none">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; ordeferred 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. <p>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.</p>
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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:

Only patients ready for care are to be included in the National Minimum Data Set - Elective surgery waiting times. 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)

Is used in the formation of [Elective surgery waiting list episode – waiting time \(at a census date\), total days N\[NNN\]](#) Health, Standard 01/03/2005

Patient present status (non-admitted patient)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient service event – patient present status, code N
<i>METeOR identifier:</i>	270081
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The presence or absence of a patient at a service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event – patient present status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Patient present with or without carer(s)/relative(s)</td></tr><tr><td>2</td><td>Carer(s)/relative(s) of the patient only</td></tr></tbody></table>	Value	Meaning	1	Patient present with or without carer(s)/relative(s)	2	Carer(s)/relative(s) of the patient only
Value	Meaning						
1	Patient present with or without carer(s)/relative(s)						
2	Carer(s)/relative(s) of the patient only						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Non-admitted patient service event - patient present status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
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Patients in residence at year end

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – patients/clients in residence at year end, total N[NNN]
<i>METeOR identifier:</i>	270046
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A headcount of all formally admitted patients/clients in residence in long-stay facilities.
Data Element Concept:	Establishment – patients/clients in residence at year end

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN]
<i>Maximum character length:</i>	4
<i>Unit of measure:</i>	Person

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>For public psychiatric hospitals and alcohol and drug hospitals, all states have either an annual census or admission tracking that would enable a statistical census. The Commonwealth Department of Health and Ageing is able to carry out a statistical census from its residential aged care service databases.</p> <p>A headcount snapshot could be achieved either by census or by the admission/discharge derivation approach.</p> <p>There are difficulties with the snapshot in view of both seasonal and day of the week fluctuations. Most of the traffic occurs in a small number of beds.</p> <p>Any headcount should avoid the problems associated with using 31 December or 1 January. The end of the normal financial year is probably more sensible (the Wednesday before the end of the financial year was suggested, but probably not necessary). This should be qualified by indicating that the data does not form a time series in its own right.</p>
<i>Comments:</i>	<p>The number of separations and bed days for individual long-stay establishments is often a poor indication of the services provided. This is because of the relatively small number of separations in a given institution. Experience has shown that the number of patients/clients in residence can often give a more reliable picture of the levels of services being provided.</p>

Source and reference attributes

Submitting organisation: Morbidity working party

Relational attributes

Related metadata references: Supersedes [Patients in residence at year end, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.9 KB)

Percutaneous coronary intervention procedure type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – percutaneous coronary intervention procedure type, code N
<i>Synonymous names:</i>	PCI procedure type
<i>METeOR identifier:</i>	359751
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of procedure performed during a percutaneous coronary intervention (PCI), as represented by a code.
Data Element Concept:	Person – percutaneous coronary intervention procedure type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	String								
<i>Format:</i>	N								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Balloon angioplasty only</td></tr><tr><td>2</td><td>Bare metal stent implantation</td></tr><tr><td>3</td><td>Drug-eluting stent implantation</td></tr></tbody></table>	Value	Meaning	1	Balloon angioplasty only	2	Bare metal stent implantation	3	Drug-eluting stent implantation
Value	Meaning								
1	Balloon angioplasty only								
2	Bare metal stent implantation								
3	Drug-eluting stent implantation								
<i>Supplementary values:</i>	99 Not stated/inadequately described								

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Balloon angioplasty only Use this code where only balloon angioplasty has been performed during a percutaneous coronary intervention.</p> <p>CODE 2 Bare metal stent implantation Use this code where a bare metal stent has been implanted during a percutaneous coronary intervention.</p> <p>CODE 3 Drug-eluting stent implantation Use this code where at least one drug-eluting stent has been implanted during a percutaneous coronary intervention (i.e. if more than one stent has been placed during the procedure and at least one stent is a drug-eluting stent).</p> <p>CODES 2 and 3 include the performance of balloon angioplasty.</p>
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Data element attributes

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

Implementation in Data Set Specifications:

[Coronary artery cluster](#) Health, Standard 01/10/2008

Conditional obligation:

Record when a percutaneous coronary intervention is performed. This includes those performed for primary, rescue or revascularisation reasons.

Perineal status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female (mother) – postpartum perineal status, code N
<i>METeOR identifier:</i>	269939
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The state of the perineum following birth, as represented by a code.
<i>Context:</i>	Perinatal
<i>Data Element Concept:</i>	Female (mother) – postpartum perineal status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Intact</td></tr><tr><td>2</td><td>1st degree laceration/vaginal graze</td></tr><tr><td>3</td><td>2nd degree laceration</td></tr><tr><td>4</td><td>3rd degree laceration</td></tr><tr><td>5</td><td>Episiotomy</td></tr><tr><td>6</td><td>Combined laceration and episiotomy</td></tr><tr><td>7</td><td>4th degree laceration</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	1	Intact	2	1st degree laceration/vaginal graze	3	2nd degree laceration	4	3rd degree laceration	5	Episiotomy	6	Combined laceration and episiotomy	7	4th degree laceration	8	Other	9	Not stated
Value	Meaning																				
1	Intact																				
2	1st degree laceration/vaginal graze																				
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4	3rd degree laceration																				
5	Episiotomy																				
6	Combined laceration and episiotomy																				
7	4th degree laceration																				
8	Other																				
9	Not stated																				
<i>Supplementary values:</i>																					

Collection and usage attributes

<i>Guide for use:</i>	Vaginal tear is included in the same group as 1st degree laceration to be consistent with ICD-10-AM code. Other degrees of laceration are as defined in ICD-10-AM.
<i>Comments:</i>	While 4th degree laceration is more severe than an episiotomy it has not been placed in order of clinical significance within the data domain. Instead it has been added to the data domain as a new code rather than modifying the existing order of data domain code values. This is because information gatherers are accustomed to the existing order of the codes. Modifying the existing order may result in miscoding of data. This approach is consistent with established practice in classifications wherein a new data 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 data domain identifier.

Data element attributes

Collection and usage attributes

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 intervention rates.

Relational attributes

Related metadata references: Supersedes [Perineal status, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.8 KB)

Period of residence in Australia

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – period of residence in Australia, years code NN
<i>METeOR identifier:</i>	270050
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Length of time in years a person has lived in Australia.
<i>Data Element Concept:</i>	Person – period of residence in Australia

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	String										
<i>Format:</i>	NN										
<i>Maximum character length:</i>	2										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>00</td><td>Under one year residence in Australia</td></tr><tr><td>01-97</td><td>1 to 97 years residence in Australia</td></tr><tr><td>98</td><td>Born in Australia</td></tr><tr><td>99</td><td>Unknown</td></tr></tbody></table>	Value	Meaning	00	Under one year residence in Australia	01-97	1 to 97 years residence in Australia	98	Born in Australia	99	Unknown
Value	Meaning										
00	Under one year residence in Australia										
01-97	1 to 97 years residence in Australia										
98	Born in Australia										
99	Unknown										
<i>Supplementary values:</i>											

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	This information may be obtained either from: <ul style="list-style-type: none">• a direct question with response values as specified in the data domain; or• derived from other questions about date of birth, birthplace and year of arrival in Australia.
<i>Comments:</i>	<p>This metadata item was included in the recommended second-level data set by the National Committee on Health and Vital Statistics (1979) to allow analyses relating to changes in morbidity patterns of ethnic subpopulations related to length of stay in host country; for example, cardiovascular disease among Greek immigrants in Australia.</p> <p>This item was not considered a high priority by the Office of Multicultural Affairs (1988) and to date only the country of birth and Indigenous status are considered by the National Health Data Committee to be justified for inclusion in the National Minimum Data Set - Admitted patient care.</p>

Source and reference attributes

Submitting organisation:

National minimum data set working parties

Relational attributes

Related metadata references:

Supersedes [Period of residence in Australia, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.6 KB)

Peripheral neuropathy (status)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – peripheral neuropathy indicator, code N
<i>METeOR identifier:</i>	302457
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether peripheral neuropathy is present, as represented by a code.
Data Element Concept:	Person – peripheral neuropathy indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if peripheral neuropathy is present in the person. CODE 2 No: Record if peripheral neuropathy is not present in the person. Record whether or not peripheral neuropathy is present determined by clinical judgement following assessment using pinprick and vibration (using perhaps a Biothesiometer) or Monofilament.
<i>Collection methods:</i>	Examine for neuropathy by testing reflexes and sensation preferably using tuning fork (standard vibration fork 128 hz), pinprick, 10g monofilament and/or biothesiometer. The preferred assessment methods are monofilament and biothesiometer. These two non-invasive tests provide more objective and repeatable results than testing sensation with pinprick or a tuning fork, which are very difficult to standardise.

1 The 'Touch-Test' Sensory Evaluation (Semens-Weinstein Monofilaments) application guidelines:

- Occlude the patient's vision by using a shield or by having the patient look away or close his or her eyes.
- Instruct the patient to respond when a stimulus is felt by saying 'touch' or 'yes'.
- Prepare to administer the stimulus to the foot (dorsal or plantar surface).
- Press the filament of the Touch
- Test at a 90 degree angle against the skin until it bows. Hold in place for approximately 1.5 seconds and then remove.

To assure the validity of the sensory test findings:

- The patient must not be able to view the administration of the stimuli so that false indications are avoided.
- The nylon filament must be applied at a 90 degree angle against the skin until it bows for approximately 1.5 second before removing.
- If the patient does not feel the filament, then protective pain sensation has been lost.

2 Testing vibration sensation with a biothesiometer - application guidelines:

- The biothesiometer has readings from 0 to 50 volts. It can be made to vibrate at increasing intensity by turning a dial.
- A probe is applied to part of the foot, usually on the big toe.
- The person being tested indicates as soon as he/she can feel the vibration and the reading on the dial at that point is recorded.

The reading is low in young normal individuals (i.e. they are very sensitive to vibration). In older individuals, the biothesiometer reading becomes progressively higher. From experience, it is known that the risk of developing a neuropathic ulcer is much higher if a person has a biothesiometer reading greater than 30-40 volts.

Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents:

1997 North Coast Medical, INC. San Jose, CA 95125; 800 821 - 9319

Duffy MD, John C and Patout MD, Charles A. 1990. 'Management of the Insensitive Foot in Diabetes: Lessons from Hansen's Disease'. *Military Medicine*, 155:575-579

Bell- Krotovski OTR, FAOT, FAOTA, Judith and Elizabeth Tomancik LOTR. 1987. The Repeatability of testing with Semmens-Weinstein Monofilaments. 'The Journal of Hand Surgery,' 12A: 155 - 161

Edmonds M, Boulton A, Buckenham T, et al. Report of the Diabetic Foot and Amputation Group. Diabet Med 1996; 13: S27 - 42

Foot Examination -an interactive guide; Aust Prescr 2002; 25:8 - 10

Relational attributes

Related metadata references:

Supersedes [Person – peripheral neuropathy status, code N](#) Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Peripheral vascular disease in feet (status)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – peripheral vascular disease indicator (foot), code N
<i>METeOR identifier:</i>	302459
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether peripheral vascular disease is present in either foot, as represented by a code.
Data Element Concept:	Person – peripheral vascular disease indicator (foot)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if peripheral vascular disease is present in either foot. CODE 2 No: Record if peripheral vascular disease is not present in either foot.
<i>Collection methods:</i>	If it is mild, peripheral vascular disease can be completely without symptoms. However, compromised blood supply in the long term could cause claudication (pain in the calf after walking for a distance or up an incline or stairs), rest pain or vascular ulceration. Physical examination is necessary to assess the peripheral vascular circulation. Purplish colour and cold temperature of feet are indications to suspect that the circulation may be impaired. Palpate pulses: The simplest method to estimate blood flow and to detect

ischaemia to the lower extremities is palpation of the foot pulses (posterior tibial and dorsalis pedis arteries) in both feet. Note whether pulses are present or absent. If pulses in the foot can be clearly felt, the risk of foot ulceration due to vascular disease is small.

Test capillary return:

A helpful confirmation sign of arterial insufficiency is pallor of the involved feet after 1 - 2 min of elevation if venous filling time is delayed beyond the normal limit of 15 sec.

Doppler probe:

If pulses cannot be palpated, apply a small hand-held Doppler, placed over the dorsalis pedis or posterior tibial arteries to detect pulses, quantify the vascular supply and listen to the quality of the signal.

When the foot pulses are very weak or not palpable, the risk assessment could be completed by measuring the ankle brachial index (ankle pressure/ brachial pressure). Normal ankle brachial index is 0.9 - 1.2. An ankle brachial index less than 0.6 indicates compromised peripheral circulation.

Source and reference attributes

Submitting organisation:

National Diabetes Data Working Group

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Supersedes [Person – peripheral vascular disease status \(foot\), code N](#) Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Person identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – person identifier, XXXXXX[X(14)]
<i>METeOR identifier:</i>	290046
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
<i>Definition:</i>	Person identifier unique within an establishment or agency.
Data Element Concept:	Person – person identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	XXXXXX[X(14)]
<i>Maximum character length:</i>	20

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Individual agencies, establishments or collection authorities may use their own alphabetic, numeric or alphanumeric coding systems. Field cannot be blank.
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Source and reference attributes

<i>Reference documents:</i>	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia
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Relational attributes

<i>Related metadata references:</i>	Supersedes Person – person identifier (within establishment/ agency), XXXXXX[X(14)] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008 Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005 Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008 Admitted patient care NMDS Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded
05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded
04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded
22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

[Alcohol and other drug treatment services NMDS](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#)
Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#)
Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#)
Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard
22/12/2009

[Community mental health care 2004-2005](#) Health, Superseded
08/12/2004

Implementation start date: 01/07/2004
Implementation end date: 30/06/2005

[Community mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005
Implementation end date: 30/06/2006

[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006
Implementation end date: 30/06/2007

[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007
Implementation end date: 30/06/2008

[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008
Implementation end date: 30/06/2009

[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009
Implementation end date: 30/06/2010

[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Health care client identification DSS](#) Health, Superseded
03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Perinatal NMDS](#) Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Residential mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Person identifier type—health care (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (identifier)—identifier type, geographic/administrative scope code A
<i>METeOR identifier:</i>	270053
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A code based on the geographical or administrative breadth of applicability of Person identifier.
Data Element Concept:	Person (identifier)—identifier type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	String								
<i>Format:</i>	A								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>L</td><td>Local</td></tr><tr><td>A</td><td>Area/region/district</td></tr><tr><td>S</td><td>State or territory</td></tr></tbody></table>	Value	Meaning	L	Local	A	Area/region/district	S	State or territory
Value	Meaning								
L	Local								
A	Area/region/district								
S	State or territory								

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE L Local</p> <p>This code is for an identifier that is applicable only inside the issuing health care establishment</p> <p>CODE A Area/region/district</p> <p>This code is for an identifier that is applicable to:</p> <ul style="list-style-type: none">• all the area/region/district health care services but not across all services in the state or territory; or• all of a specific health care service (e.g. community mental health) in an area/region/district health care services but not across all those services in the state or territory <p>CODE S State or territory</p> <p>This code is for identifiers that are applicable across all state or territory health care services.</p>
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	A person can have more than one person identifier. Each Person identifier must have an appropriate person identifier type code recorded.
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Use this field to record only identifier type. It must not be used to record any other person related information.

Source and reference attributes

Submitting organisation: Standards Australia
Origin: AS5017 Health Care Client Identification

Relational attributes

Related metadata references: Supersedes [Person identifier type - health care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.7 KB)
Implementation in Data Set Specifications: [Health care client identification](#) Health, Superseded 04/05/2005
[Health care client identification DSS](#) Health, Superseded 03/12/2008
[Health care client identification DSS](#) Health, Standard 03/12/2008

Pharmacotherapy type prescribed for acute coronary syndrome in hospital

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with acute coronary syndrome – pharmacotherapy type prescribed in hospital, code N[N]
<i>Synonymous names:</i>	ACS pharmacotherapy type prescribed
<i>METeOR identifier:</i>	344344
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of pharmacotherapy prescribed to a person in hospital for the treatment of acute coronary syndrome, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome – pharmacotherapy type prescribed in hospital

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N[N]																				
<i>Maximum character length:</i>	2																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Aspirin</td></tr><tr><td>2</td><td>Angiotensin converting enzyme (ACE) inhibitor</td></tr><tr><td>3</td><td>Angiotensin II receptor blocker</td></tr><tr><td>4</td><td>Antithrombin</td></tr><tr><td>5</td><td>Beta-blocker</td></tr><tr><td>6</td><td>Clopidogrel</td></tr><tr><td>7</td><td>Fibrinolytic</td></tr><tr><td>8</td><td>Glycoprotein IIb/IIIa receptor antagonist</td></tr><tr><td>9</td><td>Statin</td></tr></tbody></table>	Value	Meaning	1	Aspirin	2	Angiotensin converting enzyme (ACE) inhibitor	3	Angiotensin II receptor blocker	4	Antithrombin	5	Beta-blocker	6	Clopidogrel	7	Fibrinolytic	8	Glycoprotein IIb/IIIa receptor antagonist	9	Statin
Value	Meaning																				
1	Aspirin																				
2	Angiotensin converting enzyme (ACE) inhibitor																				
3	Angiotensin II receptor blocker																				
4	Antithrombin																				
5	Beta-blocker																				
6	Clopidogrel																				
7	Fibrinolytic																				
8	Glycoprotein IIb/IIIa receptor antagonist																				
9	Statin																				
<i>Supplementary values:</i>	99 Not stated/inadequately described																				

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Aspirin Includes: aspirin, astrix, cardiprin, cartia, aspro, disprin and solprin
	CODE 2 Angiotensin converting enzyme (ACE) inhibitor Includes: captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril andtrandolapril
	CODE 3 Angiotensin II receptor blocker

Includes: candesartan, eprosartan, irbesartan, losartin and temisartan

CODE 4 Antithrombin

Includes: dalteparin, danaparoid, enoxaparin, heparin, phenindione, warfarin, bivalirudin, fondaparinux, lepirudin

CODE 5 Beta-blocker

Includes: atenolol, bisoprolol, carvedilol, esmolol, labetolol, metoprolol, oxprenolol, pindolol, propranolol and sotalol

CODE 6 Clopidogrel

Includes: iscover and plavix

CODE 7 Fibrinolytic

Includes: streptokinase, tissue plasminogen activator (t-PA) (alteplase), reteplase (r-PA) and tenecteplase (TNK t-PA)

CODE 8 Glycoprotein IIb/IIIa receptor

Includes: abciximab, eptifibatide and tirofiban

CODE 9 Statin

Includes: atorvastatin, fluvastatin, pravastatin and simvastatin

Data element attributes

Collection and usage attributes

Guide for use:

A person may be prescribed one or more type of medication for acute coronary syndromes. Therefore more than one code may be recorded.

Collection methods:

This information should be recorded at the end of the person's hospital stay involving the treatment of acute coronary syndromes.

Comments:

The purpose of this data element is to collect information on the prescription of pharmacotherapy recommended for the treatment of acute coronary syndromes in the national guidelines. Additional information on the specific drug types prescribed is not required for this quality purpose.

The health service may choose to collect additional information on the specific drug types prescribed within each of the core pharmacotherapies.

Source and reference attributes

Reference documents:

National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Pharmacotherapy type taken for acute coronary syndrome post discharge

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with acute coronary syndrome – pharmacotherapy type taken post discharge from hospital, code N[N]
<i>METeOR identifier:</i>	344822
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of pharmacotherapy being taken by a person for the treatment of acute coronary syndrome following discharge from hospital, as represented by a code.
Data Element Concept:	Person with acute coronary syndrome – pharmacotherapy type taken post discharge from hospital

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N[N]														
<i>Maximum character length:</i>	2														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Aspirin</td></tr><tr><td>2</td><td>Angiotensin converting enzyme (ACE) inhibitor</td></tr><tr><td>3</td><td>Angiotensin II receptor blocker</td></tr><tr><td>4</td><td>Beta-blocker</td></tr><tr><td>5</td><td>Clopidogrel</td></tr><tr><td>6</td><td>Statin</td></tr></tbody></table>	Value	Meaning	1	Aspirin	2	Angiotensin converting enzyme (ACE) inhibitor	3	Angiotensin II receptor blocker	4	Beta-blocker	5	Clopidogrel	6	Statin
Value	Meaning														
1	Aspirin														
2	Angiotensin converting enzyme (ACE) inhibitor														
3	Angiotensin II receptor blocker														
4	Beta-blocker														
5	Clopidogrel														
6	Statin														
<i>Supplementary values:</i>	99 Not stated/inadequately described														

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Aspirin Includes: aspirin, astrix, cardiprin, cartia, aspro, disprin and solprin</p> <p>CODE 2 Angiotensin converting enzyme (ACE) inhibitor Includes: captopril, enalapril, fosinopril, lisinopril, perindopril, quinapril, ramipril andtrandolapril</p> <p>CODE 3 Angiotensin II receptor blocker Includes: candesartan, eprosartan, irbesartan, losartin and temisartan</p> <p>CODE 4 Beta-blocker Includes: atenolol, bisoprolol, carvedilol, esmolol, labetolol, metoprolol, oxprenolol, pindolol, propranolol and sotalol</p>
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CODE 5 Clopidogrel

Includes: iscover and plavix

CODE 6 Statin

Includes: atorvastatin, fluvastatin, pravastatin and simvastatin

Data element attributes

Collection and usage attributes

Guide for use:

A person may be taking one or more type of medication for acute coronary syndromes (ACS). Therefore more than one code may be recorded.

Collection methods:

Following a person's hospital stay for ACS, follow-up consultations with a clinician may occur at various intervals, such as 3, 6 or 12 months after discharge from hospital. The medications being taken by the person at the time of each follow-up consultation should be recorded.

Comments:

The pharmacotherapies for the treatment of ACS that could be taken post discharge from hospital are different from the types that could be taken during the hospital stay as not all of the pharmacotherapies used for the treatment of ACS are for out of hospital use.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Physical activity sufficiency status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – physical activity sufficiency status, code N
<i>METeOR identifier:</i>	270054
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Sufficiency of moderate or vigorous physical activity to confer a health benefit, as represented by a code.
Data Element Concept:	Person – physical activity sufficiency status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Sufficient</td></tr><tr><td>2</td><td>Insufficient</td></tr><tr><td>3</td><td>Sedentary</td></tr></tbody></table>	Value	Meaning	1	Sufficient	2	Insufficient	3	Sedentary
Value	Meaning								
1	Sufficient								
2	Insufficient								
3	Sedentary								
<i>Supplementary values:</i>	9 Not stated/inadequately described								

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The clinician makes a judgment based on assessment of the person's reported physical activity history for a usual 7-day period where:</p> <p>CODE 1: Sufficient physical activity for health benefit for a usual 7-day period is calculated by summing the total minutes of walking, moderate and/or vigorous physical activity. Vigorous physical activity is weighted by a factor of two to account for its greater intensity. Total minutes for health benefit need to be equal to or more than 150 minutes per week.</p> <p>CODE 2: Insufficient physical activity for health benefit is where the sum of the total minutes of walking, moderate and/or vigorous physical activity for a usual 7-day period is less than 150 minutes but more than 0 minutes.</p> <p>CODE 3: Sedentary is where there has been no moderate and/or vigorous physical activity during a usual 7-day period.</p>
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CODE 9:

There is insufficient information to more accurately define the person's physical activity sufficiency status or the information is not known.

Note: The National Heart Foundation of Australia and the National Physical Activity Guidelines for Australians describes moderate-intensity physical activity as causing a slight but noticeable, increase in breathing and heart rate and suggests that the person should be able to comfortably talk but not sing. Examples of moderate physical activity include brisk walking, low pace swimming, light to moderate intensity exercise classes. Vigorous physical activity is described as activity, which causes the person to 'huff and puff', and where talking in a full sentence between breaths is difficult.

Examples of vigorous physical activity include jogging, swimming (freestyle) and singles tennis.

Comments:

The above grouping subdivides a population into three mutually exclusive categories.

A sufficiently physically active person is a person who is physically active on a regular weekly basis equal to or in excess of that required for a health benefit. Sufficient physical activity for health results from participation in physical activity of adequate duration and intensity. Although there is no clear absolute threshold for health benefit, the accrual of 150 minutes of moderate (at least) intensity physical activity over a period of one week is thought to confer health benefit. Walking is included as a moderate intensity physical activity. Note that the 150 minutes of moderate physical activity should be made up of 30 minutes on most days of the week and this can be accumulated in 10 minute bouts (National Physical Activity Guidelines for Australians).

Health benefits can also be obtained by participation in vigorous physical activity, in approximate proportion to the total amount of activity performed, measured either as energy expenditure or minutes of physical activity (Pate et al. 1995).

Physical activity - health benefit for vigorous physical activity is calculated by:

- incorporating a weighted factor of 2, to account for its greater intensity
- summing the total minutes of walking, moderate and/or vigorous physical activity will then give an indication if a health benefit is likely.

Insufficient physical activity describes a person who engages in regular weekly physical activity but not to the level required for a health benefit through either moderate or vigorous physical activity.

A sedentary person is a person who does not engage in any regular weekly physical activity.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

The National Heart Foundation of Australia's Physical Activity Policy, April 2001. National Physical Activity Guidelines For Australians, developed by the University of Western Australia & the Centre for Health Promotion

Relational attributes

Related metadata references:

Supersedes [Physical activity sufficiency status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.5 KB)

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

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

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Injury event – place of occurrence, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	391334
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	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

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	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.
<i>Comments:</i>	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

<i>Origin:</i>	National Centre for Classification in Health AIHW National Injury Surveillance Unit National Data Standards for Injury Surveillance Advisory Group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Injury event – place of occurrence, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009
<i>Implementation in Data Set</i>	Admitted patient care NMDS 2010-2011 Health, Standard

Specifications:

22/12/2009

Implementation start date: 01/07/2010

[Injury surveillance DSS](#) Health, Standard 14/12/2009

Place of occurrence of external cause of injury (non-admitted patient)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Injury event – place of occurrence, non-admitted patient code N[N]
<i>METeOR identifier:</i>	268949
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	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

<i>Representation class:</i>	Code																										
<i>Data type:</i>	Number																										
<i>Format:</i>	N[N]																										
<i>Maximum character length:</i>	2																										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Home</td></tr><tr><td>1</td><td>Residential Institution</td></tr><tr><td>2</td><td>School, other institution and public administration area</td></tr><tr><td>21</td><td>School</td></tr><tr><td>22</td><td>Health service area</td></tr><tr><td>23</td><td>Building used by general public or public group</td></tr><tr><td>3</td><td>Sports and athletics area</td></tr><tr><td>4</td><td>Street and highway</td></tr><tr><td>5</td><td>Trade and service area</td></tr><tr><td>6</td><td>Industrial and construction area</td></tr><tr><td>7</td><td>Farm</td></tr><tr><td>8</td><td>Other specified places</td></tr></tbody></table>	Value	Meaning	0	Home	1	Residential Institution	2	School, other institution and public administration area	21	School	22	Health service area	23	Building used by general public or public group	3	Sports and athletics area	4	Street and highway	5	Trade and service area	6	Industrial and construction area	7	Farm	8	Other specified places
Value	Meaning																										
0	Home																										
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3	Sports and athletics area																										
4	Street and highway																										
5	Trade and service area																										
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8	Other specified places																										
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Unspecified place</td></tr></tbody></table>	9	Unspecified place																								
9	Unspecified place																										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To be used for injury surveillance purposes for non-admitted patients when it is not possible to use ICD-10-AM codes. Select the code which best characterises the type of place where the
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person was situated when the injury occurred on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list.

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes [Place of occurrence of external cause of injury, version 6, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.1 KB)

Implementation in Data Set Specifications: [Injury surveillance DSS](#) Health, Superseded 05/02/2008
[Injury surveillance DSS](#) Health, Superseded 14/12/2009
[Injury surveillance DSS](#) Health, Standard 14/12/2009
[Injury surveillance NMDS](#) Health, Superseded 03/05/2006
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Injury surveillance NMDS](#) Health, Superseded 07/12/2005

Postal delivery point identifier (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – postal delivery point identifier, {N(8)}
<i>Synonymous names:</i>	Australian delivery point identifier
<i>METeOR identifier:</i>	287220
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
<i>Definition:</i>	A unique number assigned to a person's postal address as recorded on the Australia Post Postal Address File (PAF).
Data Element Concept:	Person (address) – postal delivery point identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	{N(8)}
<i>Maximum character length:</i>	8

Source and reference attributes

<i>Origin:</i>	Customer Barcoding Technical Specifications, 1998: Australia Post
<i>Reference documents:</i>	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Australia Post maintains a Postal Address File (PAF) database which contains Australian postal delivery addresses and their corresponding eight (8) character unique identification number known as a Delivery Point Identifier (DPID). While the PAF is concerned with postal address, for many persons' a postal address will be the same as their residential address. The PAF can be used to improve the recording of address data at the time of data collection. The Postal Address File may be used at the time of data collection to confirm that the combined metadata items of address line, suburb/town/locality, Australian state/territory identifier and postcode - Australian are accurately recorded.
<i>Collection methods:</i>	The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.

Comments:

In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses.

The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

National Health Data Standards Committee

National Community Services Data Committee

Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Reference documents:

AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes [Person \(address\) – postal delivery point identifier, {N\(8\)}](#) Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is formed using [Person \(address\) – suburb/town/locality name, text \[A\(50\)\]](#) Health, Standard 04/05/2005, Community services, Standard 25/08/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Postal delivery point identifier (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – postal delivery point identifier, {N(8)}
<i>METeOR identifier:</i>	290141
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
<i>Definition:</i>	A unique number assigned to a service provider organisation's postal address as recorded on the Australia Post Postal Address File (PAF).
Data Element Concept:	Service provider organisation (address) – postal delivery point identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	{N(8)}
<i>Maximum character length:</i>	8

Source and reference attributes

<i>Origin:</i>	Customer Barcoding Technical Specifications, 1998: Australia Post
<i>Reference documents:</i>	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	The Delivery Point Identifier (DPID) is assigned electronically to recognised Australia Post delivery addresses following reference to the Postal Address File (PAF) database.
<i>Comments:</i>	<p>In October 1999, Australia Post introduced a bar-coding system for bulk mail lodgements. Agencies or establishments can use software to improve the quality of person address data it collects and records and, at the same time, receive financial benefits by reducing its postage expenses.</p> <p>The DPID is easily converted to a bar code and can be included on correspondence and address labels. If the bar code is displayed on a standard envelope that passes through a mail-</p>

franking machine (e.g. as used by most major hospitals), the postage cost is reduced. Every three months, Australia Post provides updates to the PAF database. For more information, contact Australia Post.

Source and reference attributes

Submitting organisation: Standards Australia
Origin: National Health Data Standards Committee
National Community Services Data Committee
Standards Australia 2002. Australian Standard AS5017-2002 Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references: Is formed using [Service provider organisation \(address\)—suburb/town/locality name, text \[A\(50\)\]](#) Health, Standard 04/05/2005, Community services, Standard 31/08/2005

Implementation in Data Set Specifications: [Health care provider identification DSS](#) Health, Superseded 04/07/2007
[Health care provider identification DSS](#) Health, Superseded 03/12/2008
[Health care provider identification DSS](#) Health, Standard 03/12/2008

Postal delivery service number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – postal delivery service type identifier, [X(11)]
<i>METeOR identifier:</i>	270032
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An identifier for the postal delivery service where a person is located.
Data Element Concept:	Person (address) – postal delivery service type identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	[X(11)]
<i>Maximum character length:</i>	11

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The identification of a postal delivery service may be composed of a prefix, a number, and a suffix as per the following format:</p> <p>Prefix A(3) Number N(5) Suffix A(3)</p> <p>May optionally include a prefix and suffix which are non-numeric.</p> <p>The identification may also not be required for certain services.</p> <p>Examples: PO BOX C96 CARE PO RMB 123 GPO BOX 1777Q</p>
<i>Collection methods:</i>	To be collected in conjunction with Postal delivery service type - abbreviation.

Source and reference attributes

<i>Origin:</i>	Health Data Standards Committee AS4590 Interchange of client information
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Relational attributes

Related metadata references:

Supersedes [Postal delivery service number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.3 KB)

Postal delivery service type—abbreviation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – postal delivery service type, code AA[A(9)]
<i>METeOR identifier:</i>	270027
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Type of postal delivery service for a person, as represented by a code.
Data Element Concept:	Person – postal delivery service type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																								
<i>Data type:</i>	String																								
<i>Format:</i>	AA[A(9)]																								
<i>Maximum character length:</i>	11																								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>CARE PO</td><td>Care-of Post Office (also known as Poste Restante)</td></tr><tr><td>CMA</td><td>Community Mail Agent</td></tr><tr><td>CMB</td><td>Community Mail Bag</td></tr><tr><td>GPO BOX</td><td>General Post Office Box</td></tr><tr><td>LOCKED BAG</td><td>Locked Mail Bag Service</td></tr><tr><td>MS</td><td>Mail Service</td></tr><tr><td>PO BOX</td><td>Post Office Box</td></tr><tr><td>PRIVATE BAG</td><td>Private Mail Bag Service</td></tr><tr><td>RSD</td><td>Roadside Delivery</td></tr><tr><td>RMB</td><td>Roadside Mail Box/Bag</td></tr><tr><td>RMS</td><td>Roadside Mail Service</td></tr></tbody></table>	Value	Meaning	CARE PO	Care-of Post Office (also known as Poste Restante)	CMA	Community Mail Agent	CMB	Community Mail Bag	GPO BOX	General Post Office Box	LOCKED BAG	Locked Mail Bag Service	MS	Mail Service	PO BOX	Post Office Box	PRIVATE BAG	Private Mail Bag Service	RSD	Roadside Delivery	RMB	Roadside Mail Box/Bag	RMS	Roadside Mail Service
Value	Meaning																								
CARE PO	Care-of Post Office (also known as Poste Restante)																								
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CMB	Community Mail Bag																								
GPO BOX	General Post Office Box																								
LOCKED BAG	Locked Mail Bag Service																								
MS	Mail Service																								
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PRIVATE BAG	Private Mail Bag Service																								
RSD	Roadside Delivery																								
RMB	Roadside Mail Box/Bag																								
RMS	Roadside Mail Service																								

Collection and usage attributes

<i>Collection methods:</i>	To be collected in conjunction with Person (address) – postal delivery service type identifier, [X(11)] when applicable.
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Source and reference attributes

<i>Origin:</i>	AS4590 Interchange of client information
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Data element attributes

Source and reference attributes

Origin: Health Data Standards Committee

Relational attributes

Related metadata references: Supersedes [Postal delivery service type - abbreviation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.5 KB)

Postcode—Australian (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – Australian postcode, code (Postcode datafile) {NNNN}
<i>Synonymous names:</i>	Australian postcode
<i>METeOR identifier:</i>	287224
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person.
Data Element Concept:	Person (address) – Australian postcode

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Postcode datafile
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	{NNNN}
<i>Maximum character length:</i>	4

Collection and usage attributes

<i>Comments:</i>	<p>Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible.</p> <p>When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs).</p>
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The postcode book is updated more than once annually; as postcodes are a dynamic entity and are constantly changing.
<i>Collection methods:</i>	Leave Postcode - Australian blank for:

- Any overseas address
- Unknown address
- No fixed address.

May be collected as part of Address line or separately. Postal addresses may be different from where a person actually resides.

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	National Health Data Committee National Community Services Data Committee
<i>Reference documents:</i>	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia Australia Post Postcode book. Reference through: http://www1.auspost.com.au/postcodes/

Relational attributes

<i>Related metadata references:</i>	See also Person – Australian state/territory identifier, code N Health, Standard 04/05/2005, Community services, Standard 25/08/2005, Housing assistance, Standard 10/02/2006 Supersedes Person (address) – Australian postcode (Postcode datafile), code NNN[N] Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005 Is used in the formation of Person – geographic location, community services code (ASGC 2004) NNNNN Community services, Superseded 02/05/2006 Is used in the formation of Dwelling – geographic location, remoteness structure code (ASGC 2004) N[N] Housing assistance, Retired 10/02/2006
<i>Implementation in Data Set Specifications:</i>	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006 Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007 Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009 Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009 Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008 Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008 Health care client identification DSS Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard
03/12/2008

[Health care provider identification DSS](#) Health, Superseded
04/07/2007

[Health care provider identification DSS](#) Health, Superseded
03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

[Registered chiropractic labour force DSS](#) Health, Standard
10/12/2009

[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health,
Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard
10/12/2009

[Registered nursing professional labour force DSS](#) Health,
Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard
10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard
10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard
10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard
10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard
10/12/2009

[Registered psychology labour force DSS](#) Health, Standard
10/12/2009

Postcode—Australian (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – Australian postcode, code (Postcode datafile) {NNNN}
<i>METeOR identifier:</i>	290064
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
<i>Definition:</i>	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as represented by a code.
Data Element Concept:	Service provider organisation (address) – Australian postcode

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Postcode datafile
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	{NNNN}
<i>Maximum character length:</i>	4

Collection and usage attributes

<i>Comments:</i>	<p>Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible.</p> <p>When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs).</p>
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	May be collected as part of Address line or separately. Postal addresses may be different from where a service is actually located.
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Source and reference attributes

Submitting organisation: Standards Australia

Origin: National Health Data Committee
National Community Services Data Committee
Australia Post Postcode book. Reference through:
<http://www1.auspost.com.au/postcodes/>

Reference documents: AS5017 Health Care Client Identification, 2002, Sydney:
Standards Australia
AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

Relational attributes

Implementation in Data Set Specifications: [Health care provider identification DSS](#) Health, Superseded
04/07/2007
[Health care provider identification DSS](#) Health, Superseded
03/12/2008
[Health care provider identification DSS](#) Health, Standard
03/12/2008

Postcode—Australian (workplace)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Workplace (address) – Australian postcode, code (Postcode datafile) {NNNN}
<i>METeOR identifier:</i>	386199
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a workplace, as represented by a code.
Data Element Concept:	Workplace (address) – Australian postcode

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Postcode datafile
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	{NNNN}
<i>Maximum character length:</i>	4

Collection and usage attributes

<i>Comments:</i>	<p>Postcode - Australian may be used in the analysis of data on a geographical basis, which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS) postal areas. This conversion results in some inaccuracy of information. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical Local Area (SLA)) is not always possible.</p> <p>When dealing with aggregate data, postal areas, converted from postcodes, can be mapped to Australian Standard Geographical Classification codes using an ABS concordance, for example to determine SLAs. It should be noted that such concordances should not be used to determine the SLA of any individual's postcode. Where individual street addresses are available, these can be mapped to ASGC codes (e.g. SLAs).</p>
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	May be collected as part of Address line or separately. Postal addresses may be different from where a workplace is actually located.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Implementation in Data Set Specifications:

[Main job of registered chiropractor cluster](#) Health, Standard 10/12/2009

[Main job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

[Main job of registered medical professional cluster](#) Health, Standard 10/12/2009

[Main job of registered midwife cluster](#) Health, Standard 10/12/2009

[Main job of registered nursing professional cluster](#) Health, Standard 10/12/2009

[Main job of registered optometrist cluster](#) Health, Standard 10/12/2009

[Main job of registered osteopath cluster](#) Health, Standard 10/12/2009

[Main job of registered pharmacist cluster](#) Health, Standard 10/12/2009

[Main job of registered physiotherapist cluster](#) Health, Standard 10/12/2009

[Main job of registered podiatrist cluster](#) Health, Standard 10/12/2009

[Main job of registered psychologist cluster](#) Health, Standard 10/12/2009

[Second job of registered chiropractor cluster](#) Health, Standard 10/12/2009

[Second job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

[Second job of registered medical professional cluster](#) Health, Standard 10/12/2009

[Second job of registered midwife cluster](#) Health, Standard 10/12/2009

[Second job of registered nursing professional cluster](#) Health, Standard 10/12/2009

[Second job of registered optometrist cluster](#) Health, Standard 10/12/2009

[Second job of registered osteopath cluster](#) Health, Standard 10/12/2009

[Second job of registered pharmacist cluster](#) Health, Standard 10/12/2009

[Second job of registered physiotherapist cluster](#) Health, Standard 10/12/2009

[Second job of registered podiatrist cluster](#) Health, Standard 10/12/2009

[Second job of registered psychologist cluster](#) Health, Standard 10/12/2009

Postcode—international (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address)—international postcode, text [X(10)]
<i>Synonymous names:</i>	International postcode
<i>METeOR identifier:</i>	288985
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The code for a postal delivery area, aligned with locality, suburb or place for the address of a person, as defined by the postal service of a country other than Australia, as represented by text.
Data Element Concept:	Person (address)—international postcode

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(10)]
<i>Maximum character length:</i>	10

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	This is a self-reported code from a person and may be non-verifiable without reference to the specific country's coding rules. May be collected as part of Address or separately. Postal addresses may be different from where a person actually resides.
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Health care client identification DSS Health, Superseded 03/12/2008
	Health care client identification DSS Health, Standard 03/12/2008
	Health care provider identification DSS Health, Superseded 04/07/2007
	Health care provider identification DSS Health, Superseded 03/12/2008
	Health care provider identification DSS Health, Standard 03/12/2008

Postcode—international (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – international postcode, text [X(10)]
<i>METeOR identifier:</i>	288987
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The code for a postal delivery area, aligned with locality, suburb or place for the address of an organisation, as defined by the postal service of a country other than Australia.
Data Element Concept:	Service provider organisation (address) – international postcode

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(10)]
<i>Maximum character length:</i>	10

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	This is a self-reported code from an organisation and may be non-verifiable without reference to the specific country's coding rules. May be collected as part of Address or separately. Postal addresses may be different from where a service is actually located.
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008
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Postpartum complication

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – complication (postpartum), code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	391336
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	Medical and obstetric complications of the mother occurring during the postnatal period up to the time of separation from care, as represented by a code.
Data Element Concept:	Birth event – complication (postpartum)

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Collection and usage attributes

<i>Guide for use:</i>	Complications and conditions should be coded within the Pregnancy, Childbirth, Puerperium chapter 15 of Volume 1, ICD-10-AM.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	There is no arbitrary limit on the number of conditions specified.
<i>Comments:</i>	Examples of such conditions include postpartum haemorrhage, retained placenta, puerperal infections, puerperal psychosis, essential hypertension, psychiatric disorders, diabetes mellitus, epilepsy, cardiac disease and chronic renal disease. Complications of the puerperal period may cause maternal morbidity, and occasionally death, and may be an important factor in prolonging the duration of hospitalisation after childbirth.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Origin:

International Classification of Diseases - 10th Revision,
Australian Modification (7th Edition 2010) National Centre for
Classification in Health, Sydney.

Relational attributes

Related metadata references:

Supersedes [Birth event – complication \(postpartum\), code \(ICD-10-AM 6th edn\) ANN{.N\[N\]}](#) Health, Superseded 22/12/2009

Preferred language

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – preferred language, code (ASCL 2005) NN{NN}
<i>METeOR identifier:</i>	304128
<i>Registration status:</i>	Health, Standard 08/02/2006 Community services, Standard 29/04/2006
<i>Definition:</i>	The language (including sign language) most preferred by the person for communication, as represented by a code.
Data Element Concept:	Person – preferred language

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Australian Standard Classification of Languages 2005
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NN{NN}
<i>Maximum character length:</i>	4

Collection and usage attributes

<i>Guide for use:</i>	<p>The Australian Standard Classification of Languages (ASCL) has a three-level hierarchical structure. The most detailed level of the classification consists of base units (languages) which are represented by four-digit codes. The second level of the classification comprises narrow groups of languages (the Narrow Group level), identified by the first two digits. The most general level of the classification consists of broad groups of languages (the Broad Group level) and is identified by the first digit. The classification includes Australian Indigenous languages and sign languages.</p> <p>For example, the Lithuanian language has a code of 3102. In this case 3 denote that it is an Eastern European language, while 31 denote that it is a Baltic language. The Pintupi Aboriginal language is coded as 8713. In this case 8 denote that it is an Australian Indigenous language and 87 denote that the language is Western Desert language.</p> <p>Language data may be output at the Broad Group level, Narrow Group level or base level of the classification. If necessary significant Languages within a Narrow Group can be presented separately while the remaining Languages in the Narrow Group are aggregated. The same principle can be adopted to highlight significant Narrow Groups within a Broad Group.</p>
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Data element attributes

Collection and usage attributes

Guide for use: This may be a language other than English even where the person can speak fluent English.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Reference documents: ABS cat. no. 1267.0. Australian Standard Classification of Languages (ASCL), 2005-06. Canberra: Australian Bureau of Statistics

Relational attributes

Related metadata references: See also [Person – main language other than English spoken at home, code \(ASCL 2005\) NN{NN}](#) Health, Standard 08/02/2006, Community services, Standard 29/04/2006, Housing assistance, Standard 10/02/2006

Supersedes [Person – preferred language, code NN](#) Health, Superseded 08/02/2006

Implementation in Data Set Specifications:

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Pregnancy duration at the first antenatal care visit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Pregnancy – estimated duration (at the first visit for antenatal care), completed weeks N[N]
<i>Synonymous names:</i>	Estimated pregnancy gestation in completed weeks at the first visit for antenatal care.
<i>METeOR identifier:</i>	379597
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	The total number of completed weeks of a pregnancy's estimated duration on the day of the first visit for antenatal care .
<i>Data Element Concept:</i>	Pregnancy – estimated duration

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[N]
<i>Maximum character length:</i>	2
<i>Supplementary values:</i>	Value Meaning
	99 Not stated/unknown
<i>Unit of measure:</i>	Completed weeks

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The day of the first visit for antenatal care is the day of the first contact with a midwife, medical practitioner, or other recognised health professional where antenatal care was provided. It does not include a contact if it was to confirm the pregnancy only or those contacts that occurred during the pregnancy that related to other non pregnancy related issues. It does not include a first contact after the onset of labour.</p> <p>Antenatal care visits are attributed to the pregnant woman. The duration of the pregnancy on that day is the same as the gestational age of the fetus or baby on that day.</p>
<i>Collection methods:</i>	<p>To be collected at any time during the pregnancy or birth episode after the best estimate of gestational age has been determined.</p> <p>The method of data collection will usually be from health records of pregnancy and/or birth.</p> <p>The valid range of completed weeks for Pregnancy duration at the first visit for antenatal care is 3-46.</p>

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also [Product of conception – gestational age, completed weeks N\[N\]](#) Health, Standard 02/12/2009

Implementation in Data Set Specifications: [Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009
Implementation start date: 01/07/2010

Pregnancy—current status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female – pregnancy indicator (current), code N
<i>METeOR identifier:</i>	302817
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether the female person is currently pregnant, as represented by a code.
Data Element Concept:	Female – pregnancy indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if the female individual currently pregnant. CODE 2 No: Record if the female individual not currently pregnant.
<i>Collection methods:</i>	Ask the individual if she is currently pregnant.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

<i>Related metadata references:</i>	Supersedes Female – current pregnancy status, code N Health, Superseded 21/09/2005
<i>Implementation in Data Set Specifications:</i>	Diabetes (clinical) DSS Health, Standard 21/09/2005

Premature cardiovascular disease family history (status)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – premature cardiovascular disease family history status, code N
<i>METeOR identifier:</i>	359398
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Whether a person has a first degree relative (father, mother or sibling) who has had a vascular event or condition diagnosed before the age of 60 years, as represented by a code.
Data Element Concept:	Person – premature cardiovascular disease family history status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Yes
	2	No
	3	Family history status not known
<i>Supplementary values:</i>	9	Not recorded

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1: Yes, the person has a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.
	CODE 2: No, the person does not have a first-degree relative under the age of 60 years who has had a vascular disease/condition diagnosed.
	CODE 3: Family history status not known, the existence of a premature family history for cardiovascular disease cannot be determined.
	CODE 9: Not recorded, the information as to the existence of a premature family history for cardiovascular disease has not been recorded.

Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular Data Working Group
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Origin:

Guidelines Subcommittee of the World Health Organization/International Society of Hypertension (WHO-ISH): 1999 WHO-ISH guidelines for management of hypertension. J Hypertension 1999; 17: 151 - 83.

Relational attributes

Related metadata references:

Supersedes [Person – premature cardiovascular disease family history status, code N](#) Health, Superseded 01/10/2008

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Presentation at birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – birth presentation, code N
<i>METeOR identifier:</i>	299992
<i>Registration status:</i>	Health, Standard 06/09/2006
<i>Definition:</i>	The presenting part of the fetus at birth, as represented by a code.
<i>Data Element Concept:</i>	Birth event – birth presentation

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Vertex</td></tr><tr><td>2</td><td>Breech</td></tr><tr><td>3</td><td>Face</td></tr><tr><td>4</td><td>Brow</td></tr><tr><td>8</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Vertex	2	Breech	3	Face	4	Brow	8	Other
Value	Meaning												
1	Vertex												
2	Breech												
3	Face												
4	Brow												
8	Other												
<i>Supplementary values:</i>	9 Not stated/inadequately described												

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Compound presentations (where an extremity prolapses simultaneously alongside the presenting part) should be coded to '8 Other'. All other malpresentations, including for example, cord, shoulder or hand, should be coded to '8 Other'.
<i>Collection methods:</i>	In the case of multiple births, presentation should be recorded for each baby born.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

Related metadata references:

Supersedes [Birth event – birth presentation, code N](#) Health, Superseded 06/09/2006

Implementation in Data Set Specifications:

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Previous pregnancies—ectopic

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female— number of previous pregnancies (ectopic), total N[N]
<i>METeOR identifier:</i>	269936
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of previous pregnancies of a female resulting in ectopic pregnancy.
Data Element Concept:	Female— number of previous pregnancies

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N]				
<i>Maximum character length:</i>	2				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	99	Not stated
Value	Meaning				
99	Not stated				
<i>Unit of measure:</i>	Pregnancy				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A pregnancy resulting in multiple births should be counted as once pregnancy.</p> <p>In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:</p> <ul style="list-style-type: none">• all live births• stillbirth• spontaneous abortion• induced abortion• ectopic pregnancy <p>Where the outcome was one stillbirth and one live birth, count as stillbirth.</p> <p>If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.</p>
<i>Comments:</i>	<p>The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.</p>

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Previous pregnancies—induced abortion

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female— number of previous pregnancies (induced abortion), total NN
<i>METeOR identifier:</i>	269935
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of previous pregnancies of a female resulting in induced abortion (termination of pregnancy before 20 weeks' gestation).
Data Element Concept:	Female— number of previous pregnancies

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[N]
<i>Maximum character length:</i>	2
<i>Supplementary values:</i>	Value Meaning
	99 Not stated
<i>Unit of measure:</i>	Pregnancy

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A pregnancy resulting in multiple births should be counted as once pregnancy.</p> <p>In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:</p> <ul style="list-style-type: none">• all live births• stillbirth• spontaneous abortion• induced abortion• ectopic pregnancy <p>Where the outcome was one stillbirth and one live birth, count as stillbirth.</p> <p>If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.</p>
<i>Comments:</i>	<p>The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.</p>

A previous history of induced abortion may increase the risk of some outcomes in subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Previous pregnancies—live birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female—number of previous pregnancies (live birth), total NN
<i>METeOR identifier:</i>	269931
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of previous pregnancies of a female resulting in live birth .
Data Element Concept:	Female—number of previous pregnancies

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N]				
<i>Maximum character length:</i>	2				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	99	Not stated
Value	Meaning				
99	Not stated				
<i>Unit of measure:</i>	Pregnancy				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A pregnancy resulting in multiple births should be counted as once pregnancy.</p> <p>In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:</p> <ul style="list-style-type: none">• all live births• stillbirth• spontaneous abortion• induced abortion• ectopic pregnancy <p>Where the outcome was one stillbirth and one live birth, count as stillbirth.</p> <p>If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.</p>
<i>Comments:</i>	<p>The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.</p>

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Previous pregnancies—spontaneous abortion

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female— number of previous pregnancies (spontaneous abortion), total NN
<i>METeOR identifier:</i>	269934
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of previous pregnancies of a female resulting in spontaneous abortion (less than 20 weeks' gestational age, or less than 400 g birthweight if gestational age is unknown).
Data Element Concept:	Female— number of previous pregnancies

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[N]
<i>Maximum character length:</i>	2
<i>Supplementary values:</i>	Value Meaning
	99 Not stated
<i>Unit of measure:</i>	Pregnancy

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A pregnancy resulting in multiple births should be counted as once pregnancy.</p> <p>In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:</p> <ul style="list-style-type: none">• all live births• stillbirth• spontaneous abortion• induced abortion• ectopic pregnancy <p>Where the outcome was one stillbirth and one live birth, count as stillbirth.</p> <p>If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.</p>
<i>Comments:</i>	<p>The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.</p>

A previous history of spontaneous abortion identifies the mother as high risk for subsequent pregnancies.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Previous pregnancies—stillbirth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female – number of previous pregnancies (stillbirth), total N[N]
<i>METeOR identifier:</i>	269933
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of previous pregnancies of a female resulting in stillbirth (- at least 20 weeks' gestational age or 400 g birthweight).
Data Element Concept:	Female – number of previous pregnancies

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N]				
<i>Maximum character length:</i>	2				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	99	Not stated
Value	Meaning				
99	Not stated				
<i>Unit of measure:</i>	Pregnancy				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A pregnancy resulting in multiple births should be counted as once pregnancy.</p> <p>In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:</p> <ul style="list-style-type: none">• all live births• stillbirth• spontaneous abortion• induced abortion• ectopic pregnancy <p>Where the outcome was one stillbirth and one live birth, count as stillbirth.</p> <p>If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.</p>
<i>Comments:</i>	<p>The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.</p> <p>A previous history of stillbirth identifies the mother as high risk for subsequent pregnancies.</p>

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Previous pregnancies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Previous specialised treatment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Patient – previous specialised treatment, code N
<i>METeOR identifier:</i>	270374
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether a patient has had a previous admission or service contact for treatment in the specialty area within which treatment is now being provided, as represented by a code.
Data Element Concept:	Patient – previous specialised treatment

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided</td></tr><tr><td>2</td><td>Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided</td></tr><tr><td>3</td><td>Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided</td></tr><tr><td>4</td><td>Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided</td></tr></tbody></table>	Value	Meaning	1	Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided	2	Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided	3	Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided	4	Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided
Value	Meaning										
1	Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided										
2	Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided										
3	Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided										
4	Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided										
<i>Supplementary values:</i>	5 Unknown/not stated										

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided</p> <p>Use this code for admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission.</p> <p>CODES 2-4 These codes include patients who have been seen at any time in the past within the speciality within which the patient is currently being treated (mental health or palliative care), regardless of whether it was part of the current episode or a previous admission/service contact many years in the past. Use these codes regardless of whether the previous treatment was</p>
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provided within the service in which the person is now being treated, or another equivalent specialised service (either institutional or community-based).

CODE 2 Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided

CODE 3 Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided

CODE 4 Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided

Data element attributes

Collection and usage attributes

Comments: This metadata item was originally developed in the context of mental health institutional care data development (originally metadata item Problem status and later First admission for psychiatric treatment). More recent data development work, particularly in the area of palliative care, led to the need for this item to be re-worded in more generic terms for inclusion in other data sets.

For palliative care, the value of this data element is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this data element in this way would be improved by the reporting of this data by community-based services.

Source and reference attributes

Submitting organisation: National Mental Health Information Strategy Committee

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Previous specialised treatment, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.7 KB)

Implementation in Data Set Specifications: [Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,

Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Primary site of cancer (ICD-10-AM code)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – primary site of cancer, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	391340
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICD-10-AM code.
Data Element Concept:	Person with cancer – primary site of cancer

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Collection and usage attributes

<i>Guide for use:</i>	Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer.
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Source and reference attributes

<i>Reference documents:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>In a hospital setting, primary site of cancer should be recorded on the patient's medical record by the patient's attending clinician or medical practitioner, and coded by the hospital's medical records department.</p> <p>Hospitals use Diagnosis codes from ICD-10-AM (7th edition). Valid codes must start with C or D.</p> <p>In hospital reporting, the diagnosis code for each separate primary site cancer will be reported as a Principal diagnosis or an Additional diagnosis as defined in the current edition of the Australian Coding Standards. In death reporting, the Australian Bureau of Statistics uses ICD-10.</p> <p>Some ICD-10-AM (7th edition) diagnosis codes e.g. mesothelioma</p>
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and Kaposi's sarcoma, are based on morphology and not site alone, and include tumours of these types even where the primary site is unknown.

Source and reference attributes

Origin: World Health Organization

Relational attributes

Related metadata references: Supersedes [Person with cancer – primary site of cancer, code \(ICD-10-AM 6th edn\) ANN{.N\[N\]}](#) Health, Superseded 22/12/2009

Implementation in Data Set Specifications: [Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Primary site of cancer (ICDO-3 code)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – primary site of cancer, code (ICDO-3) ANN{.N[N]}
<i>METeOR identifier:</i>	370039
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The site of origin of the tumour, as opposed to the secondary or metastatic sites, as represented by an ICDO-3 code.
Data Element Concept:	Person with cancer – primary site of cancer

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Classification of Diseases for Oncology 3rd edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Collection and usage attributes

<i>Guide for use:</i>	<p>Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer.</p> <p>In ICDO, primary site is identified using both the Cxx.x code identifying site and the behaviour code to identify whether the site is the primary site. The behaviour code numbers used in ICDO are listed below:</p> <p>0 Benign</p> <p>1 Uncertain whether benign or malignant</p> <ul style="list-style-type: none">• borderline malignancy• low malignant potential <p>2 Carcinoma in situ</p> <ul style="list-style-type: none">• intraepithelial• non-infiltrating• non-invasive <p>3 Malignant, primary site</p> <p>6 Malignant, metastatic site</p> <ul style="list-style-type: none">• malignant, secondary site <p>9 Malignant, uncertain whether primary or metastatic site</p>
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Data element attributes

Collection and usage attributes

Guide for use:

For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.

If the primary site differs on multiple pathology or other notification reports for the same tumour, use the most specific value.

For multifocal tumours with foci in more than one quadrant, use the quadrant of the largest focus.

Collection methods:

Cancer registries use Site codes from ICDO 3rd edition.

Source and reference attributes

Origin:

World Health Organization

Relational attributes

Related metadata references:

Supersedes [Person with cancer – primary site of cancer, code \(ICDO-3\) ANN{.N\[N\]}](#) Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Principal diagnosis

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]}
<i>METeOR identifier:</i>	391326
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	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

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN{.N[N]}
<i>Maximum character length:</i>	6

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>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.</p> <p>As a minimum requirement the Principal diagnosis code must be a valid code from the current edition of ICD-10-AM.</p> <p>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.</p> <p>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.</p>
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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: Supersedes [Episode of care – principal diagnosis, code \(ICD-10-AM 6th edn\) ANN{.N\[N\]} Health](#), Superseded 22/12/2009
Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v 6\) NN Health](#), Standard 22/12/2009
Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v 6\) ANNA Health](#), Standard 22/12/2009

Implementation in Data Set Specifications: [Admitted patient care NMDS 2010-2011 Health](#), Standard 22/12/2009
Implementation start date: 01/07/2010
[Admitted patient mental health care NMDS 2010-2011 Health](#), Standard 05/01/2010
Implementation start date: 01/07/2010
[Admitted patient palliative care NMDS 2010-11 Health](#), Standard 05/01/2010
Implementation start date: 01/07/2010
[Community mental health care NMDS 2010-2011 Health](#), Standard 05/01/2010
Implementation start date: 01/07/2010
[Residential mental health care NMDS 2010-2011 Health](#), Standard 05/01/2010
Implementation start date: 01/07/2010

Principal drug of concern

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – drug of concern (principal), code (ASCDC 2000 extended) NNNN
<i>METeOR identifier:</i>	270109
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The main drug, as stated by the client, that has led a person to seek treatment from the service, as represented by a code.
<i>Context:</i>	Required as an indicator of the client's treatment needs.
<i>Data Element Concept:</i>	Episode of treatment for alcohol and other drugs – drug of concern

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Australian Standard Classification of Drugs of Concern 2000	
<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	NNNN	
<i>Maximum character length:</i>	4	
<i>Supplementary values:</i>	Value	Meaning
	0005	Opioid analgesics not further defined
	0006	Psychostimulants not further defined

Collection and usage attributes

<i>Guide for use:</i>	<p>The Australian Standard Classification of Drugs of Concern (ASCDC) provides a number of supplementary codes that have specific uses and these are detailed within the ASCDC e.g. 0000 = inadequately described.</p> <p>Other supplementary codes that are not already specified in the ASCDC may be used in National Minimum Data Sets (NMDS) when required. In the Alcohol and other drug treatment service NMDS, two additional supplementary codes have been created which enable a finer level of detail to be captured:</p> <p>CODE 0005 Opioid analgesics not further defined</p> <p>This code is to be used when it is known that the client's principal drug of concern is an opioid but the specific opioid used is not known. The existing code 1000 combines opioid analgesics and non-opioid analgesics together into Analgesics nfd and the finer level of detail, although known, is lost.</p> <p>CODE 0006 Psychostimulants not further defined</p> <p>This code is to be used when it is known that the client's principal drug of concern is a psychostimulant but not which</p>
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type. The existing code 3000 combines stimulants and hallucinogens together into Stimulants and hallucinogens nfd and the finer level of detail, although known, is lost.

Psychostimulants refer to the types of drugs that would normally be coded to 3100-3199, 3300-3399 and 3400-3499 categories plus 3903 and 3905.

Data element attributes

Collection and usage attributes

Guide for use:

The principal drug of concern should be the main drug of concern to the client and is the focus of the client's treatment episode. If the client has been referred into treatment and does not nominate a drug of concern, then the drug involved in the client's referral should be chosen.

Collection methods:

To be collected on commencement of the treatment episode.

For clients whose treatment episode is related to the alcohol and other drug use of another person, this metadata item should not be collected.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Supersedes [Principal drug of concern, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.5 KB)

Implementation in Data Set Specifications:

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Principal role—health profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – principal role, health profession code N
<i>METeOR identifier:</i>	375557
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The role in which the registered health professional spent the most time in the profession, in the week before registration, as represented by a code.
Data Element Concept:	Registered health professional – principal role

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Clinician</td></tr><tr><td>2</td><td>Administrator</td></tr><tr><td>3</td><td>Teacher/educator</td></tr><tr><td>4</td><td>Researcher</td></tr><tr><td>5</td><td>Other</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Clinician	2	Administrator	3	Teacher/educator	4	Researcher	5	Other	9	Not stated/inadequately described
Value	Meaning														
1	Clinician														
2	Administrator														
3	Teacher/educator														
4	Researcher														
5	Other														
9	Not stated/inadequately described														
<i>Supplementary values:</i>															

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 CLINICIAN</p> <p>A clinician is a person mainly involved in the area of clinical practice. That is the diagnosis, care and treatment, including recommended preventative action, to patients or clients. Clinical practice may involve direct client contact or may be practised indirectly through individual case material (as in radiology and laboratory medicine).</p> <p>CODE 2 ADMINISTRATOR</p> <p>An administrator in a health profession is a person whose main job is in an administrative capacity in the profession, such as directors of nursing, medical superintendents, medical advisers in government health authorities and health profession union administrators.</p> <p>CODE 3 TEACHER/EDUCATOR</p> <p>A teacher/educator in a health profession is a person whose main job is employment by tertiary institutions or health institutions to provide education and training in the profession.</p>
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CODE 4 RESEARCHER

A researcher in a health profession is a person whose main job is to conduct research in the field of the profession, especially in the area of clinical activity. Researchers are employed by tertiary institutions, medical research bodies, health institutions, health authorities, drug companies and other bodies.

CODE 5 OTHER

Other roles include Public health/health promotion, Occupational health, Environmental health, and all other roles not covered by codes 1-4 above.

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 applicable to health professionals who were employed in the registered profession in Australia.

The health professional may be employed or self-employed in the profession.

Registered health professionals on leave at the time of registration are asked to report their usual principal role.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes [Health professional – principal role, code N](#) Health, Superseded 10/12/2009

Implementation in Data Set Specifications: [Main job of registered chiropractor cluster](#) Health, Standard 10/12/2009

[Main job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

[Main job of registered medical professional cluster](#) Health, Standard 10/12/2009

[Main job of registered midwife cluster](#) Health, Standard 10/12/2009

[Main job of registered nursing professional cluster](#) Health, Standard 10/12/2009

[Main job of registered optometrist cluster](#) Health, Standard 10/12/2009

[Main job of registered osteopath cluster](#) Health, Standard 10/12/2009

[Main job of registered pharmacist cluster](#) Health, Standard 10/12/2009

[Main job of registered physiotherapist cluster](#) Health, Standard

10/12/2009

[Main job of registered podiatrist cluster](#) Health, Standard

10/12/2009

[Main job of registered psychologist cluster](#) Health, Standard

10/12/2009

[Second job of registered chiropractor cluster](#) Health, Standard

10/12/2009

[Second job of registered dental and allied dental health professional cluster](#) Health, Standard

10/12/2009

[Second job of registered medical professional cluster](#) Health, Standard

10/12/2009

[Second job of registered midwife cluster](#) Health, Standard

10/12/2009

[Second job of registered nursing professional cluster](#) Health, Standard

10/12/2009

[Second job of registered optometrist cluster](#) Health, Standard

10/12/2009

[Second job of registered osteopath cluster](#) Health, Standard

10/12/2009

[Second job of registered pharmacist cluster](#) Health, Standard

10/12/2009

[Second job of registered physiotherapist cluster](#) Health, Standard

10/12/2009

[Second job of registered podiatrist cluster](#) Health, Standard

10/12/2009

[Second job of registered psychologist cluster](#) Health, Standard

10/12/2009

Procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – procedure, code (ACHI 7th edn) NNNNN-NN
<i>METeOR identifier:</i>	391349
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	A clinical intervention represented by a code that: <ul style="list-style-type: none">• 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

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

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Record and code all procedures undertaken during the episode of care in accordance with the ACHI (7th edition). Procedures are derived from and must be substantiated by clinical documentation.
<i>Comments:</i>	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

<i>Origin:</i>	National Centre for Classification in Health National Health Information Standards and Statistics Committee
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Relational attributes

Related metadata references:

Supersedes [Episode of admitted patient care – procedure, code \(ACHI 6th edn\) NNNNNN-NN](#) Health, Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v 6\) NN](#) Health, Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v 6\) ANNA](#) Health, Standard 22/12/2009

Implementation in Data Set Specifications:

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Proficiency in spoken English

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – proficiency in spoken English, code N
<i>METeOR identifier:</i>	270203
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	A person's self-assessed level of ability to speak English, as represented by a code.
Data Element Concept:	Person – proficiency in spoken English

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>Not applicable (persons under 5 years of age or who speak only English)</td></tr><tr><td>1</td><td>Very well</td></tr><tr><td>2</td><td>Well</td></tr><tr><td>3</td><td>Not well</td></tr><tr><td>4</td><td>Not at all</td></tr></tbody></table>	Value	Meaning	0	Not applicable (persons under 5 years of age or who speak only English)	1	Very well	2	Well	3	Not well	4	Not at all
Value	Meaning												
0	Not applicable (persons under 5 years of age or who speak only English)												
1	Very well												
2	Well												
3	Not well												
4	Not at all												
<i>Supplementary values:</i>	9 Not stated/inadequately described												

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 0 Not applicable (persons under 5 years of age or who speak only English)</p> <p>Not applicable, is to be used for people under 5 year of age and people who speak only English.</p> <p>CODE 9 Not stated/inadequately described</p> <p>Not stated/inadequately described, is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.</p>
<i>Comments:</i>	The ABS advises that the most useful information provided by this metadata item is in the distinction between the two category groups of Very well/Well and Not well/Not at all.

Source and reference attributes

Reference documents: Standards for Statistics on Cultural and Language Diversity 1999.
Cat. no. 1289.0. Canberra: ABS.

Data element attributes

Collection and usage attributes

Collection methods: This metadata item is only intended to be collected if a person has a main language other than English spoken at home; and/or first language spoken is not English.

Recommended question:
How well do you speak English? (tick one)

1. Very well
2. Well
3. Not well
4. Not at all

Generally this would be a self-reported question, but in some circumstances (particularly where a person does not speak English well) assistance will be required in answering this question. It is important that the person's self-assessed proficiency in spoken English be recorded wherever possible. This metadata item does not purport to be a technical assessment of proficiency but is a self-assessment in the four broad categories outlined above.

This metadata item is not relevant to and should not be collected for persons under the age of five years.

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

Comments: This metadata item identifies those people who may suffer disadvantage in terms of their ability to access services due to lack of ability in the spoken English language. This information can be used to target the provision of services to people whose lack of ability in spoken English is potentially a barrier to gaining access to government programs and services.

In conjunction with Indigenous status, the main language other than English spoken at home and the country of birth, this metadata item forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics.

Source and reference attributes

Origin: National Health Data Committee
National Community Services Data Committee

Relational attributes

Related metadata references:

See also [Person – main language other than English spoken at home, code \(ASCL 2005\) NN{NN}](#) Health, Standard 08/02/2006, Community services, Standard 29/04/2006, Housing assistance, Standard 10/02/2006

See also [Person – country of birth, code \(SACC 1998\) NNNN](#) Health, Superseded 01/10/2008, Community services, Superseded 02/06/2008, Housing assistance, Superseded 24/11/2008

Supersedes [Proficiency in spoken English, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf](#) (18.6 KB)

Progesterone receptor assay results

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – progesterone receptor assay results, code N
<i>METeOR identifier:</i>	291341
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The results of progesterone receptor assay at the time or diagnosis of the primary breast tumour, as represented by a code.
Data Element Concept:	Person with cancer – progesterone receptor assay results

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Test done, results positive (progesterone receptor positive)</td></tr><tr><td>2</td><td>Test done, results negative (Progesterone receptor negative)</td></tr></tbody></table>	Value	Meaning	1	Test done, results positive (progesterone receptor positive)	2	Test done, results negative (Progesterone receptor negative)
Value	Meaning						
1	Test done, results positive (progesterone receptor positive)						
2	Test done, results negative (Progesterone receptor negative)						
<i>Supplementary values:</i>	<table><tbody><tr><td>0</td><td>Test not done (test not ordered or not performed)</td></tr><tr><td>8</td><td>Test done but results unknown</td></tr><tr><td>9</td><td>Unknown</td></tr></tbody></table>	0	Test not done (test not ordered or not performed)	8	Test done but results unknown	9	Unknown
0	Test not done (test not ordered or not performed)						
8	Test done but results unknown						
9	Unknown						

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>The Australian Cancer Network Working Party established to develop guidelines for the pathology reporting of breast cancer recommends that hormone receptor assays be performed on all cases of invasive breast carcinoma. The report should include:</p> <ul style="list-style-type: none">the percentage of nuclei staining positive and the predominant staining intensity (low, medium, high), anda conclusion as to whether the assay is positive or negative.
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Source and reference attributes

<i>Origin:</i>	Royal College of Pathologists of Australasia Australian Cancer Network Commission on Cancer American College of Surgeons
<i>Reference documents:</i>	Royal College of Pathologists of Australasia Manual of Use and Interpretation of Pathology Tests: Third Edition Sydney (2001)

Australian Cancer Network Working Party The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001)

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

Relational attributes

Related metadata references:

Supersedes [Progesterone receptor assay status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.9 KB)

Implementation in Data Set Specifications:

[Cancer \(clinical\) DSS Health](#), Superseded 07/12/2005

[Cancer \(clinical\) DSS Health](#), Superseded 06/03/2009

[Cancer \(clinical\) DSS Health](#), Superseded 22/12/2009

[Cancer \(clinical\) DSS Health](#), Standard 22/12/2009

Proteinuria status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – proteinuria status, code N{.N}
<i>METeOR identifier:</i>	270346
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether there is a presence of excessive protein in the urine of the person, as represented by a code.
Data Element Concept:	Person – proteinuria status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N{.N}																
<i>Maximum character length:</i>	2																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Negative for protein</td></tr><tr><td>1.1</td><td>Microalbuminuria present</td></tr><tr><td>1.2</td><td>Microalbuminuria not present</td></tr><tr><td>1.3</td><td>Microalbuminuria not tested</td></tr><tr><td>2</td><td>Proteinuria</td></tr><tr><td>3</td><td>Not tested</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Negative for protein	1.1	Microalbuminuria present	1.2	Microalbuminuria not present	1.3	Microalbuminuria not tested	2	Proteinuria	3	Not tested	9	Not stated/inadequately described
Value	Meaning																
1	Negative for protein																
1.1	Microalbuminuria present																
1.2	Microalbuminuria not present																
1.3	Microalbuminuria not tested																
2	Proteinuria																
3	Not tested																
9	Not stated/inadequately described																
<i>Supplementary values:</i>																	

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Negative for protein Negative for proteinuria - less than 1 plus on dipstick-testing or excretion of 300 mg or less of protein from 24-hour urine collection.</p> <p>CODE 1.1 Microalbuminuria present Microalbuminuria present</p> <p>CODE 1.2 Microalbuminuria not present Microalbuminuria not present</p> <p>CODE 1.3 Microalbuminuria not tested Microalbuminuria not tested</p> <p>CODE 2 Proteinuria Proteinuria - one or more pluses of protein in dipstick urinalysis or for a 24-hour urine collection, where the patient excretes more than 300 mg/per day of protein.</p>
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CODE 3 Not tested

Not tested - no urinalysis for proteinuria was taken.

Collection methods:

Where laboratory testing is used to determine Proteinuria status the categorisation must be substantiated by clinical documentation such as an official laboratory report.

Data element attributes

Collection and usage attributes

Collection methods:

Dipstick testing can be used to test for protein in a urine specimen. Proteinuria (i.e. excessive protein in the urine) on dipstick urinalysis is described as one or more pluses of protein and for a 24-hour urine collection where the patient excretes more than 300 mg/day of protein.

Microalbuminuria can be determining using any one of the following tests: spot urine, timed urine (24-hour collection) or albumin/creatinine ratio. Although the presence of microalbuminuria does not warrant categorisation as proteinuria, it is clinically significant in the diagnosis and treatment of diabetes.

Comments:

In settings where the monitoring of a person's health is ongoing and where a measure can change over time (such as general practice), the Patient – diagnosis date, DDMMYYYY should be recorded.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Relational attributes

Related metadata references:

Supersedes [Proteinuria - status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.7 KB)

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Provider occupation category (self-identified) (ANZSCO 1st edition)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Individual service provider – occupation (self-identified), code (ANZSCO 1st edition) N[NNN]{NN}
<i>Synonymous names:</i>	Health care provider field of practice
<i>METeOR identifier:</i>	350896
<i>Registration status:</i>	Health, Standard 04/07/2007 Community services, Standard 27/03/2007
<i>Definition:</i>	A health care occupation that an individual provider identifies as being one in which they provide a significant amount of services, as represented by a code.
Data Element Concept:	Individual service provider – occupation (self-identified)

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Australian and New Zealand Standard Classification of Occupations, First edition, 2006
<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN]{NN}
<i>Maximum character length:</i>	6

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The following is a list of the more common health care occupations, however, it is not intended to represent all the possible health care occupations:</p> <ul style="list-style-type: none">Aboriginal and Torres Strait Islander Health Worker (ANZSCO code 411511)Acupuncturist (ANZSCO code 252211)Aged or disabled carer (ANZSCO code 423111)Ambulance officer (ANZSCO code 411111)Anaesthetist (ANZSCO code 253211)Audiologist (ANZSCO code 252711)Chiropractor (ANZSCO code 252111)Clinical psychologist (ANZSCO code 272311)Complementary Health Therapists n.e.c. (ANZSCO code 252299)Dental assistant (ANZSCO code 423211)
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Dental hygienist (ANZSCO code 411211)
Dental specialist (ANZSCO code 252311)
Dental technician (ANZSCO code 411213)
Dental therapist (ANZSCO code 411214)
Dentist (ANZSCO code 252312)
Dermatologist(ANZSCO code 253911)
Dietician (ANZSCO code 251111)
Drug and Alcohol Counsellor (ANZSCO code 272112)
Enrolled nurse (ANZSCO code 411411)
General medical practitioner (ANZSCO code 253111)
Health professionals (ANZSCO code 25)
Hospital pharmacist (ANZSCO code 251511)
Intensive care ambulance paramedic (AUS) / ambulance paramedic (NZ) (ANZSCO code 411112)
Massage therapist (ANZSCO code 411611)
Medical diagnostic radiographer (ANZSCO code 251211)
Medical practitioners n.e.c. (ANZSCO code 253999)
Medical radiation therapist (ANZSCO code 251212)
Midwife (ANZSCO code 254111)
Naturopath (ANZSCO code 252213)
Nuclear medicine technologist (ANZSCO code 251213)
Nurse educator (ANZSCO code 254211)
Nurse manager (ANZSCO code 254311)
Nurse practitioner (ANZSCO code 254411)
Nurse researcher (ANZSCO code 254212)
Nursing assistant support worker (ANZSCO code 423312)
Occupational therapist (ANZSCO code 252411)
Ophthalmologist (ANZSCO code 253914)
Optometrist (ANZSCO code 251411)
Orthoptist (ANZSCO code 251412)
Orthotist or Prosthetist (ANZSCO code 251912)
Osteopath (ANZSCO code 252112)
Paediatrician (ANZSCO code 253321)
Pathologist (ANZSCO code 253915)
Physiotherapist (ANZSCO code 252511)
Podiatrist (ANZSCO code 252611)
Psychiatrist (ANZSCO code 253411)
Psychologists n.e.c. (ANZSCO code 272399)
Radiologist (ANZSCO code 253916)
Registered nurse (developmental disability)(ANZSCO code 254416)

Registered nurse (mental health)(ANZSCO code 254422)
 Registered Nurses n.e.c. (ANZSCO code 254499)
 Rehabilitation counsellor (ANZSCO code 272114)
 Retail pharmacist (ANZSCO code 251513)
 Social worker (ANZSCO code 272511)
 Sonographer (ANZSCO code 251214)
 Specialist physician (general medicine) (ANZSCO code 253311)
 Speech pathologist (AUS) / speech language therapist (NZ)
 (ANZSCO code 252712)
 Surgeon (general) (ANZSCO code 253511)
 Therapy aide (ANZSCO code 423314)

Collection methods:

Data is collected at the time a health care provider identification record is created.

Multiple instances of health care occupation may be collected where the individual provides a significant amount of services in more than one category. For example, a dentist who is also a medical practitioner may practice as both.

Record as many as apply.

Accurate data are best achieved using computer assisted coding. A computer assisted coding system is available from the ABS to assist in coding occupational data to ANZSCO codes.

Data coded at the 4-digit and 6-digit level will provide more detailed information than that collected at the higher levels and may be more useful. However, the level at which data are coded and reported will depend on the purpose of collecting this information.

Comments:

ANZSCO defines 'occupation' as 'a set of jobs with similar sets of tasks'. Operationally this is defined as 'a collection of jobs which are sufficiently similar in their main tasks to be grouped together for purposes of the classification'. Job is defined as 'a set of tasks designed to be performed by one individual for a wage or salary'.

Source and reference attributes

Origin: AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia.

Reference documents: AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia.

Relational attributes

Related metadata references: Supersedes [Individual service provider – occupation \(self-identified\), code \(ASCO 2nd edn\) N\[NNN\]\[-NN\]](#) Health, Superseded 04/07/2007, Community services, Superseded 27/03/2007

Implementation in Data Set Specifications: [Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Provider occupation end date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Individual service provider – occupation end date, DDMMYYYY
<i>Synonymous names:</i>	Health care provider field of practice end date
<i>METeOR identifier:</i>	289053
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The date on which an individual health care provider ceased practising in an identified occupation.
Data Element Concept:	Individual service provider – occupation end date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Enter the date using day, month and year. In the AS4846 Health Care Provider Identification, the Australian Standard Health Care Provider Field of Practice End Date mandates the use of a Date Accuracy Indicator. This is not compulsory with the use of this data element.
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

<i>Related metadata references:</i>	See also Date – accuracy indicator, code AAA Health, Standard 04/05/2005, Community services, Standard 30/09/2005
<i>Implementation in Data Set Specifications:</i>	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Provider occupation start date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Individual service provider – occupation start date, DDMMYYYY
<i>Synonymous names:</i>	Health care provider field of practice start date
<i>METeOR identifier:</i>	289059
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The date on which an individual health care provider commenced practising in an identified occupation.
Data Element Concept:	Individual service provider – occupation start date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Enter the date using day, month and year. In the AS4846 Health Care Provider Identification, the Australian Standard Health Care Provider Field of Practice Start Date mandates the use of a Date Accuracy Indicator. This is not compulsory with the use of this data element.
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Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
<i>Origin:</i>	AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

<i>Related metadata references:</i>	See also Date – accuracy indicator, code AAA Health, Standard 04/05/2005, Community services, Standard 30/09/2005
<i>Implementation in Data Set Specifications:</i>	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008 Health care provider identification DSS Health, Standard 03/12/2008

Purchase of goods and services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Organisation— purchase of goods and services, total Australian currency NNNNN.N
<i>METeOR identifier:</i>	359935
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Expenses of an organisation consisting mainly of purchases of goods and services, in Australian currency.
Data Element Concept:	Organisation— purchase of goods and services

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Currency
<i>Format:</i>	NNNNN.N
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Australian currency (AU\$)

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Expenses relating to purchases of goods and services are to be reported in millions to the nearest 100,000 e.g. \$4,064,000 should be reported as \$4.1 million.</p> <p>When revenue from transactions are offset against expenses from transactions, the result equates to the net operating balance in accordance with Australian Accounting Standards Board 1049 (September 2006).</p> <p>Includes:</p> <ul style="list-style-type: none">• administrative expenses (excluding workers compensation premiums and payouts)• domestic services• drug supplies• food supplies• grants• medical and surgical supplies• patient transport• payments to visiting medical officers
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- repairs and maintenance
- social benefits
- subsidy expenses
- other expenses (includes contracted care services purchased from private hospitals)

Collection methods:

Data are collected and nationally collated for the reporting period - the financial year ending 30th June each year.

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Expenses relating to purchases of goods and services are to be reported for the *Health industry relevant organisation type* and *Type of health and health related functions* data elements.

Health industry relevant organisation type

State and territory health authorities are **NOT** to report the following codes:

Codes 106-109; 111; 115-119; 123; 201 and 203

Type of health and health related functions

State and territory health authorities are **NOT** to report the following codes:

Codes 199; 299; 303-305; 307; 499; 503-504; 599; 601-603; 688; 699

Comments:

In accounting terms, expenses are consumptions or losses of future economic benefits in the form of reductions in assets or increases in liabilities of the entity (other than those relating to distributions to owners) that result in a decrease in equity or net worth during the reporting period.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Origin:

Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0.

Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS.

Australian Accounting Standards Board 1049, September 2006, <www.aasb.com.au>

Relational attributes

Related metadata references:

Is used in the formation of [Organisation – expenses, total Australian currency NNNNN.N](#) Health, Standard 05/12/2007

Implementation in Data Set Specifications:

[Government health expenditure organisation expenditure data cluster](#) Health, Superseded 03/12/2008

[Government health expenditure organisation expenditure data element cluster](#) Health, Standard 01/04/2009

[Government health expenditure organisation expenditure](#)

[purchase of goods and services data element cluster](#) Health,
Superseded 01/04/2009

[Government health expenditure organisation expenditure
purchase of goods and services data element cluster](#) Health,
Standard 01/04/2009

Quality accreditation/certification standard—Australian Council on Healthcare Standards EQuIP

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – quality accreditation/certification standard indicator (Australian Council on Healthcare Standards EQuIP), code N
<i>METeOR identifier:</i>	302372
<i>Registration status:</i>	Health, Standard 14/09/2005
<i>Definition:</i>	Whether the Australian Council on Healthcare Standards EQuIP standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment – quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Report the status code as at 30 June. Code 1 Yes Record if the hospital establishment is accredited or compliant with the standard. Code 2 No Record if the hospital establishment is not accredited or compliant with the standard.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Establishment – quality accreditation/certification standard status (Australian Council on Healthcare Standards EQuIP), code N Health, Superseded 14/09/2005
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Quality accreditation/certification standard—Australian Quality Council

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment—quality accreditation/certification standard indicator (Australian Quality Council), code N
<i>METeOR identifier:</i>	302374
<i>Registration status:</i>	Health, Standard 14/09/2005
<i>Definition:</i>	Whether the Australian Quality Council standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Report the status code as at 30 June. Code 1 Yes Record if the hospital establishment is accredited or compliant with the standard. Code 2 No Record if the hospital establishment is not accredited or compliant with the standard.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Establishment—quality accreditation/certification standard status (Australian Quality Council), code N Health, Superseded 14/09/2005
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Quality accreditation/certification standard—ISO 9000 quality family

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment—quality accreditation/certification standard indicator (International Organisation for Standardisation 9000 quality family), code N
<i>METeOR identifier:</i>	302377
<i>Registration status:</i>	Health, Standard 14/09/2005
<i>Definition:</i>	Whether the International Organisation for Standardisation 9000 quality family standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment—quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Report the status code as at 30 June. Code 1 Yes Record if the hospital establishment is accredited or compliant with the standard. Code 2 No Record if the hospital establishment is not accredited or compliant with the standard.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Establishment—quality accreditation/certification standard status (International Organisation for Standardisation 9000 quality family), code N Health, Superseded 14/09/2005
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Quality accreditation/certification standard—Quality Improvement Council

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – quality accreditation/certification standard indicator (Quality Improvement Council), code N
<i>METeOR identifier:</i>	302379
<i>Registration status:</i>	Health, Standard 14/09/2005
<i>Definition:</i>	Whether the Quality Improvement Council standard has been met by the hospital establishment as a whole, as represented by a code.
Data Element Concept:	Establishment – quality accreditation/certification standard indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Report the status code as at 30 June. Code 1 Yes Record if the hospital establishment is accredited or compliant with the standard. Code 2 No Record if the hospital establishment is not accredited or compliant with the standard.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Establishment – quality accreditation/certification standard status (Quality Improvement Council), code N Health, Superseded 14/09/2005
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Radiotherapy treatment type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – radiotherapy treatment type, code N
<i>METeOR identifier:</i>	291438
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The type of radiation therapy used in initial treatment of the cancer, as represented by a code.
Data Element Concept:	Cancer treatment – radiotherapy treatment type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>External radiotherapy treatment given</td></tr><tr><td>2</td><td>Brachytherapy (radioactive implants)</td></tr><tr><td>3</td><td>Unsealed radioisotopes</td></tr></tbody></table>	Value	Meaning	1	External radiotherapy treatment given	2	Brachytherapy (radioactive implants)	3	Unsealed radioisotopes
Value	Meaning								
1	External radiotherapy treatment given								
2	Brachytherapy (radioactive implants)								
3	Unsealed radioisotopes								
<i>Supplementary values:</i>	<table><tbody><tr><td>0</td><td>No radiotherapy treatment given</td></tr><tr><td>9</td><td>Radiotherapy was administered but method was not stated</td></tr></tbody></table>	0	No radiotherapy treatment given	9	Radiotherapy was administered but method was not stated				
0	No radiotherapy treatment given								
9	Radiotherapy was administered but method was not stated								

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	If codes 1, 2, 3 or 9 are used, the amount of radiation received should also be collected. Most external beam radiotherapy is delivered on an outpatient basis. CODE 2 Brachytherapy (radioactive implants) This code is likely to be listed as a procedure for admitted patients.
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Source and reference attributes

<i>Submitting organisation:</i>	National Cancer Control Initiative
<i>Origin:</i>	Commission on Cancer, American College of Surgeons New South Wales Health Department
<i>Reference documents:</i>	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998) Public Health Division NSW Clinical Cancer Data Collection for

Outcomes and Quality. Data Dictionary Version 1 Sydney NSW Health Dept (2001)

Relational attributes

Related metadata references:

Supersedes [Radiotherapy treatment type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.0 KB)

See also [Cancer treatment – radiation dose received, total Gray N\[NNNN\]](#) Health, Standard 13/06/2004

Implementation in Data Set Specifications:

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Reason for cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – cessation reason, code N[N]
<i>METeOR identifier:</i>	270011
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs – cessation reason

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																
<i>Data type:</i>	Number																																
<i>Format:</i>	N[N]																																
<i>Maximum character length:</i>	2																																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Treatment completed</td></tr><tr><td>2</td><td>Change in main treatment type</td></tr><tr><td>3</td><td>Change in the delivery setting</td></tr><tr><td>4</td><td>Change in the principal drug of concern</td></tr><tr><td>5</td><td>Transferred to another service provider</td></tr><tr><td>6</td><td>Ceased to participate against advice</td></tr><tr><td>7</td><td>Ceased to participate without notice</td></tr><tr><td>8</td><td>Ceased to participate involuntary (non-compliance)</td></tr><tr><td>9</td><td>Ceased to participate at expiration</td></tr><tr><td>10</td><td>Ceased to participate by mutual agreement</td></tr><tr><td>11</td><td>Drug court and /or sanctioned by court diversion service</td></tr><tr><td>12</td><td>Imprisoned, other than drug court sanctioned</td></tr><tr><td>13</td><td>Died</td></tr><tr><td>98</td><td>Other</td></tr><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Treatment completed	2	Change in main treatment type	3	Change in the delivery setting	4	Change in the principal drug of concern	5	Transferred to another service provider	6	Ceased to participate against advice	7	Ceased to participate without notice	8	Ceased to participate involuntary (non-compliance)	9	Ceased to participate at expiration	10	Ceased to participate by mutual agreement	11	Drug court and /or sanctioned by court diversion service	12	Imprisoned, other than drug court sanctioned	13	Died	98	Other	99	Not stated/inadequately described
Value	Meaning																																
1	Treatment completed																																
2	Change in main treatment type																																
3	Change in the delivery setting																																
4	Change in the principal drug of concern																																
5	Transferred to another service provider																																
6	Ceased to participate against advice																																
7	Ceased to participate without notice																																
8	Ceased to participate involuntary (non-compliance)																																
9	Ceased to participate at expiration																																
10	Ceased to participate by mutual agreement																																
11	Drug court and /or sanctioned by court diversion service																																
12	Imprisoned, other than drug court sanctioned																																
13	Died																																
98	Other																																
99	Not stated/inadequately described																																
<i>Supplementary values:</i>	99 Not stated/inadequately described																																

Collection and usage attributes

<i>Guide for use:</i>	To be collected on cessation of a treatment episode. Codes 1 to 12
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listed above are set out as follows to enable a clearer picture of which codes are to be used for what purpose:

Treatment completed as planned:

CODE 1 Treatment completed

Client ceased to participate:

CODE 6 Ceased to participate against advice

CODE 7 Ceased to participate without notice

CODE 8 Ceased to participate involuntary (non-compliance)

CODE 9 Ceased to participate at expiation

Ceased to participate at expiation:

CODE 11 Drug court and /or sanctioned by court diversion service

CODE 12 Imprisoned, other than drug court sanctioned

Treatment not completed (other):

CODE 2 Change in main treatment type

CODE 3 Change in the delivery setting

CODE 4 Change in the principal drug of concern

CODE 5 Transferred to another service provider

Treatment ceased by mutual agreement:

CODE 10 Ceased to participate by mutual agreement

CODE 1 Treatment completed

This code is to be used when all of the immediate goals of the treatment have been completed as planned. Includes situations where the client, after completing this treatment, either does not commence any new treatment, commences a new treatment episode with a different main treatment or principal drug, or is referred to a different service provider for further treatment.

CODE 2 Change in main treatment type

A treatment episode will end if, prior to the completion of the existing treatment, there is a change in the main treatment type for alcohol and other drugs. See also Code 10.

CODE 3 Change in the delivery setting

A treatment episode may end if, prior to the completion of the existing treatment, there is a change in the treatment delivery setting for alcohol and other drugs. See also Code 10 and the Guide for use section in metadata item Episode of treatment for alcohol and other drugs.

CODE 4 Change in the principal drug of concern

A treatment episode will end if, prior to the completion of the existing treatment, there is a change in the principal drug of concern. See also Code 10.

CODE 5 Transferred to another service provider

This code includes situations where the service provider is no longer the most appropriate and the client is transferred/referred to another service. For example, transfers could occur for clients between non-residential and residential services or between

residential services and a hospital. Excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment (use Code 1).

CODE 6 Ceased to participate against advice

This code refers to situations where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest.

CODE 7 Ceased to participate without notice

This code refers to situations where the client ceased to receive treatment without notifying the service provider of their intention to no longer participate.

CODE 8 Ceased to participate involuntary (non-compliance)

This code refers to situations where the client's participation has been ceased by the service provider due to non-compliance with the rules or conditions of the program.

CODE 9 Ceased to participate at expiation

This code refers to situations where the client has fulfilled their obligation to satisfy expiation requirements (e.g. participate in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with further treatment.

CODE 10 Ceased to participate by mutual agreement

This code refers to situations where the client ceases participation by mutual agreement with the service provider even though the treatment plan has not been completed. This may include situations where the client has moved out of the area. Only to be used when Code 2, 3 or 4 is not applicable.

CODE 11 Drug court and/or sanctioned by court diversion service

This code applies to drug court and/or court diversion service clients who are sanctioned back into jail for non-compliance with the program.

CODE 12 Imprisoned, other than drug court sanctioned

This code applies to clients who are imprisoned for reasons other than Code 11.

Data element attributes

Collection and usage attributes

Comments:

Given the levels of attrition within alcohol and other drug treatment programs, it is important to identify the range of different reasons for ceasing treatment with a service.

Source and reference attributes

Submitting organisation:

Intergovernmental Committee on Drugs National Minimum Data Set Working Group

Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Reason for cessation of treatment episode for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.4 KB)

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Reason for non prescription of pharmacotherapy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – reason for non prescription of pharmacotherapy, code N
<i>METeOR identifier:</i>	347222
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The reason a pharmacotherapy was not prescribed for a person, as represented by a code.
Data Element Concept:	Person – reason for non prescription of pharmacotherapy

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Not indicated</td></tr><tr><td>2</td><td>Contraindicated</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Not indicated	2	Contraindicated	9	Not stated/inadequately described
Value	Meaning								
1	Not indicated								
2	Contraindicated								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Not indicated</p> <p>Record this code when a pharmacotherapy was not prescribed because it was not necessary to the treatment of the person.</p> <p>CODE 2 Contraindicated</p> <p>Record this code when a pharmacotherapy was not prescribed because of a condition or factor that increases the risks involved in using the pharmacotherapy. Examples of contraindications are allergy, intolerance, medical condition.</p>
<i>Collection methods:</i>	For each type of pharmacotherapy not prescribed for the person, record whether it was not indicated or contraindicated.

Relational attributes

<i>Related metadata references:</i>	See also Person with acute coronary syndrome – pharmacotherapy type prescribed in hospital, code N[N] Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008

Conditional obligation:

To be provided for each of the pharmacotherapies listed in the data element '*Pharmacotherapy type prescribed for acute coronary syndrome in hospital*' not prescribed.

Reason for readmission—acute coronary syndrome

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – reason for readmission following acute coronary syndrome episode, code N[N]
<i>METeOR identifier:</i>	359404
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The main reason for the admission , to any hospital, of a person within 28 days of discharge from an episode of admitted patient care for acute coronary syndrome, as represented by a code.
Data Element Concept:	Person – reason for readmission following acute coronary syndrome episode

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N[N]																				
<i>Maximum character length:</i>	2																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>ST-segment-elevation myocardial infarction</td></tr><tr><td>2</td><td>non-ST-segment-elevation ACS with high-risk features</td></tr><tr><td>3</td><td>non-ST-segment-elevation ACS with intermediate-risk features</td></tr><tr><td>4</td><td>non-ST-segment-elevation ACS with low-risk features</td></tr><tr><td>5</td><td>Percutaneous coronary intervention (PCI)</td></tr><tr><td>6</td><td>Coronary artery bypass graft (CABG)</td></tr><tr><td>7</td><td>Heart Failure (without MI)</td></tr><tr><td>8</td><td>Arrhythmia (without MI)</td></tr><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	ST-segment-elevation myocardial infarction	2	non-ST-segment-elevation ACS with high-risk features	3	non-ST-segment-elevation ACS with intermediate-risk features	4	non-ST-segment-elevation ACS with low-risk features	5	Percutaneous coronary intervention (PCI)	6	Coronary artery bypass graft (CABG)	7	Heart Failure (without MI)	8	Arrhythmia (without MI)	99	Not stated/inadequately described
Value	Meaning																				
1	ST-segment-elevation myocardial infarction																				
2	non-ST-segment-elevation ACS with high-risk features																				
3	non-ST-segment-elevation ACS with intermediate-risk features																				
4	non-ST-segment-elevation ACS with low-risk features																				
5	Percutaneous coronary intervention (PCI)																				
6	Coronary artery bypass graft (CABG)																				
7	Heart Failure (without MI)																				
8	Arrhythmia (without MI)																				
99	Not stated/inadequately described																				
<i>Supplementary values:</i>																					

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 ST-segment-elevation myocardial infarction</p> <p>This code is used when the reason for admission is persistent ST elevation of ≥ 1mm in two contiguous limb leads, or ST elevation of ≥ 2mm in two contiguous chest leads, or with new left bundle-branch block (BBB) pattern on the ECG.</p> <p>CODE 2 Non-ST-segment-elevation ACS with high-risk features</p> <p>This code is used when the reason for admission is clinical</p>
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features consistent with an acute coronary syndrome with high-risk features which include any of the following:

- repetitive or prolonged (> 10 minutes) ongoing chest pain or discomfort;
- elevated level of at least one cardiac biomarker (troponin or creatine kinase-MB isoenzyme);
- persistent or dynamic ECG changes of ST segment depression $\geq 0.5\text{mm}$ or new T wave $\geq 2\text{mm}$;
- transient ST-segment elevation ($\geq 0.5\text{ mm}$) in more than 2 contiguous leads;
- haemodynamic compromise: Blood pressure < 90 mmHg systolic, cool peripheries, diaphoresis, Killip Class > 1, and/or new onset mitral regurgitation;
- sustained ventricular tachycardia;
- syncope;
- left ventricular systolic dysfunction (left ventricular ejection fraction < 0.40);
- prior percutaneous coronary intervention within 6 months or prior coronary artery bypass surgery;
- presence of known diabetes (with typical symptoms of ACS); or
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with typical symptoms of ACS).

CODE 3 Non-ST-segment-elevation ACS with intermediate-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome and any of the following intermediate-risk features AND NOT meeting the criteria for high-risk ACS:

- chest pain or discomfort within the past 48 hours that occurred at rest, or was repetitive or prolonged (but currently resolved);
- age greater than 65yrs;
- known coronary heart disease: prior myocardial infarction with left ventricular ejection fraction ≥ 0.40 , or known coronary lesion more than >50% stenosed;
- no high-risk changes on electrocardiography (see high-risk features);
- two or more of the following risk factors: of known hypertension, family history, active smoking or hyperlipidaemia;
- presence of known diabetes (with atypical symptoms of ACS);
- chronic kidney disease (estimated glomerular filtration rate < 60mL/minute) (with atypical symptoms of ACS); or
- prior aspirin use.

CODE 4 Non-ST-segment-elevation ACS with low-risk features

This code is used when the reason for admission is clinical features consistent with an acute coronary syndrome without intermediate or high-risk features of non-ST-segment-elevation ACS. This includes onset of anginal symptoms within the last month, or worsening in severity or frequency of angina, or lowering of anginal threshold.

CODE 5 Percutaneous coronary intervention (PCI)

This code is used when the reason for admission is for a PCI, where the PCI is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated PCI undertaken, one of codes 1-4 should be coded.

CODE 6 Coronary artery bypass graft (CABG)

This code is used when the reason for admission is for a CABG, where the CABG is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission with an associated CABG undertaken, one of codes 1-4 should be coded.

CODE 7 Heart failure (without MI)

This code is used when the reason for admission is for the treatment of heart failure, where heart failure is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission, one of codes 1-4 should be coded.

CODE 8 Arrhythmia (without MI)

This code is used when the reason for admission is for the treatment of an arrhythmia, where the arrhythmia is not immediately precipitated by a recurrent ischaemic event. If a recurrent ischaemic event precipitates a readmission, one of codes 1-4 should be coded.

Data element attributes

Collection and usage attributes

Guide for use:

To determine if this item should be collected ask the person being admitted if they have been discharged from an episode of admitted patient care for acute coronary syndrome within the last 28 days.

Comments:

This metadata item is designed to identify recurrent admissions following an initial presentation with acute coronary syndromes (ACS), not necessarily to the hospital responsible for the index admission.

Source and reference attributes

Submitting organisation:

Acute coronary syndrome data working group

Steward:

The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

Related metadata references:

Supersedes [Person – reason for readmission following acute coronary syndrome episode, code N\[N\]](#) Health, Superseded
01/10/2008

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard
01/10/2008

Reason for removal from elective surgery waiting list

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – reason for removal from a waiting list, code N
<i>METeOR identifier:</i>	269959
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The reason why a patient is removed from the elective surgery waiting list, as represented by a code.
<i>Data Element Concept:</i>	Elective surgery waiting list episode – reason for removal from a waiting list

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Admitted as an elective patient for awaited procedure in this hospital or another hospital</td></tr><tr><td>2</td><td>Admitted as an emergency patient for awaited procedure in this hospital or another hospital</td></tr><tr><td>3</td><td>Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)</td></tr><tr><td>4</td><td>Treated elsewhere for awaited procedure, but not as a patient of this hospital's waiting list</td></tr><tr><td>5</td><td>Surgery not required or declined</td></tr><tr><td>6</td><td>Transferred to another hospital's waiting list</td></tr><tr><td>9</td><td>Not known</td></tr></tbody></table>	Value	Meaning	1	Admitted as an elective patient for awaited procedure in this hospital or another hospital	2	Admitted as an emergency patient for awaited procedure in this hospital or another hospital	3	Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)	4	Treated elsewhere for awaited procedure, but not as a patient of this hospital's waiting list	5	Surgery not required or declined	6	Transferred to another hospital's waiting list	9	Not known
Value	Meaning																
1	Admitted as an elective patient for awaited procedure in this hospital or another hospital																
2	Admitted as an emergency patient for awaited procedure in this hospital or another hospital																
3	Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)																
4	Treated elsewhere for awaited procedure, but not as a patient of this hospital's waiting list																
5	Surgery not required or declined																
6	Transferred to another hospital's waiting list																
9	Not known																
<i>Supplementary values:</i>																	

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Admitted as an elective patient for awaited procedure in this hospital or another hospital</p> <p>Patients undergoing the awaited procedure whilst admitted for another reason are to be coded this code.</p> <p>CODE 2 Admitted as an emergency patient for awaited procedure in this hospital or another hospital</p> <p>This code identifies patients who were admitted ahead of their normal position in the queue because the condition requiring treatment deteriorated whilst waiting. Admission as an</p>
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emergency patient could also be due to other causes such as inappropriate urgency rating, delays in the system, or unpredicted biological variation.

CODES 3 - 5

CODE 3 Could not be contacted (includes patients who have died while waiting whether or not the cause of death was related to the condition requiring treatment)

CODE 4 Treated elsewhere for awaited procedure, but not as a patient of this hospital's waiting list

CODE 5 Surgery not required or declined

These codes provide an indication of the amount of clerical audit of the waiting lists. Code 4 gives an indication of patients treated other than as a patient of the hospital's waiting list. The awaited procedure may have been performed as an emergency or as an elective procedure.

CODE 6 Transferred to another hospital's waiting list

This code identifies patients who were transferred from one hospital's elective surgery waiting list to that of another hospital. The waiting time on the waiting lists at the initial hospital and subsequent hospitals should be combined for national reporting.

CODE 9 Not known

This code identifies patients removed from the waiting list for reasons unknown.

Data element attributes

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 [Reason for removal from elective surgery waiting list, version 4, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.8 KB)

Implementation in Data Set Specifications: [Elective surgery waiting times \(removals data\) NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(removals data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Received radiation dose

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – radiation dose received, total Gray N[NNNN]
<i>METeOR identifier:</i>	291472
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The received dose of radiation measured in Gray (Gy) - ICRU.
<i>Data Element Concept:</i>	Cancer treatment – radiation dose received

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNNN]						
<i>Maximum character length:</i>	5						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>00000</td><td>No radiation therapy was administered</td></tr><tr><td>99999</td><td>Radiation therapy was administered but the dose is unknown</td></tr></tbody></table>	Value	Meaning	00000	No radiation therapy was administered	99999	Radiation therapy was administered but the dose is unknown
Value	Meaning						
00000	No radiation therapy was administered						
99999	Radiation therapy was administered but the dose is unknown						
<i>Unit of measure:</i>	Gray (Gy)						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The International Commission on Radiation Units (ICRU) recommends recording doses at the axis point where applicable (opposed fields, four field box, wedged pairs and so on). The ICRU50 reference dose should be recorded for photon therapy if available, otherwise a description of the received dose at the centre of the planning target volume.</p> <p>The ICRU58 should be recorded for brachytherapy.</p> <p>For maximum consistency in this field the ICRU recommendations should be followed whenever possible.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National Cancer Control Initiative
<i>Origin:</i>	Commission on Cancer, American College of Surgeons
<i>Reference documents:</i>	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

Relational attributes

Related metadata references:

See also [Cancer treatment – radiotherapy treatment type, code N](#) Health, Standard 13/06/2004

Supersedes [Received radiation dose, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.6 KB)

Implementation in Data Set Specifications:

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Recurrent expenditure (indirect health care)—public health and monitoring services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (indirect health care) (public health and monitoring services) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270292
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure on indirect health care that is related to public health and monitoring services, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>To be provided at the state level. Public or registered non-profit services and organisations with centralised, statewide or national public health or monitoring services. These include programs concerned primarily with preventing the occurrence of diseases and mitigating their effect, and includes such activities as mass chest X-ray campaigns, immunisation and vaccination programs, control of communicable diseases, ante-natal and post-natal clinics, preschool and school medical services, infant welfare clinics, hygiene and nutrition advisory services, food and drug inspection services, regulation of standards of sanitation, quarantine services, pest control, anti-cancer, anti-drug and anti-smoking campaigns and other programs to increase public awareness of disease symptoms and health hazards, occupational health services, Worksafe Australia, the Australian Institute of Health and Welfare and the National Health and Medical Research Council.</p> <p>Included here would be child dental services comprising expenditure incurred (other than by individual establishments) or dental examinations, provision of preventive and curative dentistry, dental health education for infants and school children and expenditure incurred in the training of dental therapists.</p> <p>Record values up to hundreds of millions of dollars.</p>
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Comments: Resources Working Party members were concerned about the possibility of double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.1 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (indirect health care)—central administrations

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (indirect health care) (central administrations) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270294
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure measured in Australian dollars on indirect health care related to central administrations, for a financial year.
<i>Data Element Concept:</i>	Establishment – recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To be provided at the state level. Expenditures relating to central health administration, research and planning for central and regional offices of State, Territory and Commonwealth health authorities and related departments (e.g. the Department of Veterans' Affairs). Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.
<i>Comments:</i>	Resources Working Party members were concerned about the possibility of double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (19.1 KB)
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Implementation in Data Set Specifications:

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (indirect health care)—central and statewide support services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (indirect health care) (central and statewide support services) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270293
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure measured in Australian dollars on indirect health care related to central and statewide support services, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To be provided at the state level. Public or registered services which provide central or statewide support services for residential establishments within the scope of the Public hospital establishments National Minimum Data Set. These include central pathology services, central linen services and frozen food services and blood banks provided on a central or statewide basis such as Red Cross. Record values up to hundreds of millions of dollars, rounded to the nearest whole dollar.
<i>Comments:</i>	Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.1 KB)

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (indirect health care)—other

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (indirect health care) (other) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270295
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure in Australian dollars on health care that cannot be directly related to programs operated by a particular establishment and is not related to patient transport services, public health and monitoring services, central and statewide support services or central administrations, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To be provided at the state level. Other: Any other indirect health care expenditure as defined above not catered for in the following categories: Patient transport services; Public health and monitoring services; Central and statewide support services; Central administrations. This might include such things as family planning and parental health counselling services and expenditure incurred in the registration of notifiable diseases and other medical information. Record values up to hundreds of millions of dollars, rounded to the nearest whole dollar.
<i>Comments:</i>	Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.1 KB)

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (indirect health care)—patient transport services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (indirect health care) (patient transport services) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270291
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Expenditure measured in Australian dollars on indirect health care related to patient transport services, for a financial year.
<i>Data Element Concept:</i>	Establishment – recurrent expenditure (indirect health care)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>To be provided at the state level. Public or registered non-profit organisations which provide patient transport (or ambulance) for services associated with inpatient or residential episodes at residential establishments within the scope of this data set.</p> <p>This category excludes patient transport services provided by other types of establishments (for example, public hospitals) as part of their normal services. This category includes centralised and statewide patient transport services (for example, Queensland Ambulance Transport Brigade) which operate independently of individual inpatient establishments.</p> <p>Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar.</p>
<i>Comments:</i>	<p>Resources Working Party members were concerned about the possibility that double-counting of programs at the hospital and again at the state level and were also concerned at the lack of uniformity between states. Where possible expenditure relating to programs operated by hospitals should be at the hospital level.</p>

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Indirect health care expenditure, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.1 KB)

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (mental health)—non-salary operating costs

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment (mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)]
<i>Synonymous names:</i>	Non-salary operating costs excluding depreciation
<i>METeOR identifier:</i>	287979
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Total expenditure by a mental health establishment relating to non-salary operating items.
Data Element Concept:	Establishment – recurrent expenditure (non-salary operating costs)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Report all expenditure in thousands of dollars (i.e. \$000s). Expenditure should include both the specific costs directly associated with the service and indirect costs, for example personnel services.</p> <p>Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate service.</p> <p>Depreciation is to be excluded from the non-salary operating costs.</p>
<i>Collection methods:</i>	<p>Non-salary recurrent expenditure, excluding depreciation, is to be reported by service setting (admitted patient care, residential care, ambulatory care).</p> <p>For the admitted patient care setting non-salary recurrent expenditure, excluding depreciation, is to be disaggregated by specialised mental health service program type and specialised mental health service target population, together.</p> <p>The sub-components of non-salary recurrent expenditure, and</p>

depreciation, are to be reported at the organisation level for the Mental health establishments NMDS. However, if the organisation is not reporting on an accrual basis then it does not need to report depreciation.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Is formed using [Establishment – recurrent expenditure \(repairs and maintenance\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(superannuation employer contributions\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(visiting medical officer payments\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(medical and surgical supplies\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(food supplies\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(patient transport cost\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(interest payments\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(drug supplies\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(domestic services\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(other recurrent expenditure\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(administrative expenses\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is used in the formation of [Establishment – recurrent expenditure \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health,

Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (mental health)—salaries and wages

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	296577
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Total salary and wage payments to all staff of a mental health establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Is formed using Establishment – recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
	Is formed using Establishment – recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
	Is formed using Establishment – recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
	Is formed using Establishment – recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
	Is formed using Establishment – recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is formed using Establishment – recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Implementation in Data Set Specifications:

Is formed using [Establishment – recurrent expenditure \(salaries and wages\) \(administrative and clerical staff\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(salaries and wages\) \(domestic and other staff\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(salaries and wages\) \(salaried medical officers\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)— administrative and clerical staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (administrative and clerical staff) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270275
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Salary and wage payments measured in Australian dollars to administrative and other clerical staff of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
	Is used in the formation of Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005
	<i>Implementation start date:</i> 01/07/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006
	<i>Implementation start date:</i> 01/07/2005
	<i>Implementation end date:</i> 30/06/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—carer consultants

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	296531
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Salary and wage payments to carer consultants of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the carer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.
<i>Collection methods:</i>	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

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Is used in the formation of Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
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Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—consultant psychiatrists and psychiatrists

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (consultant psychiatrists and psychiatrists) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288767
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Salary and wage payments to consultant psychiatrists and psychiatrists of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
	Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—consumer consultants

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	296528
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Salary and wage payments to consumer consultants of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs. This implies the person received a salary or contract fee on a regular basis. It does not refer to arrangements where the consumer only received reimbursements of expenses or occasional sitting fees for attendance at meetings.
<i>Collection methods:</i>	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

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Is used in the formation of Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
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Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—diagnostic and health professionals

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270274
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Salary and wage payments measured in Australian dollars to diagnostic and health professionals of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—domestic and other staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (domestic and other staff) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270276
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Salary and wage payments measured in Australian dollars to domestic and other staff of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
<i>Implementation in Data Set Specifications:</i>	

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—enrolled nurses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270270
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Salary and wage payments measured in Australian dollars to enrolled nurses of an establishment, for a financial year.
<i>Data Element Concept:</i>	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
<i>Implementation in Data Set Specifications:</i>	

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—occupational therapists

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (occupational therapists) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288778
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Salary and wage payments to occupational therapists of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
	Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—other diagnostic and health professionals

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (other diagnostic and health professionals) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288786
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Salary and wage payments to other diagnostic and health professionals of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
	Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—other medical officers

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (other medical officers) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288776
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Salary and wage payments to other medical officers of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Other medical officers are those who are neither registered as psychiatrists within the State or Territory nor formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—other personal care staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270273
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Salary and wage payments measured in Australian dollars to other personal care staff of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
<i>Implementation in Data Set Specifications:</i>	

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—psychiatry registrars and trainees

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (psychiatry registrars and trainees)(financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288774
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Salary and wage payments to psychiatry registrars and trainees of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
	Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)— psychologists

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (psychologists) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288784
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Salary and wage payments to psychologists of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
	Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—registered nurses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270269
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Salary and wage payments measured in Australian dollars to registered nurses of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
<i>Implementation in Data Set Specifications:</i>	

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—salaried medical officers

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (salaried medical officers) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270265
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Salary and wage payments measured in Australian dollars to salaried medical officers of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB) Is used in the formation of Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
<i>Implementation in Data Set Specifications:</i>	

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—social workers

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (social workers) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288780
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Salary and wage payments to social workers of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007
	Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—student nurses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (student nurses) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270271
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Salary and wage payments measured in Australian dollars to student nurses of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Student nurses are persons employed by the establishment currently studying in years one to three of a three year certificate course. This includes any person commencing or undertaking a three year course of training leading to registration as a nurse by the state or territory registration board. This includes full time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post basic training courses.</p> <p>Note: This code is not to be reported for the Mental health establishments National Minimum Data Set.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—total

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270470
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Salary and wage payments measured in Australian dollars for all employees of the establishment (including contract staff employed by an agency, provided staffing data is also available).
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record as currency up to hundreds of millions of dollars. Figures should be supplied for each of the staffing categories: C1.1 Salaried medical officers C1.2 Registered nurses C1.3 Enrolled nurses C1.4 Student nurses C1.5 Trainee / pupil nurses C1.6 Other personal care staff C1.7 Diagnostic and health professionals C1.8 Administrative and clerical staff C1.9 Domestic and other staff
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
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Implementation in Data Set Specifications:

[Community mental health establishments NMDS 2004-2005](#) Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure (salaries and wages)—trainee/pupil nurses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (salaries and wages) (trainee/pupil nurses) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270272
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Salary and wage payments measured in Australian dollars to trainee/pupil nurses of an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (salaries and wages)

Value domain attributes

Representational attributes

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

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Salaries and wages, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (16.5 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008 Public hospital establishments NMDS 2008-2009 Health,

Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—Department of Veterans' Affairs funded

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	377992
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	Total recurrent expenditure measured in Australian dollars funded by block grants or activity payments provided by the Department of Veterans' Affairs (DVA) for provision of mental health services and payments made for mental health treatment and care of DVA clients.
Data Element Concept:	Establishment – recurrent expenditure (Department of Veterans' Affairs funded)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Australian dollars. Rounded to nearest whole dollar.
<i>Collection methods:</i>	DVA-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure is available. Where DVA-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possibility of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Establishment – recurrent expenditure (Department of Veterans' Affairs funded), total Australian currency N[N(8)] Health, Superseded 02/12/2009
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*Implementation in Data Set
Specifications:*

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—National Mental Health Strategy funded

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (National Mental Health Strategy funded), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	289502
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Total recurrent expenditure funded by monies allocated by the Commonwealth to the state or territory to assist in implementation of the National Mental Health Strategy.
Data Element Concept:	Establishment – recurrent expenditure (National Mental Health Strategy payments)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Australian dollars. Rounded to the nearest whole dollar.
<i>Collection methods:</i>	Report only the expenditure from those funds used to resource recurrent Expenditure on services within the scope of the NMDS – Mental Health Establishments. National Mental Health Strategy-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	See also Establishment – recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
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Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—State or Territory health authority funded

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288965
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The total recurrent expenditure from funds provided by the State or Territory health authority which were used to support the delivery and/or administration of mental health services reported by the organisation, region or central administration.
Data Element Concept:	Establishment – recurrent expenditure (state or territory health authority funded)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Australian dollars. Rounded to nearest whole dollar. Includes specific mental health allocations as well as health funds appropriated for general or other specific purpose.
<i>Collection methods:</i>	State or Territory health authority-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level. Where State or Territory health authority-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references:

See also [Establishment – recurrent expenditure \(other revenue funded expenditure\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is used in the formation of [Establishment – recurrent expenditure \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—administrative expenses

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (administrative expenses) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270107
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The expenditure measured in Australian dollars incurred by establishments (but not central administrations) of a management expenses/administrative support nature such as any rates and taxes, printing, telephone, stationery and insurance (including workers compensation), for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (administrative expenses)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Rounded to the nearest whole dollar.
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Administrative expenses, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)
	Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (community mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,

Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—depreciation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (depreciation) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270279
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Depreciation charges measured in Australian dollars for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (depreciation)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Depreciation is to be reported by service setting (admitted patient care, residential care, ambulatory care). For admitted patient care settings, depreciation is to be disaggregated by specialised mental health service program type and specialised mental health service target population, together.
<i>Comments:</i>	With the long-term trend towards accrual accounting in the public sector, this metadata item will ultimately become significant for public sector establishments. Public sector establishments in some states have adopted modified accrual accounting identifying depreciation only, before reaching full accrual accounting. Depreciation is now reported for most public sector establishments and should be reported as a separate recurrent expenditure. Depreciation should be identified separately from other recurrent expenditure categories.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

Related metadata references:

Supersedes [Depreciation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Is used in the formation of [Establishment \(community mental health\) – recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,

Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,

Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,

Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—domestic services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (domestic services) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270283
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The costs measured in Australian dollars of all domestic services including electricity, other fuel and power, domestic services for staff, accommodation and kitchen expenses but not including salaries and wages, food costs or equipment replacement and repair costs, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (domestic services)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.
<i>Comments:</i>	The possibility of separating fuel, light and power from domestic services which would bring the overall non-salary recurrent expenditure categories closer to the old Hospitals and Allied Services Advisory Council categories was briefly considered by the Resources Working Party but members did not hold strong views in this area.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Domestic services, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB) Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
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Implementation in Data Set Specifications:

Is used in the formation of [Establishment \(mental health\) – recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is used in the formation of [Establishment \(community mental health\) – recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

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[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

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[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

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Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

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[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

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Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,

Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,

Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,

Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—drug supplies

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (drug supplies) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270282
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The cost measured in Australian dollars of all drugs including the cost of containers, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (drug supplies)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Drug supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB) Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
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Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

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[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

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[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

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[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

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[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

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[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

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[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

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Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—food supplies

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (food supplies) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270284
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The cost measured in Australian dollars of all food and beverages but not including kitchen expenses such as utensils, cleaning materials, cutlery and crockery, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (food supplies)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Food supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB) Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (community mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health,
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Implementation in Data Set Specifications:

Standard 01/03/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

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Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

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[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

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[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

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[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

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Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,

Superseded 05/01/2010

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[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—interest payments

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (interest payments) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270186
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Payments in Australian dollars made by or on behalf of the establishment in respect of borrowings (e.g. interest on bank overdraft) provided the establishment is permitted to borrow, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (interest payments)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.
<i>Comments:</i>	The item would not have been retained if the data set was restricted to the public sector. In some States, public hospitals may not be permitted to borrow funds or it may be entirely a State treasury matter, not identifiable by the health authority. Even where public sector establishment borrowings might be identified, this appears to be a sensitive area and also of less overall significance than in the private sector.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Interest payments, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)
	Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (mental health) –

Implementation in Data Set Specifications:

[recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is used in the formation of [Establishment \(community mental health\) – recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

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[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

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[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

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[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

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Implementation start date: 01/07/2006

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[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

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[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—medical and surgical supplies

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (medical and surgical supplies) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270358
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The cost in Australian dollars of all consumables of a medical or surgical nature (excluding drug supplies) but not including expenditure on equipment repairs, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (medical and surgical supplies)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Gross expenditure should be reported with no revenue offsets, except for inter-hospital transfers.
<i>Collection methods:</i>	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Medical and surgical supplies, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
	Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (community mental health) – recurrent expenditure (non-salary operating costs)

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[\(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

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Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

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[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

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Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

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[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

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[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

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[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

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[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

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Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—non-salary operating costs (excluding depreciation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment (community mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270297
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Total expenditure relating to non-salary operating items, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (non-salary operating costs)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record values up to hundreds of millions of dollars. Rounded to the nearest whole dollar. Total is calculated from expenditure including: <ul style="list-style-type: none">• Payments to visiting medical officers• Superannuation employer contributions (including funding basis)• Drug supplies• Medical and surgical supplies• Food supplies• Domestic services• Repairs and maintenance• Patient transport• Administrative expenses• Interest payments• Depreciation
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- Other recurrent expenditure.

Expenditure should include both the specific costs directly associated with the service and indirect costs for example personnel services.

Research and academic units that function as an integral part of ambulatory care should be reported against the appropriate service.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Non-salary operating costs, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.2 KB)

Is formed using [Establishment – recurrent expenditure \(administrative expenses\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(other recurrent expenditure\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(domestic services\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(drug supplies\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(interest payments\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(patient transport cost\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(food supplies\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(depreciation\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(medical and surgical supplies\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(visiting medical officer payments\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(superannuation employer contributions\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(repairs and maintenance\) \(financial year\), total Australian currency](#)

*Implementation in Data Set
Specifications:*

[N\[N\(8\)\] Health, Standard 01/03/2005](#)

[Community mental health establishments NMDS 2004-2005](#)

Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

Recurrent expenditure—other Commonwealth Government funded

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (other Commonwealth Government funded expenditure), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288031
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Total recurrent expenditure by an organisation, region or central administration funded from other revenue paid directly by the Commonwealth Government and used to resource recurrent expenditure on services within the scope of the NMDS – Mental Health Establishments.
Data Element Concept:	Establishment – recurrent expenditure (other Commonwealth Government funded expenditure)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Australian dollars. Rounded to nearest whole dollar.</p> <p>Includes expenditure where the funding is from nursing home and hostel subsidies for the care of patients in specialised mental health services, and any other special purpose grants including rural health support, education and training funds and incentive package funds made available under the Australian Health Care Agreements.</p> <p>Excludes expenditure funded by the Commonwealth under grants from the Department of Veterans' Affairs or from the National Mental Health Strategy.</p>
<i>Collection methods:</i>	<p>Other Commonwealth Government-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level.</p> <p>Where other Commonwealth Government-funded expenditure could be allocated to more than one level it is important to</p>

allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: See also [Establishment – recurrent expenditure \(other revenue funded expenditure\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is used in the formation of [Establishment – recurrent expenditure \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

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[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—other State or Territory funded

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288075
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The total recurrent expenditure from state or territory funding sources from government departments external to the health department portfolio which were used to support the delivery and/or administration of mental health services.
Data Element Concept:	Establishment – recurrent expenditure (other state or territory funded expenditure)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	State or territory-funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred, e.g. at the state, regional or organisational level.
<i>Collection methods:</i>	<p>Where state or territory-funded expenditure could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.</p> <p>Expenditure funded from all other revenue, excluding those reported separately, to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level.</p>

Relational attributes

<i>Related metadata references:</i>	See also Establishment – recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004
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Implementation in Data Set Specifications:

Is used in the formation of [Establishment – recurrent expenditure \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

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[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

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Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—other patient revenue funded

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (other patient revenue funded expenditure), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290583
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Recurrent expenditure funded from other revenue paid directly by patients or third parties, such as private health insurers, on behalf of patients under care of the organisation, region or central administration mental health services, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (other patient revenue funded expenditure)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Australian dollars. Rounded to the nearest whole dollar.
<i>Collection methods:</i>	<p>Other patient revenue funded expenditure to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the State, regional or organisational level.</p> <p>Note: this excludes expenditure funded by Department of Veterans' Affairs payments in respect of specific patients, or funded by the Commonwealth nursing home or hostel subsidies which should be reported in Department of Veterans' Affairs funded expenditure or Commonwealth Government funded expenditure respectively.</p> <p>Where other patient revenue funded expenditure could be allocated to more than one level, it is important to allocate it to the single most appropriate statistical unit level to avoid the possibility of counting the expended funds more than once. For example, funding provided for service delivery expenditure should be reported at the lowest statistical unit level possible only.</p>

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: See also [Establishment – recurrent expenditure \(other revenue funded expenditure\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is used in the formation of [Establishment – recurrent expenditure \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Implementation in Data Set Specifications: [Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—other recurrent expenditure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (other recurrent expenditure) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270126
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	All other recurrent expenditure measured in Australian dollars not included elsewhere in any of the recurrent expenditure categories, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (other recurrent expenditure)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National Minimum Data Set Working Parties
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Relational attributes

<i>Related metadata references:</i>	Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (community mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded
21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—other revenue funded

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288071
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The total recurrent expenditure funded from all other revenue that was received by the organisation, region and central administration and has not been reported elsewhere.
Data Element Concept:	Establishment – recurrent expenditure (other revenue funded expenditure)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Australian dollars. Rounded to nearest whole dollar.
<i>Collection methods:</i>	Expenditure funded from all other revenue, excluding those reported separately, to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the State, regional or organisational level. Expenditure reported separately are listed below under the Relational attributes section.

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	See also Establishment – recurrent expenditure (state or territory health authority funded), total Australian currency N[N(8)] Health, Standard 08/12/2004 See also Establishment – recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 See also Establishment – recurrent expenditure (other state or territory funded expenditure), total Australian currency N[N(8)]
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Health, Standard 08/12/2004

See also [Establishment – recurrent expenditure \(other patient revenue funded expenditure\), total Australian currency N\[N\(8\)\]](#)
Health, Standard 08/12/2004

See also [Establishment – recurrent expenditure \(other Commonwealth Government funded expenditure\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

See also [Establishment – recurrent expenditure \(National Mental Health Strategy funded\), total Australian currency N\[N\(8\)\]](#)
Health, Standard 08/12/2004

See also [Establishment – recurrent expenditure \(Department of Veterans' Affairs funded\), total Australian currency N\[N\(8\)\]](#)
Health, Superseded 02/12/2009

Is used in the formation of [Establishment – recurrent expenditure \(financial year\), total Australian currency N\[N\(8\)\]](#) Health,
Standard 08/12/2004

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—patient transport

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (patient transport cost) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270048
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The direct cost in Australian dollars of transporting patients excluding salaries and wages of transport staff where payment is made by an establishment, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (patient transport cost)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Patient transport, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)
	Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Is used in the formation of Establishment (community mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—payments to visiting medical officers

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270049
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	All payments measured in Australian dollars made by an institutional health care establishment to visiting medical officers for medical services provided to hospital (public) patients on an honorary, sessionally paid, or fee for service basis, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (visiting medical officer payments)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.
<i>Comments:</i>	Although accepting the need to include visiting medical officer payments, the Resources Working Party decided not to include data on visiting medical officer services (whether hours or number of sessions or number of services provided) due to collection difficulties and the perception that use of visiting medical officers was purely a hospital management issue.

Source and reference attributes

<i>Submitting organisation:</i>	National Minimum Data Set Working Parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Payments to visiting medical officers, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB) Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
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Implementation in Data Set Specifications:

Is used in the formation of [Establishment \(mental health\) – recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is used in the formation of [Establishment \(community mental health\) – recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,

Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—recoveries funded

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (recoveries funded expenditure), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288685
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Recurrent expenditure funded from revenue that is in the nature of a recovery of expenditure incurred, including income from provision of meals and accommodation, use of facilities, etc. for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (recoveries funded expenditure)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Australian dollars. Rounded to nearest whole dollar.
<i>Collection methods:</i>	Expenditure funded from recoveries to be reported only once and for the specific statistical unit level at which the expenditure actually occurred e.g. at the state, regional or organisational level. Where expenditure funded from recoveries could be allocated to more than one level it is important to allocate it to the single most appropriate statistical unit level to avoid the possible of counting the expended funds more than once. For example, recoveries received through service delivery expenditure should be reported at the lowest statistical unit level possible only.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	See also Establishment – recurrent expenditure (other revenue funded expenditure), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment – recurrent expenditure
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Implementation in Data Set Specifications:

[\(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Recurrent expenditure—repairs and maintenance

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (repairs and maintenance) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	269970
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The costs in Australian dollars incurred in maintaining, repairing, replacing and providing additional equipment, maintaining and renovating building and minor additional works, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (repairs and maintenance)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record values up to hundreds of millions of dollars. Rounded to nearest whole dollar. Expenditure of a capital nature should not be included here. Do not include salaries and wages of repair and maintenance staff. Gross expenditure should be reported with no revenue offsets (except for inter-hospital transfers).
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Source and reference attributes

<i>Submitting organisation:</i>	National Minimum Data Set Working Parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Repairs and maintenance, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB) Is used in the formation of Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004 Is used in the formation of Establishment (mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
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Implementation in Data Set Specifications:

Is used in the formation of [Establishment \(community mental health\) – recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—superannuation employer contributions

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (superannuation employer contributions) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	270371
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Contributions paid in Australian dollars or (for an emerging cost scheme) that should be paid (as determined by an actuary) on behalf of establishment employees either by the establishment or a central administration such as a state health authority, to a superannuation fund providing retirement and related benefits to establishment employees, for a financial year.
Data Element Concept:	Establishment – recurrent expenditure (superannuation employer contributions)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.
<i>Comments:</i>	<p>The definition specifically excludes employee superannuation contributions (not a cost to the establishment) and superannuation final benefit payments.</p> <p>In private enterprise some superannuation schemes are partially funded but this is considered too complex a distinction for national minimum data sets.</p> <p>It is noted that the emergence of salary sacrifice schemes allows employees to forego salary for higher superannuation contributions. If these become significant, national minimum data sets may have to take them into account at a future stage.</p>

Source and reference attributes

<i>Submitting organisation:</i>	National Minimum Data Set Working Parties
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Relational attributes

Related metadata references:

Supersedes [Superannuation employer contributions \(including funding basis\), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.4 KB)

Is used in the formation of [Establishment \(mental health\) – recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is used in the formation of [Establishment \(community mental health\) – recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Recurrent expenditure—total

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – recurrent expenditure (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	288993
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure relating to salaries and wages, non-salary recurrent expenditure and depreciation for a financial year.
Data Element Concept:	Establishment – recurrent expenditure

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Australian dollars. Rounded to nearest whole dollar. Total is calculated from expenditure including: salaries and wages; depreciation; and non-salary recurrent expenditure comprising: payments to visiting medical officers; superannuation employer contributions (including funding basis); drug supplies; medical and surgical supplies; food supplies; domestic services; repairs and maintenance; patient transport; administrative expenses; interest payments; and other recurrent expenditure.
<i>Collection methods:</i>	The total grant made to non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding. Can be reported as the total recurrent expenditure if detailed expenditure data are not available.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Is formed using Establishment – recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
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Is formed using [Establishment – recurrent expenditure \(patient transport cost\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(other recurrent expenditure\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(other patient revenue funded expenditure\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is formed using [Establishment – recurrent expenditure \(medical and surgical supplies\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(interest payments\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(food supplies\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(drug supplies\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(domestic services\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(administrative expenses\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(superannuation employer contributions\)](#) Health, Standard 01/03/2005

Is formed using [Establishment – recurrent expenditure \(state or territory health authority funded\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is formed using [Establishment – recurrent expenditure \(recoveries funded expenditure\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is formed using [Establishment – recurrent expenditure \(other state or territory funded expenditure\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is formed using [Establishment – recurrent expenditure \(other revenue funded expenditure\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is formed using [Establishment – recurrent expenditure \(other Commonwealth Government funded expenditure\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is formed using [Establishment \(mental health\) – recurrent expenditure \(non-salary operating costs\) \(financial year\), total Australian currency N\[N\(8\)\]](#) Health, Standard 08/12/2004

Is formed using [Establishment – recurrent expenditure \(National](#)

Implementation in Data Set Specifications:

[Mental Health Strategy funded\), total Australian currency N\[N\(8\)\] Health, Standard 08/12/2004](#)

Is formed using [Establishment – recurrent expenditure \(Department of Veterans’ Affairs funded\), total Australian currency N\[N\(8\)\] Health, Superseded 02/12/2009](#)

Is formed using [Establishment – recurrent expenditure \(repairs and maintenance\) \(financial year\), total Australian currency N\[N\(8\)\] Health, Standard 01/03/2005](#)

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

Referral destination to further care (from specialised mental health residential care)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of residential care – referral destination (mental health care), code N
<i>METeOR identifier:</i>	270130
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of health care the resident is referred to by the residential mental health care service for further care at the end of residential stay, as represented by a code.
Data Element Concept:	Episode of residential care – referral destination (mental health care)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Specialised mental health admitted patient care</td></tr><tr><td>2</td><td>Specialised mental health residential care</td></tr><tr><td>3</td><td>Specialised mental health ambulatory care</td></tr><tr><td>4</td><td>Private psychiatrist care</td></tr><tr><td>5</td><td>General practitioner care</td></tr><tr><td>6</td><td>Other care</td></tr><tr><td>7</td><td>Not referred</td></tr><tr><td>8</td><td>Not applicable (i.e. end of reference period)</td></tr><tr><td>9</td><td>Unknown/not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Specialised mental health admitted patient care	2	Specialised mental health residential care	3	Specialised mental health ambulatory care	4	Private psychiatrist care	5	General practitioner care	6	Other care	7	Not referred	8	Not applicable (i.e. end of reference period)	9	Unknown/not stated/inadequately described
Value	Meaning																				
1	Specialised mental health admitted patient care																				
2	Specialised mental health residential care																				
3	Specialised mental health ambulatory care																				
4	Private psychiatrist care																				
5	General practitioner care																				
6	Other care																				
7	Not referred																				
8	Not applicable (i.e. end of reference period)																				
9	Unknown/not stated/inadequately described																				
<i>Supplementary values:</i>																					

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where the resident is referred to two or more types of health care, the type of health care provided by the service primarily responsible for the care of the resident is to be reported.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Referral from specialised mental health residential care, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.5 KB)
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Implementation in Data Set Specifications:

[Residential mental health care NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Referral destination to further care (psychiatric patients)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care (mental health care) – referral destination, code N
<i>METeOR identifier:</i>	269990
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of further health service care to which a person is referred from mental health, as represented by a code.
Data Element Concept:	Episode of admitted patient care – referral destination

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Not referred</td></tr><tr><td>2</td><td>Private psychiatrist</td></tr><tr><td>3</td><td>Other private medical practitioner</td></tr><tr><td>4</td><td>Mental health/alcohol and drug in-patient facility</td></tr><tr><td>5</td><td>Mental health/alcohol and drug non in-patient facility</td></tr><tr><td>6</td><td>Acute hospital</td></tr><tr><td>7</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Not referred	2	Private psychiatrist	3	Other private medical practitioner	4	Mental health/alcohol and drug in-patient facility	5	Mental health/alcohol and drug non in-patient facility	6	Acute hospital	7	Other
Value	Meaning																
1	Not referred																
2	Private psychiatrist																
3	Other private medical practitioner																
4	Mental health/alcohol and drug in-patient facility																
5	Mental health/alcohol and drug non in-patient facility																
6	Acute hospital																
7	Other																

Data element attributes

Source and reference attributes

Submitting organisation: National Minimum Data Set Working Parties

Relational attributes

Related metadata references: Supersedes [Referral to further care \(psychiatric patients\), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.3 KB)

Implementation in Data Set Specifications: [Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Referred to ophthalmologist (diabetes mellitus)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – referral to ophthalmologist indicator (last 12 months), code N
<i>METeOR identifier:</i>	302823
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether the individual was referred to an ophthalmologist within the last 12 months, as represented by a code.
Data Element Concept:	Person – referral to ophthalmologist indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if the individual was referred to an ophthalmologist during the last 12 months. CODE 2 No: Record if the individual was not referred to an ophthalmologist during the last 12 months.
<i>Collection methods:</i>	Ask the individual if he/she was referred to an ophthalmologist during the last 12 months. Alternatively, obtain this information from appropriate documentation.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents:

Diabetes Control and Complications Trial: DCCT New England
Journal of Medicine, 329(14), September 30, 1993.

Relational attributes

Related metadata references:

Supersedes [Health service event – referral to ophthalmologist status \(last 12 months\), code N](#) Health, Superseded 21/09/2005

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Region code

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – region identifier, X[X]
<i>METeOR identifier:</i>	269940
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An alphanumeric identifier for the location of health services in a defined geographic or administrative area.
Data Element Concept:	Establishment – region identifier

Value domain attributes

Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	X[X]
<i>Maximum character length:</i>	2

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Domain values are specified by individual states/territories. Regions may also be known as Areas or Districts. Any valid region code created by a jurisdiction is permitted.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Region code, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)
	Is used in the formation of Establishment – organisation identifier (Australian), NNX[X]NNNNN Health, Standard 01/03/2005
<i>Implementation in Data Set Specifications:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005
	<i>Implementation start date:</i> 01/07/2005
	<i>Implementation end date:</i> 30/06/2006
	Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006
	<i>Implementation start date:</i> 01/07/2006
	<i>Implementation end date:</i> 30/06/2007
	Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008
	<i>Implementation start date:</i> 01/07/2007
	<i>Implementation end date:</i> 30/06/2008
	Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009

Implementation start date: 01/07/2008
Implementation end date: 30/06/2009
[Admitted patient care NMDS 2009-2010](#) Health, Superseded
22/12/2009
Implementation start date: 01/07/2009
Implementation end date: 30/06/2010
[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009
Implementation start date: 01/07/2010
[Community mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008
Implementation start date: 01/07/2007
Implementation end date: 30/06/2008
[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009
[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010
Implementation start date: 01/07/2009
Implementation end date: 30/06/2010
[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010
Implementation start date: 01/07/2010
[Health care client identification](#) Health, Superseded 04/05/2005
[Health care client identification DSS](#) Health, Superseded
03/12/2008
[Health care client identification DSS](#) Health, Standard
03/12/2008
[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 07/12/2005
Implementation start date: 01/07/2005
[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 21/03/2006
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

[Residential mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Region of first recurrence

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – region of first recurrence of cancer, code N
<i>METeOR identifier:</i>	289136
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The region of first recurrence of primary cancer after a disease free intermission or remission, as represented by a code.
Data Element Concept:	Person with cancer – region of first recurrence of cancer

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Local</td></tr><tr><td>2</td><td>Regional</td></tr><tr><td>3</td><td>Both local and regional</td></tr><tr><td>4</td><td>Distant</td></tr><tr><td>5</td><td>Distant and either local or regional</td></tr><tr><td>6</td><td>Local, regional and distant</td></tr></tbody></table>	Value	Meaning	1	Local	2	Regional	3	Both local and regional	4	Distant	5	Distant and either local or regional	6	Local, regional and distant
Value	Meaning														
1	Local														
2	Regional														
3	Both local and regional														
4	Distant														
5	Distant and either local or regional														
6	Local, regional and distant														
<i>Supplementary values:</i>	<table><tbody><tr><td>0</td><td>None, patient is disease-free</td></tr><tr><td>7</td><td>Patient was never disease-free</td></tr><tr><td>8</td><td>Recurred but site unknown</td></tr><tr><td>9</td><td>Unknown if recurred</td></tr></tbody></table>	0	None, patient is disease-free	7	Patient was never disease-free	8	Recurred but site unknown	9	Unknown if recurred						
0	None, patient is disease-free														
7	Patient was never disease-free														
8	Recurred but site unknown														
9	Unknown if recurred														

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The region of the first recurrence following the initial diagnosis should be recorded.</p> <p>The record should not be updated with subsequent recurrences.</p> <p>The cancer may recur in more than one site (e.g. both regional and distant metastases).</p> <p>Record the highest numbered applicable response.</p>
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Source and reference attributes

<i>Origin:</i>	Commission on Cancer, American College of Surgeons
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Reference documents:

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

Relational attributes

Related metadata references:

Supersedes [Region of first recurrence, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.0 KB)

Implementation in Data Set Specifications:

[Cancer \(clinical\) DSS Health](#), Superseded 07/12/2005

[Cancer \(clinical\) DSS Health](#), Superseded 06/03/2009

[Cancer \(clinical\) DSS Health](#), Superseded 22/12/2009

[Cancer \(clinical\) DSS Health](#), Standard 22/12/2009

Regional lymph nodes positive

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – number of positive regional lymph nodes, total N[N]
<i>METeOR identifier:</i>	370027
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The total number of regional lymph nodes reported as containing tumour after examination by a pathologist.
Data Element Concept:	Person with cancer – number of positive regional lymph nodes

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N]				
<i>Maximum character length:</i>	3				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>997</td><td>Number of lymph nodes unknown</td></tr></tbody></table>	Value	Meaning	997	Number of lymph nodes unknown
Value	Meaning				
997	Number of lymph nodes unknown				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A list of which lymph nodes are defined as regional lymph nodes for each cancer site may be found in the TNM Classification of Tumours, 6th Edition, UICC.</p> <p>Number includes all positive nodes regardless of whether removed/examined at a single or multiple procedures, e.g. for breast cancer, record the sum of positive nodes detected in node sampling/sentinel node biopsy and those removed at axillary clearance.</p> <p>For cancer registries, collection of this data item should only be from notification and pathology reports relating to initial diagnosis and not for recurrent or metastatic disease.</p>
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Source and reference attributes

<i>Origin:</i>	Australian Cancer Network Commission on Cancer American College of Surgeons
<i>Reference documents:</i>	Australian Cancer Network The pathology reporting of breast cancer. A guide for pathologists, surgeons and radiologists Second Edition Sydney (2001) Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998)

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 [Person with cancer – number of positive regional lymph nodes, total N\[N\]](#) Health, Superseded 06/03/2009

See also [Person with cancer – number of regional lymph nodes examined, total N\[N\]](#) Health, Superseded 06/03/2009

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Removal date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – waiting list removal date, DDMMYYYY
<i>METeOR identifier:</i>	270082
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date on which a patient is removed from an elective surgery waiting list.
Data Element Concept:	Elective surgery waiting list episode – waiting list removal date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This date is recorded when a patient is removed from an elective surgery waiting list. Removal date will be the same as admission date for patients in Reason for removal from elective surgery waiting list categories 1 and 2.
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Removal date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB) Is used in the formation of Elective surgery waiting list episode – waiting time (at removal), total days N[NNN] Health, Standard 01/03/2005
<i>Implementation in Data Set Specifications:</i>	Elective surgery waiting times (removals data) NMDS Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2002 <i>Implementation end date:</i> 30/06/2006 Elective surgery waiting times (removals data) NMDS 2006-2009 Health, Superseded 03/12/2008 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2009

Elective surgery waiting times (removals data) NMDS 2009-
Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Renal disease therapy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – renal disease therapy, code N
<i>METeOR identifier:</i>	270264
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The therapy the person is receiving for renal disease, as represented by a code.
Data Element Concept:	Person – renal disease therapy

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Drugs for modification of renal disease</td></tr><tr><td>2</td><td>Drugs for treatment of complications of renal disease</td></tr><tr><td>3</td><td>Peritoneal dialysis</td></tr><tr><td>4</td><td>Haemodialysis</td></tr><tr><td>5</td><td>Functioning renal transplant</td></tr></tbody></table>	Value	Meaning	1	Drugs for modification of renal disease	2	Drugs for treatment of complications of renal disease	3	Peritoneal dialysis	4	Haemodialysis	5	Functioning renal transplant
Value	Meaning												
1	Drugs for modification of renal disease												
2	Drugs for treatment of complications of renal disease												
3	Peritoneal dialysis												
4	Haemodialysis												
5	Functioning renal transplant												

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Drugs for modification of renal disease</p> <p>This code is used to indicate drugs for modification of renal disease, includes drugs intended to slow progression of renal failure. Examples include antiproteinurics such as angiotensin converting enzyme inhibitors (ACEI), angiotensin II receptor antagonists (ATRA) and immunosuppressants.</p> <p>CODE 2 Drugs for treatment of complications of renal disease</p> <p>This code is used to indicate drugs for the treatment of the complications of renal disease. Examples include antihypertensive agents and drugs that are intended to correct biochemical imbalances caused by renal disease (e.g. loop diuretics, ACEI, erythropoietin, calcitriol, etc).</p> <p>CODE 3 Peritoneal dialysis</p> <p>This code is used to indicate peritoneal dialysis, chronic peritoneal dialysis, delivered at home, at a dialysis satellite centre or in hospital.</p> <p>CODE 4 Haemodialysis</p> <p>This code is used to indicate haemodialysis, chronic</p>
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haemodialysis delivered at home, at a dialysis satellite centre or in hospital.

CODE 5 Functioning renal transplant

This code is used to indicate functioning renal transplant, the presence of a functioning renal transplant.

Data element attributes

Collection and usage attributes

Guide for use:

More than one code can be recorded.

Collection methods:

To be collected on commencement of treatment and regularly reviewed.

Source and reference attributes

Submitting organisation:

Cardiovascular Data Working Group

Origin:

Caring for Australians with Renal Impairment Guidelines.
Australian Kidney Foundation

Relational attributes

Related metadata references:

Supersedes [Renal disease therapy, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.5 KB)

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Renal disease—end-stage (diabetes complication)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – end-stage renal disease status (diabetes complication), code N
<i>METeOR identifier:</i>	270373
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether an individual has end-stage renal disease as a complication of diabetes, and has required dialysis or has undergone a kidney transplant, as represented by a code.
Data Element Concept:	Person – end-stage renal disease status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>End-stage renal disease - developed in the last 12 months</td></tr><tr><td>2</td><td>End-stage renal disease - developed prior to the last 12 months</td></tr><tr><td>3</td><td>No end-stage of renal disease</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	End-stage renal disease - developed in the last 12 months	2	End-stage renal disease - developed prior to the last 12 months	3	No end-stage of renal disease	9	Not stated/inadequately described
Value	Meaning										
1	End-stage renal disease - developed in the last 12 months										
2	End-stage renal disease - developed prior to the last 12 months										
3	No end-stage of renal disease										
9	Not stated/inadequately described										
<i>Supplementary values:</i>											

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Ask the individual if he/she has required dialysis or has undergone a kidney (renal) transplant (due to diabetic nephropathy). Alternatively obtain the relevant information from appropriate documentation.
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Source and reference attributes

<i>Submitting organisation:</i>	National Diabetes Data Working Group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

<i>Related metadata references:</i>	Supersedes Renal disease - end stage, diabetes complication, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (17.9 KB)
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*Implementation in Data Set
Specifications:*

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Residential stay start date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Residential stay – episode start date, DDMMYYYY
<i>METeOR identifier:</i>	269953
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date on which a resident formally started a residential stay.
<i>Data Element Concept:</i>	Residential stay – episode start date

Value domain attributes

Representational attributes

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

Data element attributes

Relational attributes

<i>Related metadata references:</i>	Supersedes Residential stay start date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.6 KB)
<i>Implementation in Data Set Specifications:</i>	Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008 <i>Implementation start date:</i> 01/07/2007 <i>Implementation end date:</i> 30/06/2008 Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009 <i>Implementation start date:</i> 01/07/2008 <i>Implementation end date:</i> 30/06/2009 Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010 <i>Implementation start date:</i> 01/07/2009 <i>Implementation end date:</i> 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—Mental Health Act Regulation or related legislation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service – residual expenditure (Mental Health Act Regulation or related legislation), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	376828
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	Total residual expenditure measured in Australian dollars incurred in the establishment and operation of Mental Health Act review bodies.
Data Element Concept:	Specialised mental health service – residual expenditure (Mental Health Act Regulation or related legislation)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
<i>Collection methods:</i>	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Report Mental Health Act Regulation or related legislation expenditure only where the activity occurred independently to service units and where that expenditure is not reported elsewhere. Where the Mental Health Act Regulation or related legislation activity occurs as an integral component of service delivery (e.g. in cases where the service is already reporting activity data), the expenditure should be reported under the relevant service unit.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—academic positions

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service—residual expenditure (academic positions), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290151
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Academic positions refer to grants from the organisation, region or state/territory administration to academic institutions for the establishment and maintenance of academic positions in psychiatry or related disciplines. This item also includes the costs of the other academic positions associated with the professional position where these are financed from within the organisation, region or central administration's recurrent budget.
Data Element Concept:	Specialised mental health service—residual expenditure (academic positions)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.</p> <p>This item also includes the costs of the other academic positions associated with the professional position where these are financed from within the organisation, region or central administration's recurrent budget.</p>
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Collection methods:

Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable:

- Report academic expenditure in this section only where the academic unit operates independently. Where the academic unit or position operates as an integral part of the service (e.g. an acute inpatient unit), the expenditure should be reported for the relevant organisation.
- Where academic grants are paid directly by organisation, region or state/territory administration, these should be reported at that level.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—education and training

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service – residual expenditure (education and training), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290149
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Education and training refers to the cost of professional training and staff development activity within the mental health services managed by the organisation, region or state/territory administration that have not been included in expenditure reported elsewhere.
Data Element Concept:	Specialised mental health service – residual expenditure (education and training)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.</p> <p>Grants made to external agencies for the development of training-related resources materials or programs may also be reported under this category.</p>
<i>Collection methods:</i>	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one

level. Expenditure should be reported for these categories, where applicable.

Where they do exist, expenditure on schools of nursing should be reported at the organisation level.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—insurance

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service – residual expenditure (insurance), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290164
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Insurance refers to public risk and other insurance amounts paid by the organisation, region or central administration in respect to its mental health services and not reported elsewhere.
Data Element Concept:	Specialised mental health service – residual expenditure (insurance)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
<i>Collection methods:</i>	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable. Note: insurance expenditure already included in an establishment's expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—mental health promotion

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service—residual expenditure (mental health promotion), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290156
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the organisation, region or state/territory administration expenditure dedicated specifically to mental health promotion objectives. Mental health promotion is defined as activities designed to lead to improvement of the mental health functioning of persons through prevention, education and intervention activities and services.
Data Element Concept:	Specialised mental health service—residual expenditure (mental health promotion)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.</p> <p>Reporting expenditure against this item is not intended to be based on costing of activities that retrospectively, entailed a significant mental health promotion component. Instead it should be confined to financial allocations that were clearly targeted towards mental health promotion objectives.</p>
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Collection methods:

Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—mental health research

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service—residual expenditure (mental health research), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290153
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditures by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to expenditure on basic or applied research in the mental health field funded by the organisation, region or state/territory administration.
Data Element Concept:	Specialised mental health service—residual expenditure (mental health research)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
<i>Collection methods:</i>	<p>Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable:</p> <p>Report research expenditure for this category only where the research operated independently and where that expenditure is not reported elsewhere. Where the research activity occurs as an integral component of service delivery (e.g. in cases where</p>

research staff are also clinical staff within a hospital unit), the expenditure should be reported under the relevant service unit (at the organisation-level).

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—other indirect expenditure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service—residual expenditure (other indirect expenditure), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290187
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). Includes any other indirect expenditure (excluding grants to non-government organisations to provide mental health services other than residential services) that is incurred in the delivery of mental health services and is not reported elsewhere.
Data Element Concept:	Specialised mental health service—residual expenditure (other indirect expenditure)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
<i>Collection methods:</i>	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—patient transport services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service – residual expenditure (patient transport services), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290183
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to direct cost of transporting patients of mental health services.
Data Element Concept:	Specialised mental health service – residual expenditure (patient transport services)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
<i>Collection methods:</i>	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005
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[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—program administration

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service—residual expenditure (program administration), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290145
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to costs of administration and other support services (such as program management, admissions reception office, medical records etc.) at the mental health program-level (i.e. at state or territory, region or organisation level). Generally, these are resources that are specifically dedicated to the mental health program, are under the direct management control of the program and are funded by the program.
Data Element Concept:	Specialised mental health service—residual expenditure (program administration)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Generally, these are resources that are specifically dedicated to the mental health program, are under the direct management control of the program and are funded by the program.</p> <p>Excludes grants to non-government organisations for services that are to be reported separately. These include grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.</p>
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Collection methods:

Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable:

Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—property leasing costs

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service—residual expenditure (property leasing costs), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290185
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the costs of leasing premises used for the provision of mental health services (e.g. community clinics).
Data Element Concept:	Specialised mental health service—residual expenditure (property leasing costs)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
<i>Collection methods:</i>	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level.

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005 <i>Implementation start date:</i> 01/07/2005
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[Mental health establishments NMDS 2005-2006](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,
Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—service development

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service – residual expenditure (service development), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	373040
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	Residual expenditure measured in Australian dollars relating to the development of new mental health services funded by the organisation, region or state/territory administration that are not yet operational and providing activity data.
Data Element Concept:	Specialised mental health service – residual expenditure (service development)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.</p> <p>Residual expenditures by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit).</p>
<i>Collection methods:</i>	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable.

Report service development expenditure only where the service development operates independently and where that expenditure is not reported elsewhere. Where the service development activity occurs as an integral component of service delivery (e.g. in cases where the service is already reporting activity data), the expenditure should be reported under the relevant service unit.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)— superannuation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service—residual expenditure (superannuation), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290158
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It includes superannuation employer contributions paid, or for an emerging cost scheme, that should be paid on behalf of the employee and that are not reported elsewhere. Emerging cost schemes are those in which the cost of benefits is met at the time a benefit becomes payable, that is, there is no ongoing invested fund from which benefits are paid.
Data Element Concept:	Specialised mental health service—residual expenditure (superannuation)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
<i>Collection methods:</i>	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable.

Note: Superannuation expenditure already included in establishments expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—support services

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service—residual expenditure (support services), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290147
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure in Australian dollars by specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to the cost of administration and other support services provided at the region-level. Such services include regional administration, information systems, personnel, finance and accounting functions. These services are usually provided from a central pool of resources managed at a regional level.
Data Element Concept:	Specialised mental health service—residual expenditure (support services)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
<i>Collection methods:</i>	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Expenditure should be reported for these categories, where applicable: These services are usually provided from a central pool of

resources managed at a regional level. Do not count these costs if they have been included in the expenditure reported by service delivery organisations within the region.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Residual expenditure (mental health service)—workers compensation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service – residual expenditure (workers compensation), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	290160
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditures in Australian dollars specialised mental health services that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit). It refers to workers compensation premiums and payments made by the organisation, region or central administration on behalf of its employees and not reported elsewhere.
Data Element Concept:	Specialised mental health service – residual expenditure (workers compensation)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Excludes grants to non-government organisations for services that are to be reported separately. These are grants for accommodation services, advocacy services, community awareness services, counselling services, independent living skills support services, pre-vocational training services, psychosocial support services, recreational services, respite services, self-help support group services and other unspecified services grants.
<i>Collection methods:</i>	Residual mental health expenditure is to be reported only at the level at which the expenditure occurred (state/territory, region or organisational), and should not be counted at more than one level. Note: Workers compensation expenditure already included in establishments expenditure should not be included in this data element.

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Resuscitation of baby—method

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – baby resuscitation method, code N
<i>METeOR identifier:</i>	270116
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Active measures taken immediately after birth to establish independent respiration and heartbeat, or to treat depressed respiratory effect and to correct metabolic disturbances, as represented by a code.
Data Element Concept:	Birth event – baby resuscitation method

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>None</td></tr><tr><td>2</td><td>Suction only</td></tr><tr><td>3</td><td>Oxygen therapy only</td></tr><tr><td>4</td><td>Intermittent positive pressure respiration (IPPR) through bag and mask</td></tr><tr><td>5</td><td>Endotracheal intubation and IPPR</td></tr><tr><td>6</td><td>External cardiac massage and ventilation</td></tr><tr><td>9</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	1	None	2	Suction only	3	Oxygen therapy only	4	Intermittent positive pressure respiration (IPPR) through bag and mask	5	Endotracheal intubation and IPPR	6	External cardiac massage and ventilation	9	Not stated
Value	Meaning																
1	None																
2	Suction only																
3	Oxygen therapy only																
4	Intermittent positive pressure respiration (IPPR) through bag and mask																
5	Endotracheal intubation and IPPR																
6	External cardiac massage and ventilation																
9	Not stated																
<i>Supplementary values:</i>																	

Collection and usage attributes

<i>Guide for use:</i>	CODE 3 Oxygen therapy only If oxygen is given by bag and mask without IPPR, code as 'oxygen therapy'.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This metadata item does not include drug therapy. Code the most severe measure used.
<i>Comments:</i>	Required to analyse need for resuscitation after complications of labour and delivery and to evaluate level of services needed for different birth settings.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Resuscitation of baby, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.6 KB)

Retirement status in registered profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – retirement status in registered profession, code N
<i>METeOR identifier:</i>	383426
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	Whether a registered health professional is retired from their registered profession, as represented by a code.
Data Element Concept:	Registered health professional – retirement status in registered profession

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Retired</td></tr><tr><td>2</td><td>Not retired</td></tr><tr><td>9</td><td>Unknown/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Retired	2	Not retired	9	Unknown/inadequately described
Value	Meaning								
1	Retired								
2	Not retired								
9	Unknown/inadequately described								
<i>Supplementary values:</i>									

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Reference documents:</i>	Retirement and Retirement Intentions, Australia, Jul 2006 to Jun 2007 (ABS Cat. no. 6238.0)

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 RETIRED</p> <p>This category includes persons who have retired from working or looking for work in the registered profession, and who do not intend to look for or take up work in the registered profession in the future. This definition is based on the ABS definition of 'retired from the labour force', as used in the ABS Retirement and Retirement Intentions survey.</p> <p>CODE 2 NOT RETIRED</p> <p>All persons who are not 'retired' as defined above.</p> <p>Data is self-reported based on the retirement status in the registered profession in the week before registration.</p>
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The data element is only applicable to health professionals who are not employed in the registered profession in Australia.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Labour force status cluster](#) Health, Standard 10/12/2009

Revenue—other

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – revenue (other revenue) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	364799
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	All other revenue measured in Australian dollars received by the establishment for a financial year, that is not included under patient revenue or recoveries (but not including revenue payments received from State or Territory governments).
Data Element Concept:	Establishment – revenue (other revenue)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record as currency up to hundreds of millions of dollars. Rounded to the nearest whole dollar.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Establishment – revenue (other revenue) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008 <i>Implementation start date:</i> 01/07/2008 <i>Implementation end date:</i> 30/06/2009 Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010 <i>Implementation start date:</i> 01/07/2009 Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010 <i>Implementation start date:</i> 01/07/2010

Revenue—patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment—revenue (patient) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	364797
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	All revenue measured in Australian dollars for a financial year, received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges.
Data Element Concept:	Establishment—revenue (patient)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Establishment—revenue (patient) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS 2008-2009 Health, Superseded 03/12/2008 <i>Implementation start date:</i> 01/07/2008 <i>Implementation end date:</i> 30/06/2009 Public hospital establishments NMDS 2009-2010 Health, Superseded 05/01/2010 <i>Implementation start date:</i> 01/07/2009 Public hospital establishments NMDS 2010-2011 Health, Standard 05/01/2010 <i>Implementation start date:</i> 01/07/2010

Revenue—recoveries

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – revenue (recoveries) (financial year), total Australian currency N[N(8)]
<i>METeOR identifier:</i>	364805
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	All revenue received in Australian dollars for a financial year, that is in the nature of a recovery of expenditure incurred.
Data Element Concept:	Establishment – revenue (recoveries)

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record as currency up to hundreds of millions of dollars. Rounded to nearest whole dollar. This metadata item relates to all revenue received by establishments except for general revenue payments received from state or territory governments.
<i>Comments:</i>	The Resources Working Party had considered splitting recoveries into staff meals and accommodation, and use of hospital facilities (private practice) and other recoveries. Some states had felt that use of facilities was too sensitive as a separate identifiable item in a national minimum data set. Additionally, it was considered that total recoveries was an adequate category for health financing analysis purposes at the national level.

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Related metadata references:</i>	Supersedes Establishment – revenue (recoveries) (financial year), total Australian currency N[N(8)] Health, Superseded 05/12/2007
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Implementation in Data Set Specifications:

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Satisfaction with participation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – level of satisfaction with participation in a life area, code N
<i>METeOR identifier:</i>	320216
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The degree to which a person is satisfied with their involvement in a specified life area, as represented by a code.
<i>Context:</i>	Human functioning and disability
<i>Data Element Concept:</i>	Person – level of satisfaction with participation in a life area

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>High satisfaction with participation</td></tr><tr><td>1</td><td>Moderate satisfaction with participation</td></tr><tr><td>2</td><td>Neither satisfied nor dissatisfied with participation</td></tr><tr><td>3</td><td>Moderate dissatisfaction with participation</td></tr><tr><td>4</td><td>Extreme dissatisfaction with participation</td></tr><tr><td>5</td><td>Complete restriction and dissatisfaction</td></tr></tbody></table>	Value	Meaning	0	High satisfaction with participation	1	Moderate satisfaction with participation	2	Neither satisfied nor dissatisfied with participation	3	Moderate dissatisfaction with participation	4	Extreme dissatisfaction with participation	5	Complete restriction and dissatisfaction
Value	Meaning														
0	High satisfaction with participation														
1	Moderate satisfaction with participation														
2	Neither satisfied nor dissatisfied with participation														
3	Moderate dissatisfaction with participation														
4	Extreme dissatisfaction with participation														
5	Complete restriction and dissatisfaction														
<i>Supplementary values:</i>	<table><tbody><tr><td>8</td><td>Not specified</td></tr><tr><td>9</td><td>Not applicable</td></tr></tbody></table>	8	Not specified	9	Not applicable										
8	Not specified														
9	Not applicable														

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item contributes to the definition of the concept 'Disability' and gives an indication of the experience of disability for a person.</p> <p>In the context of health, participation is involvement in a life situation. Participation restrictions are problems an individual may experience in involvement in life situations.</p> <p>This metadata item gives a rating of the person's degree of satisfaction with participation in a domain of life, in relation to their current life goals. Satisfaction with participation corresponds to the person's own perspective on their participation, and reflects their attitude to their participation in the various life areas. It is essentially a summary measure in</p>
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which are embedded the concepts of choice, opportunity and importance.

CODE 0 High satisfaction with participation

Used if a person is involved in the specified life situation as he or she wishes to fulfil his or her current life goals in terms of duration, frequency, manner and outcome.

CODE 1 Moderate satisfaction with participation

Used if the person is reasonably satisfied with their participation in this life situation, in terms of duration, frequency, manner and outcome. This could occur if one of the criteria (duration, frequency, manner or outcome) is not fulfilled and that criterion is not critical to the person's goals. For example, the person does not participate in the specified life situation as frequently as wished, but the other criteria are met and the frequency is not so affected that it is critical to the person's satisfaction.

CODE 2 Neither satisfied nor dissatisfied with participation

Used if the person is neither satisfied nor dissatisfied with their participation in this life situation, in terms of duration, frequency, manner and outcome.

CODE 3 Moderate dissatisfaction with participation

Used if two or three criteria (duration, frequency, manner or outcome) are not fulfilled, but are not so badly affected, in relation to the person's goals in that life area, that the person is extremely dissatisfied. For example, a person is able to participate in work, but is placed in supported employment rather than employment in the open labour market. This is not in line with the person's goals, so that the manner and outcome of the participation are not fulfilled.

CODE 4 Extreme dissatisfaction with participation

Used when all criteria (duration, frequency, manner and outcome) are not fulfilled for the specified life situation, or where any of the criteria are so badly affected in relation to the person's goals that they consider themselves to be extremely dissatisfied with this life area. An example of the latter would arise when a person is extremely dissatisfied with participation in interpersonal activities because his/her goal in terms of duration of social visits is never fulfilled, although other criteria (frequency and manner) may be fulfilled.

CODE 5 Complete restriction and dissatisfaction

Used when the person does not participate in this life situation in line with his or her own goals, i.e. in an area where they wish to participate and is completely dissatisfied with not participating in this life situation.

CODE 9 Not applicable

Used when participation in a life situation is not relevant, such as employment of an infant or where there is no participation and the person has no desire to participate in this area. For example, a personal preference not to participate in specific areas of community, social and civic life such as sport or hobbies. The area may not be applicable to the person's current life goals.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.
<i>Origin:</i>	WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
<i>Reference documents:</i>	Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites: <ul style="list-style-type: none">• WHO ICF website http://www.who.int/classifications/icf/en/• Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.cfm

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Satisfaction with participation should be coded from the perspective of the person. This data element should be coded in conjunction with the Person – activities and participation life area, code (ICF 2001) AN[NNN] data element. For example, a person's 'moderate satisfaction with participation in exchange of information'.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.
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Relational attributes

<i>Related metadata references:</i>	See also Person – activity and participation life area, code (ICF 2001) AN[NNN] Health, Standard 29/11/2006, Community services, Standard 16/10/2006
<i>Implementation in Data Set Specifications:</i>	Activities and Participation cluster Health, Standard 29/11/2006 Community services, Standard 16/10/2006

Scheduled admission date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Admitted patient care waiting list episode – scheduled admission date, DDMMYYYY
<i>METeOR identifier:</i>	269978
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.
Data Element Concept:	Admitted patient care waiting list episode – scheduled admission date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Comments:</i>	<p>If this metadata item were to be used to compare different hospitals or geographical locations, it would be necessary to specify when the scheduled date is to be allocated (for example, on addition to the waiting list).</p> <p>This metadata item is required for the purposes of hospital management - allocation of beds, operating theatre time and other resources.</p>
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Scheduled admission date, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.5 KB)
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Separation date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – separation date, DDMMYYYY
<i>METeOR identifier:</i>	270025
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date on which an admitted patient completes an episode of care.
Data Element Concept:	Episode of admitted patient care – separation date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Comments:</i>	There may be variations amongst jurisdictions with respect to the recording of separation date. This most often occurs for patients who are statistically separated after a period of leave (and who do not return for further hospital care). In this case, some jurisdictions may record the separation date as the date of statistical separation (and record intervening days as leave days) while other jurisdictions may retrospectively separate patients on the first day of leave. Despite the variations in recording of separation date for this group of patients, the current practices provide for the accurate recording of length of stay.
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Separation date, version 5, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.2 KB)
	Is used in the formation of Establishment – number of separations (financial year), total N[NNNNN] Health, Standard 01/03/2005
	Is used in the formation of Episode of admitted patient care – major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009
	Is used in the formation of Episode of admitted patient care – diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v5.1\) ANNA](#) Health, Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v5.1\) NN](#) Health, Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – length of stay \(including leave days\), total N\[NN\]](#) Health, Standard 04/07/2007

Is used in the formation of [Episode of admitted patient care – length of stay \(including leave days\) \(postnatal\), total N\[NN\]](#) Health, Standard 04/07/2007

Is used in the formation of [Episode of admitted patient care – length of stay \(excluding leave days\), total N\[NN\]](#) Health, Standard 01/03/2005

Is used in the formation of [Episode of care – number of psychiatric care days, total N\[NNNN\]](#) Health, Standard 01/03/2005

Is used in the formation of [Episode of admitted patient care – length of stay \(including leave days\), total N\[NN\]](#) Health, Superseded 04/07/2007

Is used in the formation of [Episode of admitted patient care \(postnatal\) – length of stay \(including leave days\), total N\[NN\]](#) Health, Superseded 04/07/2007

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

[Perinatal NMDS](#) Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Separation time

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – separation time, hhmm
<i>METeOR identifier:</i>	270026
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Time at which an admitted patient completes an episode of care.
Data Element Concept:	Episode of admitted patient care – separation time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Comments:</i>	Required to identify the time of completion of the episode or hospital stay, for calculation of length of stay.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Separation time, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf (13.3 KB)
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Separations

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – number of separations (financial year), total N[NNNNN]
<i>Synonymous names:</i>	Discharge
<i>METeOR identifier:</i>	270407
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of separations occurring during the reference period. This includes both formal and statistical separations.
Data Element Concept:	Establishment – number of separations

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNNN]
<i>Maximum character length:</i>	6
<i>Unit of measure:</i>	Separation

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	May be calculated at: <ul style="list-style-type: none">• individual establishment level; or• system (i.e. state/territory) level i.e. the sum of the number of establishments. The sum of the number of separations where the separation date has a value: <ul style="list-style-type: none">• >= the beginning of the reference period (typically a financial year); and• <= the end of the reference period.
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Is formed using Episode of admitted patient care – separation date, DDMMYYYY Health, Standard 01/03/2005 Supersedes Separations, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.3 KB)
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Implementation in Data Set Specifications:

[Community mental health establishments NMDS 2004-2005](#) Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Service contact date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service contact – service contact date, DDMMYYYY
<i>METeOR identifier:</i>	270122
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date of service contact between a health service provider and patient/client.
Data Element Concept:	Service contact – service contact date

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	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.
<i>Collection methods:</i>	For collection from community based (ambulatory and non-residential) agencies.

Relational attributes

<i>Related metadata references:</i>	Supersedes Service contact date, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)
	Is used in the formation of Person – number of service contact dates, total N[NN] Health, Standard 01/03/2005
<i>Implementation in Data Set Specifications:</i>	Cardiovascular disease (clinical) DSS Health, Superseded 15/02/2006
	Cardiovascular disease (clinical) DSS Health, Superseded 04/07/2007
	Cardiovascular disease (clinical) DSS Health, Superseded 22/12/2009
	Cardiovascular disease (clinical) DSS Health, Standard 22/12/2009

[Community mental health care 2004-2005](#) Health, Superseded
08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Service mode (non-admitted patient)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient service event – service mode, hospital code N{.N}
<i>METeOR identifier:</i>	270096
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Relative physical location of the patient, provider and the hospital campus of the provider of a non-admitted patient service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event – service mode

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N{.N}														
<i>Maximum character length:</i>	2														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Patient and provider in the same physical location</td></tr><tr><td>1.1</td><td>On the hospital campus of the provider</td></tr><tr><td>1.2</td><td>Not on the hospital campus of the provider</td></tr><tr><td>2</td><td>Patient and provider not in the same physical location, and communicating via:</td></tr><tr><td>2.1</td><td>Telephone</td></tr><tr><td>2.2</td><td>Telemedicine</td></tr></tbody></table>	Value	Meaning	1	Patient and provider in the same physical location	1.1	On the hospital campus of the provider	1.2	Not on the hospital campus of the provider	2	Patient and provider not in the same physical location, and communicating via:	2.1	Telephone	2.2	Telemedicine
Value	Meaning														
1	Patient and provider in the same physical location														
1.1	On the hospital campus of the provider														
1.2	Not on the hospital campus of the provider														
2	Patient and provider not in the same physical location, and communicating via:														
2.1	Telephone														
2.2	Telemedicine														

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1.1 On the hospital campus of the provider</p> <p>Patient and provider in the same physical location refers to face to face contacts. If this occurs at the hospital campus of the provider, use code 1.1.</p> <p>CODE 1.2 Not on the hospital campus of the provider</p> <p>If the service event does not occur on the hospital campus of the provider (hospital-based outreach services), use code 1.2.</p> <p>Hospital-based outreach service events occur when the patient is treated by hospital staff in a location that is not part of the hospital campus (such as in the patient's home or place of work).</p> <p>Patient and provider not in the same physical location refers to service events delivered via a telephone call or video link (telemedicine). The provider may or may not be physically present on their hospital campus.</p>
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A service event delivered via a telephone call is included if

- it is a substitute for a face-to-face service event, and
- it is pre-arranged, and
- a record of the service event is included in the patient's medical record

A service event can be counted at each site participating via a video link.

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Non-admitted patient service mode, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.8 KB)

Service type (non-admitted patient)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient service event – service event type (clinical), code N[N]
<i>METeOR identifier:</i>	270090
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of clinical service provided to a non-admitted patient in a non-admitted patient service event, as represented by a code.
Data Element Concept:	Non-admitted patient service event – service event type (clinical)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																								
<i>Data type:</i>	Number																								
<i>Format:</i>	N[N]																								
<i>Maximum character length:</i>	2																								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Allied health and/or clinical nurse specialist</td></tr><tr><td>2</td><td>Dental</td></tr><tr><td>3</td><td>Imaging</td></tr><tr><td>4</td><td>Medical</td></tr><tr><td>5</td><td>Obstetrics and gynaecology</td></tr><tr><td>6</td><td>Paediatrics</td></tr><tr><td>7</td><td>Pathology</td></tr><tr><td>8</td><td>Pharmacy</td></tr><tr><td>9</td><td>Psychiatric</td></tr><tr><td>10</td><td>Surgical</td></tr><tr><td>11</td><td>Emergency department</td></tr></tbody></table>	Value	Meaning	1	Allied health and/or clinical nurse specialist	2	Dental	3	Imaging	4	Medical	5	Obstetrics and gynaecology	6	Paediatrics	7	Pathology	8	Pharmacy	9	Psychiatric	10	Surgical	11	Emergency department
Value	Meaning																								
1	Allied health and/or clinical nurse specialist																								
2	Dental																								
3	Imaging																								
4	Medical																								
5	Obstetrics and gynaecology																								
6	Paediatrics																								
7	Pathology																								
8	Pharmacy																								
9	Psychiatric																								
10	Surgical																								
11	Emergency department																								

Collection and usage attributes

<i>Guide for use:</i>	<p>The following provides a guide to types of clinical services that are included in each of the categories in the data domain. Clinical services that are not specifically identified in this Guide for use should be classified as one of the groups in the data domain on the basis of the type of clinical professional staff involved in providing the service event.</p> <p>In paediatric hospitals, the full range of service types should be used. That is, paediatric medical should be reported as medical and paediatric surgical should be reported as surgical.</p>
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Clinical service type	Clinical service examples
Allied health and/or clinical nurse specialist	Audiology Clinical pharmacy Diabetes education Neuropsychology Nutrition/dietetics Occupational therapy Optometry Orthoptics Orthotics Physiotherapy Podiatry Prosthetics Psychology Social work Speech pathology Stomal therapy Wound management
Dental	Dental
Imaging	Medical imaging
Medical	Aged care Alcohol and other drug Allergy Anti-coagulant Asthma Cardiology Clinical measurement Dermatology Dementia Developmental disabilities Diabetes Endocrine Epilepsy Falls Gastroenterology General internal medicine Genetic Haematology Hepatobiliary Hypertension Hyperbaric medicine Immunology Infectious diseases Medical oncology Metabolic bone Nephrology Neurology Occupational medicine Palliative care

	Pain management Pulmonary Radiation oncology Rehabilitation Respiratory Rheumatology Spinal Transplants
Obstetrics and gynaecology	Family planning Gynaecology Gynaecology oncology Obstetrics
Pathology	Pathology
Paediatrics	Adolescent health Neonatal Paediatric medicine Paediatric surgery
Pharmacy	Dispensing pharmacy
Psychiatric	Psychiatry
Surgical	Breast Burns Cardiac surgery Colorectal Craniofacial Ear, nose and throat Fracture General surgery Neurosurgery Ophthalmology Orthopaedics Plastic surgery Pre-admission Pre-anaesthesia Thoracic surgery Urology Vascular surgery
Emergency department	Emergency department

An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

Data element attributes

Relational attributes

Related metadata references:

Supersedes [Non-admitted patient service type, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (25.1 KB)

Sex

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – sex, code N
<i>METeOR identifier:</i>	287316
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	The biological distinction between male and female, as represented by a code.
Data Element Concept:	Person – sex

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Male</td></tr><tr><td>2</td><td>Female</td></tr><tr><td>3</td><td>Intersex or indeterminate</td></tr></tbody></table>	Value	Meaning	1	Male	2	Female	3	Intersex or indeterminate
Value	Meaning								
1	Male								
2	Female								
3	Intersex or indeterminate								
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	9	Not stated/inadequately described						
9	Not stated/inadequately described								

Collection and usage attributes

<i>Guide for use:</i>	Diagnosis and procedure codes should be checked against the national ICD-10-AM sex edits, unless the person is undergoing, or has undergone a sex change or has a genetic condition resulting in a conflict between sex and ICD-10-AM code. CODE 3 Intersex or indeterminate Intersex or indeterminate, refers to a person, who because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason. Intersex or indeterminate, should be confirmed if reported for people aged 90 days or greater.
<i>Comments:</i>	The definition for Intersex in Guide for use is sourced from the ACT Legislation (Gay, Lesbian and Transgender) Amendment Act 2003.

Source and reference attributes

<i>Origin:</i>	Australian Capital Territory 2003. Legislation (Gay, Lesbian and Transgender) Amendment Act 2003
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Reference documents:

Legislation (Gay, Lesbian and Transgender) Amendment Act 2003. See <http://www.legislation.act.gov.au/a/2003-14/20030328-4969/pdf/2003-14.pdf>.

Data element attributes

Collection and usage attributes

Collection methods:

Operationally, sex is the distinction between male and female, as reported by a person or as determined by an interviewer.

When collecting data on sex by personal interview, asking the sex of the respondent is usually unnecessary and may be inappropriate, or even offensive. It is usually a simple matter to infer the sex of the respondent through observation, or from other cues such as the relationship of the person(s) accompanying the respondent, or first name. The interviewer may ask whether persons not present at the interview are male or female.

A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment, transsexual surgery, transgender reassignment or sexual reassignment. Throughout this process, which may be over a considerable period of time, the person's sex could be recorded as either Male or Female.

In data collections that use the ICD-10-AM classification, where sex change is the reason for admission, diagnoses should include the appropriate ICD-10-AM code(s) that clearly identify that the person is undergoing such a process. This code(s) would also be applicable after the person has completed such a process, if they have a procedure involving an organ(s) specific to their previous sex (e.g. where the patient has prostate or ovarian cancer).

CODE 3 Intersex or indeterminate

Is normally used for babies for whom sex has not been determined for whatever reason.

Should not generally be used on data collection forms completed by the respondent.

Should only be used if the person or respondent volunteers that the person is intersex or where it otherwise becomes clear during the collection process that the individual is neither male nor female.

CODE 9 Not stated/inadequately described

Is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Source and reference attributes

Origin:

Australian Institute of Health and Welfare (AIHW) National Mortality Database 1997/98 AIHW 2001 National Diabetes Register, Statistical Profile, December 2000 (Diabetes Series No. 2.)

Reference documents:

Australian Bureau of Statistics

AS4846 Health Care Provider Identification, 2004, Sydney:
Standards Australia

AS5017 Health Care Client Identification, 2002, Sydney:
Standards Australia

In AS4846 and AS5017 alternative codes are presented. Refer to
the current standard for more details.

Relational attributes

Related metadata references:

Supersedes [Person – sex, code N](#) Health, Superseded 04/05/2005,
Community services, Superseded 31/08/2005

Is used in the formation of [Record – linkage key, code 581
XXXXDDMMYYYYN](#) Community services, Standard
21/05/2010

Is used in the formation of [Episode of admitted patient care –
major diagnostic category, code \(AR-DRG v 6\) NN](#) Health,
Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care –
diagnosis related group, code \(AR-DRG v 6\) ANNA](#) Health,
Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care –
diagnosis related group, code \(AR-DRG v5.1\) ANNA](#) Health,
Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care –
major diagnostic category, code \(AR-DRG v5.1\) NN](#) Health,
Superseded 22/12/2009

*Implementation in Data Set
Specifications:*

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard
01/10/2008

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded
05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded
04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded
22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

[Admitted patient palliative care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient palliative care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient palliative care NMDS 2007-08](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient palliative care NMDS 2008-09](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient palliative care NMDS 2009-10](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient palliative care NMDS 2010-11](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

[Alcohol and other drug treatment services NMDS](#) Health,
Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#)
Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#)
Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#)
Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard
22/12/2009

[Community mental health care 2004-2005](#) Health, Superseded
08/12/2004

Implementation start date: 01/07/2004
Implementation end date: 30/06/2005
[Community mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006
[Community mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007
[Community mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008
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Implementation end date: 30/06/2008
[Community mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009
Implementation start date: 01/07/2008
Implementation end date: 30/06/2009
[Community mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010
Implementation start date: 01/07/2009
Implementation end date: 30/06/2010
[Community mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010
Implementation start date: 01/07/2010
[Computer Assisted Telephone Interview demographic module
DSS](#) Health, Superseded 03/12/2008
[Computer Assisted Telephone Interview demographic module
DSS](#) Health, Standard 03/12/2008
[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005
[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005
[Health care client identification DSS](#) Health, Superseded
03/12/2008
[Health care client identification DSS](#) Health, Standard
03/12/2008
[Health care provider identification DSS](#) Health, Superseded
04/07/2007
[Health care provider identification DSS](#) Health, Superseded
03/12/2008
[Health care provider identification DSS](#) Health, Standard
03/12/2008
[Non-admitted patient emergency department care NMDS](#)

Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Non-admitted patient emergency department care NMDS](#)

Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#)

Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Perinatal NMDS](#) Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

[Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009

[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard
10/12/2009

[Registered nursing professional labour force DSS](#) Health,
Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard
10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard
10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard
10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard
10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard
10/12/2009

[Registered psychology labour force DSS](#) Health, Standard
10/12/2009

[Residential mental health care NMDS 2005-2006](#) Health,
Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Residential mental health care NMDS 2006-2007](#) Health,
Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Residential mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Residential mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Residential mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Residential mental health care NMDS 2010-2011](#) Health, Standard
05/01/2010

Implementation start date: 01/07/2010

Source of public and private revenue

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Health industry relevant organisation – source of revenue, public and private code NNN
<i>METeOR identifier:</i>	352427
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The source of revenue received by a health industry relevant organisation, as represented by a code.
Data Element Concept:	Health industry relevant organisation – source of revenue

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																								
<i>Data type:</i>	Number																																								
<i>Format:</i>	NNN																																								
<i>Maximum character length:</i>	3																																								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td></td><td>Public sector</td></tr><tr><td>101</td><td>Australian Health Care Agreements</td></tr><tr><td>102</td><td>Other Special Purpose Payments</td></tr><tr><td>103</td><td>Medicare</td></tr><tr><td>104</td><td>Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme</td></tr><tr><td>105</td><td>National Health and Medical Research Council</td></tr><tr><td>106</td><td>Department of Veterans' Affairs</td></tr><tr><td>107</td><td>Other Australian government departments</td></tr><tr><td>108</td><td>State/Territory non-health departments</td></tr><tr><td>188</td><td>Other public sector revenue</td></tr><tr><td></td><td>Private sector</td></tr><tr><td>201</td><td>Private health insurance</td></tr><tr><td>202</td><td>Workers compensation insurance</td></tr><tr><td>203</td><td>Motor vehicle third party insurance</td></tr><tr><td>204</td><td>Other compensation (e.g. Public liability, common law, medical negligence)</td></tr><tr><td>205</td><td>Private households (self-funded and out-of-pocket expenditure)</td></tr><tr><td>206</td><td>Non-profit institutions serving households</td></tr><tr><td>207</td><td>Corporations (other than health insurance)</td></tr><tr><td>288</td><td>Other private sector revenue</td></tr></tbody></table>	Value	Meaning		Public sector	101	Australian Health Care Agreements	102	Other Special Purpose Payments	103	Medicare	104	Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme	105	National Health and Medical Research Council	106	Department of Veterans' Affairs	107	Other Australian government departments	108	State/Territory non-health departments	188	Other public sector revenue		Private sector	201	Private health insurance	202	Workers compensation insurance	203	Motor vehicle third party insurance	204	Other compensation (e.g. Public liability, common law, medical negligence)	205	Private households (self-funded and out-of-pocket expenditure)	206	Non-profit institutions serving households	207	Corporations (other than health insurance)	288	Other private sector revenue
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206	Non-profit institutions serving households																																								
207	Corporations (other than health insurance)																																								
288	Other private sector revenue																																								

301	Overseas
999	Not further defined

Collection and usage attributes

Guide for use:

Public sector

CODE 101 Australian Health Care Agreements

This item is not currently required to be reported by state or territory health authorities.

Revenue received from the Australian Government Department of Health and Ageing under the Australian Health Care Agreements to assist in the cost of providing public patients with free access to public hospital services within a clinically appropriate time irrespective of where patients live.

CODE 102 Other Special Purpose Payments

This item is not currently required to be reported by state or territory health authorities.

Includes Specific Purpose Payments provided by the Australian Government to the states and territories such as:

- Public Health Outcomes Funding Agreement grants
- Highly Specialised Drugs grants
- National Radiotherapy grants
- National Mental Health Information Development grant
- Magnetic Resonance Imaging grants
- Postgraduate Medical Training grants
- Hepatitis C Education and Prevention grant
- Royal Flying Doctor Service grants

Excludes AHCA grants, Medicare or PBS/RPBS payments.

CODE 103 Medicare

This item is not currently required to be reported by state or territory health authorities.

Includes revenue received for services listed in the Medical Benefits Schedule that are provided by registered medical practitioners. Many medical services in Australia are provided on a fee-for-service basis and attract benefits or revenue from the Australian Government under Medicare.

Includes revenue received for medical services provided to private admitted patients in hospitals as well as some revenue that is not based on fee-for-service (i.e. alternative funding arrangements).

CODE 104 Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceuticals Benefits Scheme (RPBS)

Includes pharmaceuticals in the PBS and RPBS for which the Australian Government paid a benefit.

Excludes:

- revenue received for pharmaceuticals for which no PBS or RPBS benefit was paid;

- revenue received for other non-pharmaceutical medications;
- pharmaceuticals listed in the PBS or RPBS, the total costs of which are equal to, or less than, the statutory patient contribution for the class of patient concerned;
- medicines dispensed through private prescriptions that do not fulfil the criteria for payment under the PBS or RPBS; and
- over-the-counter medicines such as pharmacy-only medicines, aspirin, cough and cold medicines, vitamins and minerals, herbal and other complementary medicines, and a range of medical non-durables, such as bandages, band aids and condoms.

CODE 105 National Health and Medical Research Council

Includes health research funded by the National Health and Medical Research Council that is not reported elsewhere.

CODE 106 Department of Veterans' Affairs

Includes revenues received for health services provided to veterans, war widows and widowers with gold or white DVA cards. Types of services include public and private hospitals, local medical officers and specialists, residential aged care subsidy, allied health, rehabilitation appliances, dental services, community nursing, Veterans' Home Care and travel for treatment.

Excludes revenues received for pharmaceuticals provided to veterans, war widows and widowers with gold, white or orange DVA cards which are reported under code 104.

CODE 107 Other Australian Government Departments

Includes other revenues received for health services from, for example, the Department of Immigration and Citizenship and Department of Defence. Excludes Medicare payments from Medicare Australia (part of Department of Human Services) reported under code 103.

CODE 108 State/Territory non-health Departments

Includes correctional facilities, and departments that have contributed funding for the provision of a health service e.g. public health, emergency services, NSW Food Authority, NSW Health Care Complaints Commission, South Australia Ambulance Service, National Blood Authority, Red Cross, and prison health services such as WA Health services directorate and St Vincent's Correctional Health Service Victoria.

CODE 188 Other public sector revenue

Includes all public sector revenue other than those reported under codes 101 to 108. May include revenue from Local governments.

Private sector

CODE 201 Private health insurance

Includes revenue from businesses mainly engaged in providing insurance cover for hospital, medical, dental or pharmaceutical expenses or costs.

Excludes:

1. accident and sickness insurance

2. liability insurance
3. life insurance
4. general insurance
5. other insurance business excluded by the Private Health Insurance (Health Insurance Business) Rules
6. overseas visitors for whom travel insurance is the major funding source.

State and territory health authorities may report revenues for admitted patients, from private health insurance funds and private households, as a combined total if these revenues are not able to be reported separately.

CODE 202 Workers compensation insurance

Includes benefits paid under workers compensation insurance to the health industry relevant organisation for health care provided to workers, including trainees and apprentices, who have experienced a work-related injury. Type of benefits includes fees for medical or related treatment.

Excludes benefits paid under public liability, common law or medical negligence.

CODE 203 Motor vehicle third party insurance

Includes personal injury claims arising from motor accidents and compensation for accident victims and their families for injuries or death. Excludes benefits paid under workers compensation insurance, public liability, common law or medical negligence.

CODE 204 Other compensation (e.g. Public liability, common law, medical negligence).

This item is not currently required to be reported by state or territory health authorities.

Includes revenues received from:

- public liability insurance for injury arising from an incident related to the organisation's normal activities;
- a court-ordered settlement for damages because of negligence under specific conditions a duty of care exists and was breached and material damage resulted as a consequence;
- health professionals employed by health authorities or otherwise covered by health authority professional indemnity arrangements; and
- a common law settlement cancels all other entitlements to workers compensation benefits. If a common law claim is not successful, the worker will continue to receive workers compensation under the statutory scheme.

Excludes benefits paid under motor vehicle third party insurance.

CODE 205 Private households (self-funded and out-of-pocket expenditure)

Includes payments received from the patient, the patient's family or friends, or other benefactors (i.e. patient revenue).

Includes cost-sharing and informal payments to health care

providers. Cost-sharing is a provision of health insurance or third-party payment that requires the individual who is covered to pay part of the cost of health care received. This is distinct from the payment of a health insurance premium, contribution or tax which is paid whether health care is received or not.

Cost-sharing can be in the form of co-payments, co-insurance or deductibles:

- co-payment: cost-sharing in the form of a fixed amount to be paid for a service;
- co-insurance: cost-sharing in the form of a set proportion of the cost of a service; and
- deductibles: cost-sharing in the form of a fixed amount which must be paid for a service before any payment of benefits can take place.

CODE 206 Non-profit institutions serving households

Non-profit institutions serving households (NPISHs) (i.e. non-profit NGOs) consist of non-profit institutions which provide goods or services to households free or at prices that are not economically significant. Such NPISHs may provide health care goods or services on a non-market basis to households in need, including households affected by natural disasters or war.

The revenues received from such NPISHs are provided mainly by donations in cash or in kind from the general public, corporations or governments. These include organisations such as the National Heart Foundation, Diabetes Australia or the Cancer Council etc. Excludes non-profit institutions that are market producers of goods and services.

NOTE: This item is to be used for the reporting of revenues received from trusts or charities.

CODE 207 Corporations (other than health insurance)

This item is not currently required to be reported by state or territory health authorities.

Include revenues received from all corporations or quasi-corporations, whose principal activity is the production of market goods or services (other than health insurance). Included are all resident non-profit institutions that are market producers of goods or non-financial services. These include health or health-related organisations such as hospitals, pharmacies, medical and diagnostic laboratories, residential aged care facilities and providers of medical specialist services, and non-health organisations such as research organisations.

CODE 288 Other private sector revenue

Includes all private sector revenue other than those reported under codes 201 to 207.

CODE 301 Overseas

This item is not currently required to be reported by state or territory health authorities.

Includes funds provided from overseas countries for areas of health care such as research. Funds may be channelled through

government or non-government organisations or private institutions. Also includes overseas visitors receiving health care for whom travel insurance is the major funding source.

CODE 999 Not further defined

Includes all revenue that could be a combination of categories 101 to 108, 188, 201 to 207 and 288 but which could not be further disaggregated.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Reference documents:

Australian Institute of Health and Welfare 2007. Episode of care – principal source of funding, hospital code NN. Viewed 26 July 2007. <<http://meteor.aihw.gov.au/content/index.phtml/itemId/339080>>

Organisation for Economic Co-operation and Development A system of health accounts, Version 1. OECD 2000.

Australian Bureau of Statistics 2006, Australian and New Zealand Standard Industrial Classification (ANZSIC), 2006, cat. no. 1292.0, ABS, Canberra

Standard Economic Sector Classifications of Australia (SESCA), 2002, cat. no. 1218.0, ABS, Canberra

Private Health Insurance Act 2007 No. 31, 2007 Chapter 4, Part 4–3 at <http://www.comlaw.gov.au/>

Data element attributes

Collection and usage attributes

Guide for use:

If there is an expected source of revenue followed by a finalised actual source of revenue (for example, in relation to compensation claims), then the actual revenue source known at the end of the reporting period should be recorded.

The expected revenue source should be reported if the fee has not been paid but is not to be waived.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Relational attributes

Implementation in Data Set Specifications:

[Government health expenditure function revenue data cluster](#)
Health, Superseded 03/12/2008

[Government health expenditure function revenue data element cluster](#) Health, Standard 03/12/2008

[Government health expenditure organisation revenue data element cluster](#) Health, Superseded 03/12/2008

[Government health expenditure organisation revenue data element cluster](#) Health, Superseded 01/04/2009

[Government health expenditure organisation revenue data element cluster](#) Health, Standard 01/04/2009

Source of referral to alcohol and other drug treatment service

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – referral source, code NN
<i>METeOR identifier:</i>	269946
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The source from which the person was transferred or referred to the alcohol and other drug treatment service, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs – referral source

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																										
<i>Data type:</i>	String																										
<i>Format:</i>	NN																										
<i>Maximum character length:</i>	2																										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Self</td></tr><tr><td>02</td><td>Family member/friend</td></tr><tr><td>03</td><td>Medical practitioner</td></tr><tr><td>04</td><td>Hospital</td></tr><tr><td>05</td><td>Mental health care service</td></tr><tr><td>06</td><td>Alcohol and other drug treatment service</td></tr><tr><td>07</td><td>Other community/health care service</td></tr><tr><td>08</td><td>Correctional service</td></tr><tr><td>09</td><td>Police diversion</td></tr><tr><td>10</td><td>Court diversion</td></tr><tr><td>98</td><td>Other</td></tr><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	01	Self	02	Family member/friend	03	Medical practitioner	04	Hospital	05	Mental health care service	06	Alcohol and other drug treatment service	07	Other community/health care service	08	Correctional service	09	Police diversion	10	Court diversion	98	Other	99	Not stated/inadequately described
Value	Meaning																										
01	Self																										
02	Family member/friend																										
03	Medical practitioner																										
04	Hospital																										
05	Mental health care service																										
06	Alcohol and other drug treatment service																										
07	Other community/health care service																										
08	Correctional service																										
09	Police diversion																										
10	Court diversion																										
98	Other																										
99	Not stated/inadequately described																										
<i>Supplementary values:</i>																											

Collection and usage attributes

<i>Guide for use:</i>	CODE 03 Medical practitioner Includes medical specialists, vocationally registered general practitioners, vocationally registered general practitioner trainees and other primary-care medical practitioners in private practice. CODE 04 Hospital Includes public and private hospitals, hospitals specialising in dental, ophthalmic aids and other specialised medical or surgical
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care, satellite units managed and staffed by a hospital, emergency departments of hospitals, and mothercraft hospitals. Excludes psychiatric hospitals, psychiatric units and drug and alcohol units located within or operating from hospitals, and outpatient clinics (see codes 05-07).

CODE 05 Mental health care service

Includes both residential and non-residential services. Includes psychiatric hospitals and psychiatric units within and outside of hospitals.

CODE 06 Alcohol and other drug treatment service

Includes both residential and non-residential services. Includes drug and alcohol units within and outside of hospitals.

CODE 07 Other community/health care service

Includes outpatient clinics and aged care facilities.

CODE 09 Police diversion

This code should be used when a person detained for a minor drug offence is formally referred to treatment by the police in order to divert the offender from the criminal justice pathway.

CODE 10 Court diversion

This code refers to the diversion of an offender into drug education, assessment and treatment at the discretion of a magistrate. This may occur at the point of bail or prior to sentencing.

CODE 98 Other

Includes persons referred under a legislative act (other than Drug Diversion Act) e.g. *Mental Health Act*.

Data element attributes

Collection and usage attributes

Comments: Source of referral is important in assisting in the analyses of inter-sectoral patient/client flow and for health care planning.

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes [Source of referral to alcohol and other drug treatment service, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.2 KB)

Implementation in Data Set Specifications: [Alcohol and other drug treatment services NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#)

Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#)

Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#)

Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Source of referral to public psychiatric hospital

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – referral source, public psychiatric hospital code NN
<i>METeOR identifier:</i>	269947
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Source from which the person was transferred/referred to the public psychiatric hospital, as represented by a code.
<i>Context:</i>	To assist in analyses of intersectoral patient flow and health care planning.
<i>Data Element Concept:</i>	Episode of admitted patient care – referral source

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																						
<i>Data type:</i>	String																						
<i>Format:</i>	NN																						
<i>Maximum character length:</i>	2																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Private psychiatric practice</td></tr><tr><td>02</td><td>Other private medical practice</td></tr><tr><td>03</td><td>Other public psychiatric hospital</td></tr><tr><td>04</td><td>Other health care establishment</td></tr><tr><td>05</td><td>Other private hospital</td></tr><tr><td>06</td><td>Law enforcement agency</td></tr><tr><td>07</td><td>Other agency</td></tr><tr><td>08</td><td>Outpatient department</td></tr><tr><td>09</td><td>Other</td></tr><tr><td>10</td><td>Unknown</td></tr></tbody></table>	Value	Meaning	01	Private psychiatric practice	02	Other private medical practice	03	Other public psychiatric hospital	04	Other health care establishment	05	Other private hospital	06	Law enforcement agency	07	Other agency	08	Outpatient department	09	Other	10	Unknown
Value	Meaning																						
01	Private psychiatric practice																						
02	Other private medical practice																						
03	Other public psychiatric hospital																						
04	Other health care establishment																						
05	Other private hospital																						
06	Law enforcement agency																						
07	Other agency																						
08	Outpatient department																						
09	Other																						
10	Unknown																						
<i>Supplementary values:</i>																							

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: [Supersedes Source of referral to public psychiatric hospital, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf \(14.7 KB\)](#)

Implementation in Data Set Specifications:

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised mental health service program type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service – admitted patient care program type, code N
<i>METeOR identifier:</i>	288889
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Type of admitted patient care program provided by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service – admitted patient care program type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Acute care
	2	Other

Collection and usage attributes

<i>Guide for use:</i>	<p>The categorisation of the admitted patient program is based on the principal purpose(s) of the program rather than the classification of the individual patients.</p> <p>CODE 1 Acute care</p> <p>Programs primarily providing specialist psychiatric care for people with acute episodes of mental disorder. These episodes are characterised by recent onset of severe clinical symptoms of mental disorder that have potential for prolonged dysfunction or risk to self and/or others. The key characteristic of acute services is that this treatment effort is focused on short-term treatment. Acute services may be focused on assisting people who have had no prior contact or previous psychiatric history, or individuals with a continuing mental disorder for whom there has been an acute exacerbation of symptoms. This category applies only to services with a mental health service setting of overnight admitted patient care or residential care.</p> <p>CODE 2 Other</p> <p>Refers to all other programs primarily providing admitted patient care.</p> <p>Includes programs providing rehabilitation services that have a primary focus on intervention to reduce functional impairments</p>
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that limit the independence of patients. Rehabilitation services are focused on disability and the promotion of personal recovery.

They are characterised by an expectation of substantial improvement over the short to mid-term. Patients treated by rehabilitation services usually have a relatively stable pattern of clinical symptoms.

Also includes programs providing extended care services that primarily provide care over an indefinite period for patients who have a stable but severe level of functional impairment and an inability to function independently, thus requiring extensive care and support. Patients of extended care services present a stable pattern of clinical symptoms, which may include high levels of severe unremitting symptoms of mental disorder. Treatment is focused on preventing deterioration and reducing impairment; improvement is expected to occur slowly.

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 admitted patient settings in mental health service units (see Specialised mental health service – service setting, code N data element).

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Specialised mental health service setting

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service – service setting, code N
<i>METeOR identifier:</i>	288899
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The setting for care provided by a specialised mental health service, as represented by a code.
Data Element Concept:	Specialised mental health service – service setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Admitted patient care setting</td></tr><tr><td>2</td><td>Residential care setting</td></tr><tr><td>3</td><td>Ambulatory care setting</td></tr></tbody></table>	Value	Meaning	1	Admitted patient care setting	2	Residential care setting	3	Ambulatory care setting
Value	Meaning								
1	Admitted patient care setting								
2	Residential care setting								
3	Ambulatory care setting								
<i>Supplementary values:</i>	9 Unknown/not stated/inadequately described								

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Admitted patient care setting</p> <p>The component of specialised mental health services that provides admitted patient care. These are specialised psychiatric hospitals and specialist psychiatric units located within hospitals that are not specialised psychiatric hospitals. Excludes hospital outpatient clinics.</p> <p>CODE 2 Residential care setting</p> <p>The component of specialised mental health services that provides residential care within residential mental health services. Excludes components that provide ambulatory care to patients or clients who are not residents.</p> <p>CODE 3 Ambulatory care setting</p> <p>The component of specialised mental health services that provides ambulatory care (service contacts). They include hospital outpatient clinics and non-hospital community mental health services, such as crisis or mobile assessment and treatment services, day programs, outreach services and consultation/liaison services.</p>
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Data element attributes

Collection and usage attributes

Guide for use:

A single mental health service unit may provide care in more than one setting. This data element is intended to allow staffing, resource and expenditure data related to these settings to be identified and reported separately.

Relational attributes

Related metadata references:

Supersedes [Specialised mental health service – service delivery setting, code N](#) Health, Superseded 08/12/2004

Implementation in Data Set Specifications:

[Community mental health establishments NMDS 2004-2005](#) Health, Superseded 08/12/2004

Implementation start date: 01/07/2004

Implementation end date: 30/06/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Specialised mental health service target population

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service – target population group, code N
<i>METeOR identifier:</i>	288957
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	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

<i>Representation class:</i>	Code										
<i>Data type:</i>	String										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Child and adolescent</td></tr><tr><td>2</td><td>Older person</td></tr><tr><td>3</td><td>Forensic</td></tr><tr><td>4</td><td>General</td></tr></tbody></table>	Value	Meaning	1	Child and adolescent	2	Older person	3	Forensic	4	General
Value	Meaning										
1	Child and adolescent										
2	Older person										
3	Forensic										
4	General										

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Child and adolescent</p> <p>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.</p> <p>CODE 2 Older person</p> <p>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.</p> <p>CODE 3 Forensic</p> <p>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</p>
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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 or services for older people. It excludes forensic services.

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 admitted patient settings in mental health service units (see service setting data element).

The order of priority for coding is:

- where the forensic services are for children/adolescents 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.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health,

Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Specialised mental health service—hours staffed

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service—number of hours staffed, average hours NN
<i>METeOR identifier:</i>	288877
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of hours per day during which a residential mental health service has appropriately trained staff employed on-site. Training may include formal qualifications and/or on the job training.
Data Element Concept:	Specialised mental health service—number of hours staffed

Value domain attributes

Representational attributes

<i>Representation class:</i>	Average	
<i>Data type:</i>	Number	
<i>Format:</i>	NN	
<i>Maximum character length:</i>	2	
<i>Supplementary values:</i>	Value	Meaning
	99	Unknown/not stated/inadequately described
<i>Unit of measure:</i>	Hour (h)	

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Whole numbers of hours staffed (no decimals or fractions). Valid numbers are 1 to 24. The hours staffed provides a measure of service intensity for the reporting and analysis of staff, financial and activity data. For residential mental health services, this refers to the number of hours per day during which appropriately trained staff (either with formal qualifications and/or on the job training) are employed on site, as their normal place of employment, within the service unit. It excludes periods where the service unit is only staffed by a resident sleepover staff member or any period where staff are present but not employed on site at the service unit. Excludes ambulatory and admitted patient services. Round to nearest whole hour. Where the number of hours staffed varies by day, average the number of hours staffed over a week, including the weekend.
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Relational attributes

Implementation in Data Set Specifications:

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

[Mental health establishments NMDS 2005-2006](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Mental health establishments NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Mental health establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Mental health establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Mental health establishments NMDS 2009-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Mental health establishments NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Specialised mental health service—supported public housing places

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Specialised mental health service—number of supported public housing places, total N[N(5)]
<i>METeOR identifier:</i>	373054
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	The total number of places in public housing supported by specialised mental health services available at 30 June, targeted to people affected by mental illness or psychiatric disability.
Data Element Concept:	Specialised mental health service—number of supported public housing places

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[N(5)]
<i>Maximum character length:</i>	6

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>These are places provided by the public housing authority under a partnership agreement with the relevant State or Territory health and/or community service authority. Such agreements commit the State or Territory health and/or community service authority to assist people within their homes by providing ongoing clinical and disability support, including outreach services.</p> <p>'Place' refers to capacity as at June 30, not throughput over the entire year.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Specialised mental health service—number of supported public housing places, total N[N(5)] Health, Superseded 02/12/2009
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*Implementation in Data Set
Specifications:*

[Mental health establishments NMDS 2010-2011](#) Health, Standard
02/12/2009

Implementation start date: 01/07/2010

Specialised service indicators—acquired immune deficiency syndrome unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (acquired immune deficiency syndrome unit), yes/no code N
<i>METeOR identifier:</i>	270448
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the treatment of Acquired Immune Deficiency Syndrome (AIDS) patients is provided within an establishment as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006
Implementation start date: 01/07/2005
Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006
Implementation start date: 01/07/2006
Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—acute renal dialysis unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (acute renal dialysis unit), yes/no code N
<i>METeOR identifier:</i>	270435
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to dialysis of renal failure patients requiring acute care is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Boolean	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Yes
	2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Standard 05/01/2010

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Specialised service indicators—acute spinal cord injury unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (acute spinal cord injury unit), yes/no code N
<i>METeOR identifier:</i>	270432
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the initial treatment and subsequent ongoing management and rehabilitation of patients with acute spinal cord injury, largely conforming to Australian Health Minister’s Advisory Council guidelines for service provision, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—alcohol and drug unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (alcohol and drug unit), yes/no code N
<i>METeOR identifier:</i>	270431
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a facility/service dedicated to the treatment of alcohol and drug dependence is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—bone marrow transplantation unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (bone marrow transplantation unit), yes/no code N
<i>METeOR identifier:</i>	308862
<i>Registration status:</i>	Health, Standard 07/09/2005
<i>Definition:</i>	Whether or not a specialised facility for bone marrow transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—burns unit (level III)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (burns unit (level III)), yes/no code N
<i>METeOR identifier:</i>	270438
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the initial treatment and subsequent rehabilitation of the severely injured burns patient (usually >10 per cent of the patient's body surface affected) is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—cardiac surgery unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (cardiac surgery unit), yes/no code N
<i>METeOR identifier:</i>	270434
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to operative and peri-operative care of patients with cardiac disease is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Boolean	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Yes
	2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—clinical genetics unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (clinical genetics unit), yes/no code N
<i>METeOR identifier:</i>	270444
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to diagnostic and counselling services for clients who are affected by, at risk of, or anxious about genetic disorders, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

<i>Related metadata references:</i>	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
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Specialised service indicators—comprehensive epilepsy centre

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (comprehensive epilepsy centre), yes/no code N
<i>METeOR identifier:</i>	270442
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to seizure characterisation, evaluation of therapeutic regimes, pre-surgical evaluation and epilepsy surgery for patients with refractory epilepsy, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Standard 05/01/2010

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Specialised service indicators—coronary care unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (coronary care unit), yes/no code N
<i>METeOR identifier:</i>	270433
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to acute care services for patients with cardiac diseases is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Standard 05/01/2010

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Specialised service indicators—diabetes unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (diabetes unit), yes/no code N
<i>METeOR identifier:</i>	270449
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the treatment of diabetics is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Standard 05/01/2010

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Specialised service indicators—domiciliary care service

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (domiciliary care service), yes/no code N
<i>METeOR identifier:</i>	270430
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a facility/service dedicated to the provision of nursing or other professional paramedical care or treatment and non-qualified domestic assistance to patients in their own homes or in residential institutions not part of the establishment is provided by the establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—geriatric assessment unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (geriatric assessment unit), yes/no code N
<i>METeOR identifier:</i>	270429
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not facilities dedicated to the Commonwealth-approved assessment of the level of dependency of (usually) aged individuals either for purposes of initial admission to a long-stay institution or for purposes of reassessment of dependency levels of existing long-stay institution residents, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—heart, lung transplantation unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (heart, lung transplantation unit), yes/no code N
<i>METeOR identifier:</i>	308866
<i>Registration status:</i>	Health, Standard 07/09/2005
<i>Definition:</i>	Whether or not a specialised facility for heart including heart lung transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

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Specialised service indicators—hospice care unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (hospice care unit), yes/no code N
<i>METeOR identifier:</i>	270427
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a facility dedicated to the provision of palliative care to terminally ill patients is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Boolean	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Yes
	2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—in-vitro fertilisation unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (in-vitro fertilisation unit), yes/no code N
<i>METeOR identifier:</i>	270441
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the investigation of infertility provision of in-vitro fertilisation services is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—**infectious diseases unit**

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (infectious diseases unit), yes/no code N
<i>METeOR identifier:</i>	270447
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the treatment of infectious diseases is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—intensive care unit (level III)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (intensive care unit (level III)), yes/no code N
<i>METeOR identifier:</i>	270426
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the care of paediatric and adult patients requiring intensive care and sophisticated technological support services is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—liver transplantation unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (liver transplantation unit), yes/no code N
<i>METeOR identifier:</i>	308868
<i>Registration status:</i>	Health, Standard 07/09/2005
<i>Definition:</i>	Whether or not a specialised facility for liver transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—maintenance renal dialysis centre

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (maintenance renal dialysis centre), yes/no code N
<i>METeOR identifier:</i>	270437
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a specialised facility dedicated to maintenance dialysis of renal failure patients, as represented by a code. It may be a separate facility (possibly located on hospital grounds) or known as a satellite centre or a hospital-based facility but is not a facility solely providing training services.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—major plastic/reconstructive surgery unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (major plastic/reconstructive surgery unit), yes/no code N
<i>METeOR identifier:</i>	270439
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to general purpose plastic and specialised reconstructive surgery, including maxillofacial, microsurgery and hand surgery, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—neonatal intensive care unit (level III)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (neonatal intensive care unit (level III)), yes/no code N
<i>METeOR identifier:</i>	270436
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the care of neonates requiring care and sophisticated technological support, is provided within an establishment, as represented by a code. Patients usually require intensive cardiorespiratory monitoring, sustained assistance ventilation, long-term oxygen administration and parenteral nutrition.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—neurosurgical unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (neurosurgical unit), yes/no code N
<i>METeOR identifier:</i>	270446
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the surgical treatment of neurological conditions is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

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Specialised service indicators—nursing home care unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (nursing home care unit), yes/no code N
<i>METeOR identifier:</i>	270428
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a facility dedicated to the provision of nursing home care is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—obstetric/maternity

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (obstetric/maternity), yes/no code N
<i>METeOR identifier:</i>	270150
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the care of obstetric/maternity patients is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Specialised service indicators—oncology unit, cancer treatment

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (oncology unit) (cancer treatment), yes/no code N
<i>METeOR identifier:</i>	270440
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to multidisciplinary investigation, management, rehabilitation and support services for cancer patients, is provided within an establishment, as represented by a code. Treatment services include surgery, chemotherapy and radiation.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

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Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—pancreas transplantation unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (pancreas transplantation unit), yes/no code N
<i>METeOR identifier:</i>	308870
<i>Registration status:</i>	Health, Standard 07/09/2005
<i>Definition:</i>	Whether or not a specialised facility for pancreas transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
<i>Implementation in Data Set Specifications:</i>	Public hospital establishments NMDS Health, Superseded 21/03/2006 <i>Implementation start date:</i> 01/07/2005 <i>Implementation end date:</i> 30/06/2006 Public hospital establishments NMDS Health, Superseded 23/10/2006 <i>Implementation start date:</i> 01/07/2006 <i>Implementation end date:</i> 30/06/2007 Public hospital establishments NMDS 2007-2008 Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—psychiatric unit/ward

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (psychiatric unit/ward), yes/no code N
<i>METeOR identifier:</i>	270425
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised unit/ward dedicated to the treatment and care of admitted patients with psychiatric, mental, or behavioural disorders, is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—rehabilitation unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (rehabilitation unit), yes/no code N
<i>METeOR identifier:</i>	270450
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not dedicated units within recognised hospitals which provide post-acute rehabilitation and are designed as such by the State health authorities (see metadata item Type of episode of care) are provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—renal transplantation unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (renal transplantation unit), yes/no code N
<i>METeOR identifier:</i>	308864
<i>Registration status:</i>	Health, Standard 07/09/2005
<i>Definition:</i>	Whether or not a specialised facility for renal transplantation is provided within the establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—sleep centre

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (sleep centre), yes/no code N
<i>METeOR identifier:</i>	270445
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility linked to a sleep laboratory dedicated to the investigation and management of sleep disorders is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—specialist paediatric

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (specialist paediatric), yes/no code N
<i>METeOR identifier:</i>	270424
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to the care of children aged 14 or less is provided within an establishment, as represented by a code.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Boolean	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Yes
	2	No

Data element attributes

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (22.0 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health,
Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Specialised service indicators—transplantation unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – specialised service indicator (transplantation unit), yes/no code N
<i>METeOR identifier:</i>	270443
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether or not a specialised facility dedicated to organ retrieval, transplantation and ongoing care of the transplant recipient, is provided within an establishment. <ul style="list-style-type: none">• bone marrow• renal• heart, including heart-lung• liver• pancreas.
Data Element Concept:	Establishment – specialised service indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Specialised service indicators, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (22.0 KB)
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Specialist private sector rehabilitation care indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – specialist private sector rehabilitation care indicator, code N
<i>METeOR identifier:</i>	270397
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether the rehabilitation care that a patient receives from a private hospital meets the criteria for 'Specialist private sector rehabilitation care', as represented by a code.
Data Element Concept:	Episode of care – specialist private sector rehabilitation care indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

Guide for use: This metadata item is a qualifier of the three 'Rehabilitation' care types for admitted patients in private hospitals. When an admitted patient in a private hospital is receiving rehabilitation care (as defined in Hospital service – care type, code N[N].N), this metadata item should be recorded to denote whether or not that care meets the criteria for 'specialist rehabilitation'.

These are the criteria determined by The Commonwealth Department of Health and Ageing in respect of patients treated in the private sector, specialist rehabilitation is:

- Provided by a specialist rehabilitation unit (a separate physical space and a specialist rehabilitation team providing admitted patient and/or ambulatory care) meeting guidelines issued by the Commonwealth Department of Health and Ageing, and
- provided by a multi-disciplinary team which is under the clinical management of a consultant in rehabilitation medicine or equivalent, and
- provided for a person with limited functioning (impairments, activity limitations and participation restrictions) and for whom there is a reasonable expectation of functional gain, and

- for whom the primary treatment goal is improvement in functioning status which is evidenced in the medical record by:
 - an individualised and documented initial and periodic assessment of functional ability, or
 - an individualised multi-disciplinary rehabilitation plan which includes agreed rehabilitation goals and indicative timeframes.

Comments:

This metadata item has been developed by the Private Rehabilitation Working Group, and agreed by the private rehabilitation hospital sector, the private health insurance sector and the Commonwealth Department of Health and Ageing. Whilst most patients will be treated by a consultant in rehabilitation medicine (a Fellow of the Australasian Faculty of Rehabilitation Medicine) there are circumstances in which the treating doctor will not be a Fellow of the Faculty. These include, but are not limited to, care provided in geographic areas where there is a shortage of Fellows of the Australasian Faculty of Rehabilitation Medicine.

Source and reference attributes

Submitting organisation:

Private Rehabilitation Working Group
Commonwealth Department of Health and Ageing

Staging basis of cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer staging – staging basis of cancer, code A
<i>METeOR identifier:</i>	296981
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The timing and evidence for T, N and M cancer stage values, as represented by a code.
Data Element Concept:	Cancer staging – staging basis of cancer

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	String						
<i>Format:</i>	A						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>P</td><td>Pathological</td></tr><tr><td>C</td><td>Clinical</td></tr></tbody></table>	Value	Meaning	P	Pathological	C	Clinical
Value	Meaning						
P	Pathological						
C	Clinical						

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE P Pathological</p> <p>Pathological stage is based on histological evidence acquired before treatment, supplemented or modified by additional evidence acquired from surgery and from pathological examination.</p> <p>CODE C Clinical</p> <p>Clinical stage is based on evidence obtained prior to treatment from physical examination, imaging, endoscopy, biopsy, surgical exploration or other relevant examinations.</p> <p>Refer to the latest edition of the UICC reference manual TNM Classification of Malignant Tumours for coding rules.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	From information provided by the treating doctor and recorded on the patient's medical record.
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Relational attributes

Implementation in Data Set Specifications:

[Cancer \(clinical\) DSS Health](#), Superseded 07/12/2005

[Cancer \(clinical\) DSS Health](#), Superseded 06/03/2009

[Cancer \(clinical\) DSS Health](#), Superseded 22/12/2009

[Cancer \(clinical\) DSS Health](#), Standard 22/12/2009

Staging scheme source

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer staging – cancer staging scheme source, code N
<i>METeOR identifier:</i>	296988
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer at the time of diagnosis, as represented by a code.
Data Element Concept:	Cancer staging – cancer staging scheme source

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>TNM Classification of Malignant Tumours (UICC)</td></tr><tr><td>2</td><td>Durie & Salmon for multiple myeloma staging</td></tr><tr><td>3</td><td>FAB for leukaemia classification</td></tr><tr><td>4</td><td>Australian Clinico-Pathological Staging (ACPS) System</td></tr><tr><td>8</td><td>Other</td></tr><tr><td>9</td><td>Unknown</td></tr></tbody></table>	Value	Meaning	1	TNM Classification of Malignant Tumours (UICC)	2	Durie & Salmon for multiple myeloma staging	3	FAB for leukaemia classification	4	Australian Clinico-Pathological Staging (ACPS) System	8	Other	9	Unknown
Value	Meaning														
1	TNM Classification of Malignant Tumours (UICC)														
2	Durie & Salmon for multiple myeloma staging														
3	FAB for leukaemia classification														
4	Australian Clinico-Pathological Staging (ACPS) System														
8	Other														
9	Unknown														
<i>Supplementary values:</i>															

Source and reference attributes

<i>Reference documents:</i>	<p>Durie BGM, Salmon SE. <i>A clinical staging system for multiple myeloma correlation of measured myeloma cell mass with presenting clinical features, response to treatment and survival.</i> Cancer 36:842-54 (1975).</p> <p>Bennett JM, Catovsky D, Daniel MT, Flandrin G, Galton DA, Gralnick HR, Sultan C. <i>Proposed revised criteria for the classification of acute myeloid leukemia: a report of the French-American-British Cooperative Group.</i> Ann Intern Med 103(4): 620-625 (1985).</p> <p>Cheson BD, Cassileth PA, Head DR, Schiffer CA, Bennett JM, Bloomfield CD, Brunning R, Gale RP, Grever MR, Keating MJ, et al. <i>Report of the National Cancer Institute-sponsored workshop on definitions of diagnosis and response in acute myeloid leukemia.</i> J Clin Oncol 8(5): 813-819 (1990).</p> <p>Davis NC, Newland RC. <i>The reporting of colorectal cancer: the Australian Clinicopathological Staging system.</i> Aust NZ J Surg</p>
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52:395-397 (1982).

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

NHMRC *Guidelines for the prevention, early detection and management of colorectal cancer (CRC)* (1999)).

Data element attributes

Collection and usage attributes

Guide for use:

It is recommended that the TNM Manual of the UICC be used whenever it is applicable. The classifications published in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual are identical to the TNM classifications of the UICC.

TNM is not applicable to all tumour sites. Staging is of limited use in acute leukaemias, although a staging system is used for chronic lymphocytic leukaemia. Separate staging systems exist for lymphomas and myeloma. The *NHMRC Guidelines for the prevention, early detection and management of colorectal cancer (CRC)* support the use of the Australian Clinico-Pathological Staging (ACPS) System. A table of correspondences between ACPS and TNM classifications is available.

The current edition of each staging scheme should be used.

Source and reference attributes

Origin:

International Union Against Cancer (UICC).

FAB (French-American-British) Group.

NSW Health Department.

National Health & Medical Research Council.

Clinical Oncological Society of Australia.

Australian Cancer Network.

Relational attributes

Related metadata references:

Supersedes [Staging scheme source, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.8 KB)

See also [Cancer staging – cancer staging scheme source edition number, code N\[N\]](#) Health, Standard 04/06/2004

Implementation in Data Set Specifications:

[Cancer \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Cancer \(clinical\) DSS](#) Health, Superseded 06/03/2009

Conditional obligation:

Recorded if the recommended data standard is not used, e.g. the recommended standard specifies the 6th edition, but the 5th edition is used; or if another classification (not the TNM) is used to stage the cancer, e.g. FAB for leukaemia classification is used.

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Staging scheme source edition number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer staging – cancer staging scheme source edition number, code N[N]
<i>METeOR identifier:</i>	297011
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The edition of the reference used for the purposes of staging the cancer, as represented by a code.
Data Element Concept:	Cancer staging – cancer staging scheme source edition number

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N[N]						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>88</td><td>Not applicable (Cases that do not have a recommended staging scheme)</td></tr><tr><td>99</td><td>Unknown edition</td></tr></tbody></table>	Value	Meaning	88	Not applicable (Cases that do not have a recommended staging scheme)	99	Unknown edition
Value	Meaning						
88	Not applicable (Cases that do not have a recommended staging scheme)						
99	Unknown edition						

Collection and usage attributes

<i>Guide for use:</i>	Record the edition number (i.e. 1 - 87).
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Source and reference attributes

<i>Origin:</i>	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998).
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Relational attributes

<i>Related metadata references:</i>	Supersedes Staging scheme source edition number, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.7 KB)
<i>Implementation in Data Set Specifications:</i>	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009

Conditional obligation:
Recorded if the recommended data standard is not used, e.g. the recommended standard specifies the 6th edition, but the 5th edition is used; or if another classification (not the TNM)

is used to stage the cancer, e.g. FAB for leukaemia classification is used.

[Cancer \(clinical\) DSS Health](#), Superseded 22/12/2009

[Cancer \(clinical\) DSS Health](#), Standard 22/12/2009

Standards assessment indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – standards assessment indicator, yes/no code N
<i>METeOR identifier:</i>	356457
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Whether a service provider organisation routinely undertakes or undergoes formal assessment against defined industry standards, as represented by a code.
Data Element Concept:	Service provider organisation – standards assessment indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Formal assessment against the relevant standards may occur via self-assessment or external assessment methods. A 'formal' self-assessment should involve a number of aspects, including the planning and development of a clear structure for the assessment process; the use of an accepted evaluation method such as a peer review; and the use of validated tools where these are available. A 'formal' assessment also includes a formal in-depth review against the relevant standards by an independent external reviewer. This may take place in the context of an accreditation process for the service provider organisation or the organisation of which the service provider organisation is a sub-unit.</p> <p>CODE 1 Yes The service provider organisation routinely undertakes or undergoes formal assessment against the specified healthcare standards.</p> <p>CODE 2 No The service provider organisation does not routinely undertake or undergo formal assessment against the specified healthcare standards.</p>
<i>Collection methods:</i>	Record only one code.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: [Palliative care performance indicators DSS](#) Health, Standard
05/12/2007

Standards assessment level

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – standards assessment level, code N
<i>METeOR identifier:</i>	359019
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The level of assessment undertaken or undergone by a service provider organisation against relevant industry standards as represented by a code.
Data Element Concept:	Service provider organisation – standards assessment level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Formally assessed</td></tr><tr><td>2</td><td>Accredited</td></tr></tbody></table>	Value	Meaning	1	Formally assessed	2	Accredited
Value	Meaning						
1	Formally assessed						
2	Accredited						

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Formally assessed Formal assessment may entail self-assessment and/or assessment by an independent external reviewer. This assessment may take place in the context of an accreditation process for the organisation. A formal assessment, whether self-assessed or externally reviewed, should involve a number of aspects, including the planning and development of a clear structure for the assessment process, the use of an accepted evaluation method such as a peer review, and the use of validated tools where these are available. CODE 2 Accredited This code should only be recorded where accreditation has been granted to the organisation and is current.
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Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Palliative Care Intergovernmental Forum
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Relational attributes

Implementation in Data Set Specifications:

[Palliative care performance indicators DSS](#) Health, Standard
05/12/2007

Conditional obligation:

Recorded when the data element Service provider organisation – standards assessment indicator, yes/no code N value is 'yes' (code 1).

Standards assessment method

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – standards assessment method, code N
<i>METeOR identifier:</i>	287762
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The method used by a service provider organisation to undertake or undergo formal assessment against defined industry standards, as represented by a code.
Data Element Concept:	Service provider organisation – standards assessment method

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Formal self-assessment</td></tr><tr><td>2</td><td>In-depth external review</td></tr></tbody></table>	Value	Meaning	1	Formal self-assessment	2	In-depth external review
Value	Meaning						
1	Formal self-assessment						
2	In-depth external review						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Formal self-assessment</p> <p>The service provider organisation undertakes formal self-assessment, on a routine basis, against the agreed criteria outlined in the defined industry standards.</p> <p>A formal self-assessment should involve a number of aspects, including the planning and development of a clear structure for the assessment process; the use of an accepted evaluation method such as a peer review; and the use of validated tools where these are available.</p> <p>CODE 2 In-depth external review</p> <p>The service provider organisation routinely undergoes an in-depth review against the defined industry standards by an independent external reviewer. This may take place in the context of an accreditation process for the service provider organisation.</p>
<i>Collection methods:</i>	More than one code can be recorded.

Source and reference attributes

Submitting organisation: Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications: [Palliative care performance indicators DSS](#) Health, Standard 05/12/2007

Conditional obligation:

Recorded when the data element *Service provider organisation – standards assessment indicator, yes/no code N* value is 'yes' (code 1).

State/Territory of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – state/territory of birth, code N
<i>METeOR identifier:</i>	270151
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The state/territory in which the baby was delivered, as represented by a code.
Data Element Concept:	Birth event – state/territory of birth

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																				
<i>Data type:</i>	Number																				
<i>Format:</i>	N																				
<i>Maximum character length:</i>	1																				
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>New South Wales</td></tr><tr><td>2</td><td>Victoria</td></tr><tr><td>3</td><td>Queensland</td></tr><tr><td>4</td><td>South Australia</td></tr><tr><td>5</td><td>Western Australia</td></tr><tr><td>6</td><td>Tasmania</td></tr><tr><td>7</td><td>Northern Territory</td></tr><tr><td>8</td><td>Australian Capital Territory</td></tr><tr><td>9</td><td>Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)</td></tr></tbody></table>	Value	Meaning	1	New South Wales	2	Victoria	3	Queensland	4	South Australia	5	Western Australia	6	Tasmania	7	Northern Territory	8	Australian Capital Territory	9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)
Value	Meaning																				
1	New South Wales																				
2	Victoria																				
3	Queensland																				
4	South Australia																				
5	Western Australia																				
6	Tasmania																				
7	Northern Territory																				
8	Australian Capital Territory																				
9	Other territories (Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)																				

Collection and usage attributes

<i>Guide for use:</i>	The order presented here is the standard for the Australian Bureau of Statistics (ABS). Other organisations (including the Australian Institute of Health and Welfare) publish data in state order based on population (that is, Western Australia before South Australia and Australian Capital Territory before Northern Territory).
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Source and reference attributes

<i>Reference documents:</i>	Australian Bureau of Statistics. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS.
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Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [State/Territory of birth, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.2 KB)

Implementation in Data Set Specifications: [Health care client identification](#) Health, Superseded 04/05/2005

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Perinatal NMDS](#) Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Status of the baby

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth – birth status, code N
<i>METeOR identifier:</i>	269949
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The status of the baby at birth as represented by a code.
Data Element Concept:	Birth – birth status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Live birth</td></tr><tr><td>2</td><td>Stillbirth (fetal death)</td></tr></tbody></table>	Value	Meaning	1	Live birth	2	Stillbirth (fetal death)
Value	Meaning						
1	Live birth						
2	Stillbirth (fetal death)						
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated</td></tr></tbody></table>	9	Not stated				
9	Not stated						

Collection and usage attributes

<i>Guide for use:</i>	<p>Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn (WHO, 1992 definition).</p> <p>Stillbirth is a fetal death prior to the complete expulsion or extraction from its mother of a product of conception of 20 or more completed weeks of gestation or of 400 g or more birthweight; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. (This is the same as the WHO definition of fetal death, except that there are no limits of gestational age or birthweight for the WHO definition.)</p>
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Source and reference attributes

<i>Reference documents:</i>	International Classification of Diseases and Related Health Problems, 10 th Revision, Vol 1, WHO 1992.
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Data element attributes

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: Supersedes [Status of the baby, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.9 KB)

Implementation in Data Set Specifications: [Perinatal NMDS](#) Health, Superseded 06/09/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Perinatal NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Perinatal NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Perinatal NMDS 2008-2010](#) Health, Superseded 02/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Street name (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – street name, text [A(30)]
<i>Synonymous names:</i>	Australian street name
<i>METeOR identifier:</i>	270019
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The concatenation of a person's street type and street suffix resulting in a name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality, as represented by text.
Data Element Concept:	Person (address) – street name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(30)]
<i>Maximum character length:</i>	30

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To be used in conjunction with street type. To be used in conjunction with street suffix.
<i>Comments:</i>	Where suburb/town/locality, state/territory and Postcode - Australian are insufficient to assign a Statistical Local Area (SLA) code from the Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0), the Street name metadata item in conjunction with street type, house/property identifier and street suffix should also be used.

Source and reference attributes

<i>Origin:</i>	Health Data Standards Committee Australia Post Address Presentation Standard
<i>Reference documents:</i>	AS4846 Health Care Provider Identification, 2006, Sydney: Standards Australia

Relational attributes

<i>Related metadata references:</i>	Supersedes Street name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB) Is used in the formation of Person (address) – address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
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Implementation in Data Set Specifications:

Is used in the formation of [Person \(address\) – health address line, text \[X\(180\)\]](#) Health, Superseded 04/05/2005

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Street name (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – street name, text [A(30)]
<i>METeOR identifier:</i>	290218
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The concatenation of an organisation's street type and street suffix resulting in a name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality, as represented by text.
Data Element Concept:	Service provider organisation (address) – street name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(30)]
<i>Maximum character length:</i>	30

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To be used in conjunction with street type. To be used in conjunction with street suffix.
<i>Comments:</i>	Where suburb/town/locality, state/territory and Postcode - Australian are insufficient to assign a Statistical Local Area (SLA) code from the Australian Standard Geographical Classification (Australian Bureau of Statistics, Cat. No. 1216.0), the Street name metadata item in conjunction with Street type, House/property identifier and Street suffix should also be used.

Source and reference attributes

<i>Origin:</i>	Health Data Standards Committee Australia Post Address Presentation Standard
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Relational attributes

<i>Related metadata references:</i>	Is used in the formation of Service provider organisation (address) – address line, text [X(180)] Health, Standard 04/05/2005, Community services, Standard 30/09/2005
<i>Implementation in Data Set Specifications:</i>	Health care provider identification DSS Health, Superseded 04/07/2007 Health care provider identification DSS Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard
03/12/2008

Street suffix code (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – street suffix, code A[A]
<i>METeOR identifier:</i>	270022
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The abbreviated suffix that identifies the type of street where a person resides, as represented by a code.
Data Element Concept:	Person (address) – street suffix

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																										
<i>Data type:</i>	String																										
<i>Format:</i>	A[A]																										
<i>Maximum character length:</i>	2																										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>CN</td><td>Central</td></tr><tr><td>E</td><td>East</td></tr><tr><td>EX</td><td>Extension</td></tr><tr><td>LR</td><td>Lower</td></tr><tr><td>N</td><td>North</td></tr><tr><td>NE</td><td>North East</td></tr><tr><td>NW</td><td>North West</td></tr><tr><td>S</td><td>South</td></tr><tr><td>SE</td><td>South East</td></tr><tr><td>SW</td><td>South West</td></tr><tr><td>UP</td><td>Upper</td></tr><tr><td>W</td><td>West</td></tr></tbody></table>	Value	Meaning	CN	Central	E	East	EX	Extension	LR	Lower	N	North	NE	North East	NW	North West	S	South	SE	South East	SW	South West	UP	Upper	W	West
Value	Meaning																										
CN	Central																										
E	East																										
EX	Extension																										
LR	Lower																										
N	North																										
NE	North East																										
NW	North West																										
S	South																										
SE	South East																										
SW	South West																										
UP	Upper																										
W	West																										

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	To be used in conjunction with street name. To be used in conjunction with street type. For example: Browns Rd W
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Origin:

AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:

Supersedes [Street suffix code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.9 KB)

Is used in the formation of [Person \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of [Person \(address\) – health address line, text \[X\(180\)\]](#) Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Street suffix code (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – street suffix, code A[A]
<i>METeOR identifier:</i>	290170
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The abbreviated suffix that identifies the type of street where an organisation is located, as represented by a code.
Data Element Concept:	Service provider organisation (address) – street suffix

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																										
<i>Data type:</i>	String																										
<i>Format:</i>	A[A]																										
<i>Maximum character length:</i>	2																										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>CN</td><td>Central</td></tr><tr><td>E</td><td>East</td></tr><tr><td>EX</td><td>Extension</td></tr><tr><td>LR</td><td>Lower</td></tr><tr><td>N</td><td>North</td></tr><tr><td>NE</td><td>North East</td></tr><tr><td>NW</td><td>North West</td></tr><tr><td>S</td><td>South</td></tr><tr><td>SE</td><td>South East</td></tr><tr><td>SW</td><td>South West</td></tr><tr><td>UP</td><td>Upper</td></tr><tr><td>W</td><td>West</td></tr></tbody></table>	Value	Meaning	CN	Central	E	East	EX	Extension	LR	Lower	N	North	NE	North East	NW	North West	S	South	SE	South East	SW	South West	UP	Upper	W	West
Value	Meaning																										
CN	Central																										
E	East																										
EX	Extension																										
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N	North																										
NE	North East																										
NW	North West																										
S	South																										
SE	South East																										
SW	South West																										
UP	Upper																										
W	West																										

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	To be used in conjunction with street name. To be used in conjunction with street type. For example: Browns Rd W
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Origin: AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Is used in the formation of [Service provider organisation \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications: [Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Street type code (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – street type, code A[AAA]
<i>METeOR identifier:</i>	270020
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The type of public thoroughfare where a person resides, as represented by a code.
Data Element Concept:	Person (address) – street type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	A[AAA]
<i>Maximum character length:</i>	4

Collection and usage attributes

Guide for use: The following is a list of commonly used abbreviations from AS 4590:

Street Type	Abbreviation
Alley	Ally
Arcade	Arc
Avenue	Ave
Boulevard	Bvd
Bypass	Bypa
Circuit	Cct
Close	Cl
Corner	Crn
Court	Ct
Crescent	Cres
Cul-de-sac	Cds
Drive	Dr
Esplanade	Esp
Green	Grn
Grove	Gr
Highway	Hwy

Junction	Jnc
Lane	Lane
Link	Link
Mews	Mews
Parade	Pde
Place	Pl
Ridge	Rdge
Road	Rd
Square	Sq
Street	St
Terrace	Tce

Data element attributes

Source and reference attributes

Submitting organisation:

Standards Australia

Origin:

Health Data Standards Committee

AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references:

Supersedes [Street type code, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (14.8 KB)

Is used in the formation of [Person \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Is used in the formation of [Person \(address\) – health address line, text \[X\(180\)\]](#) Health, Superseded 04/05/2005

Implementation in Data Set Specifications:

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Street type code (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – street type, code A[AAA]
<i>METeOR identifier:</i>	290193
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The type of public thoroughfare where an organisation is located, as represented by a code.
Data Element Concept:	Service provider organisation (address) – street type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	A[AAA]
<i>Maximum character length:</i>	4

Collection and usage attributes

Guide for use: The following is a list of commonly used abbreviations from AS 4590:

Street Type	Abbreviation
Alley	Ally
Arcade	Arc
Avenue	Ave
Boulevard	Bvd
Bypass	Bypa
Circuit	Cct
Close	Cl
Corner	Crn
Court	Ct
Crescent	Cres
Cul-de-sac	Cds
Drive	Dr
Esplanade	Esp
Green	Grn
Grove	Gr

Highway	Hwy
Junction	Jnc
Lane	Lane
Link	Link
Mews	Mews
Parade	Pde
Place	Pl
Ridge	Rdge
Road	Rd
Square	Sq
Street	St
Terrace	Tce

Data element attributes

Collection and usage attributes

Collection methods: To be collected in conjunction with street name. To be collected in conjunction with street suffix.

Source and reference attributes

Origin: AS4590 Interchange of client information, Australia Post Address Presentation Standard

Relational attributes

Related metadata references: Is used in the formation of [Service provider organisation \(address\) – address line, text \[X\(180\)\]](#) Health, Standard 04/05/2005, Community services, Standard 30/09/2005

Implementation in Data Set Specifications: [Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Suburb/town/locality name (person)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (address) – suburb/town/locality name, text [A(50)]
<i>METeOR identifier:</i>	287326
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
<i>Definition:</i>	The full name of the locality contained within the specific address of a person, as represented by text.
Data Element Concept:	Person (address) – suburb/town/locality name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(50)]
<i>Maximum character length:</i>	50

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community.</p> <p>This metadata item may be used to describe the location of person. It can be a component of a street or postal address.</p> <p>The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names.</p>
<i>Collection methods:</i>	Enter 'Unknown' when the locality name or geographic area for a person or event is not known. Enter 'No fixed address' when a person has no fixed address or is homeless .

Source and reference attributes

<i>Origin:</i>	National Health Data Committee National Community Services Data Committee
<i>Reference documents:</i>	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia Australia Post 2005. Australia Postcode File. Viewed 12 April, www.auspost.com.au/postcodes

Relational attributes

Related metadata references:

Supersedes [Person \(address\) – suburb/town/locality name, text \[A\(50\)\]](#) Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005

Is used in the formation of [Person \(address\) – postal delivery point identifier, {N\(8\)}](#) Health, Standard 04/05/2005, Community services, Standard 25/08/2005

Is used in the formation of [Dwelling – geographic location, remoteness structure code \(ASGC 2004\) N\[N\]](#) Housing assistance, Retired 10/02/2006

Implementation in Data Set Specifications:

[Computer Assisted Telephone Interview demographic module DSS](#) Health, Superseded 03/12/2008

[Computer Assisted Telephone Interview demographic module DSS](#) Health, Standard 03/12/2008

[Health care client identification DSS](#) Health, Superseded 03/12/2008

[Health care client identification DSS](#) Health, Standard 03/12/2008

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

[Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009

[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard 10/12/2009

[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard 10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard 10/12/2009

[Registered psychology labour force DSS](#) Health, Standard 10/12/2009

Suburb/town/locality name (service provider organisation)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation (address) – suburb/town/locality name, text [A(50)]
<i>METeOR identifier:</i>	290059
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 31/08/2005
<i>Definition:</i>	The full name of the general locality containing the specific address of an organisation, as represented by text.
Data Element Concept:	Service provider organisation (address) – suburb/town/locality name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(50)]
<i>Maximum character length:</i>	50

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community.</p> <p>The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names.</p> <p>This metadata item may be used to describe the location of an organisation. It can be a component of a street or postal address.</p>
<i>Collection methods:</i>	Enter 'Unknown' when the locality name or geographic area for an organisation is not known.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee National Community Services Data Committee Australia Post 2005. Australia Postcode File. Viewed 12 April www.auspost.com.au/postcodes
<i>Reference documents:</i>	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Is used in the formation of [Service provider organisation \(address\) – postal delivery point identifier, {N\(8\)}](#) Health, Standard 04/05/2005, Community services, Standard 31/08/2005

Implementation in Data Set Specifications:

[Health care provider identification DSS](#) Health, Superseded 04/07/2007

[Health care provider identification DSS](#) Health, Superseded 03/12/2008

[Health care provider identification DSS](#) Health, Standard 03/12/2008

Suburb/town/locality name (workplace)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Workplace (address) – suburb/town/locality name, text [A(50)]
<i>METeOR identifier:</i>	386195
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The full name of the general locality containing the specific address of a workplace, as represented by text.
Data Element Concept:	Workplace (address) – suburb/town/locality name

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[A(50)]
<i>Maximum character length:</i>	50

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The suburb/town/locality name may be a town, city, suburb or commonly used location name such as a large agricultural property or Aboriginal community.</p> <p>The Australian Bureau of Statistics has suggested that a maximum field length of 50 characters should be sufficient to record the vast majority of locality names.</p> <p>This metadata item may be used to describe the location of a workplace. It can be a component of a street or postal address.</p>
<i>Collection methods:</i>	Enter 'Unknown' when the locality name or geographic area for an organisation is not known.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	<p>Main job of registered chiropractor cluster Health, Standard 10/12/2009</p> <p>Main job of registered dental and allied dental health professional cluster Health, Standard 10/12/2009</p> <p>Main job of registered medical professional cluster Health, Standard 10/12/2009</p> <p>Main job of registered midwife cluster Health, Standard 10/12/2009</p>
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[Main job of registered nursing professional cluster](#) Health, Standard 10/12/2009

[Main job of registered optometrist cluster](#) Health, Standard 10/12/2009

[Main job of registered osteopath cluster](#) Health, Standard 10/12/2009

[Main job of registered pharmacist cluster](#) Health, Standard 10/12/2009

[Main job of registered physiotherapist cluster](#) Health, Standard 10/12/2009

[Main job of registered podiatrist cluster](#) Health, Standard 10/12/2009

[Main job of registered psychologist cluster](#) Health, Standard 10/12/2009

[Second job of registered chiropractor cluster](#) Health, Standard 10/12/2009

[Second job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

[Second job of registered medical professional cluster](#) Health, Standard 10/12/2009

[Second job of registered midwife cluster](#) Health, Standard 10/12/2009

[Second job of registered nursing professional cluster](#) Health, Standard 10/12/2009

[Second job of registered optometrist cluster](#) Health, Standard 10/12/2009

[Second job of registered osteopath cluster](#) Health, Standard 10/12/2009

[Second job of registered pharmacist cluster](#) Health, Standard 10/12/2009

[Second job of registered physiotherapist cluster](#) Health, Standard 10/12/2009

[Second job of registered podiatrist cluster](#) Health, Standard 10/12/2009

[Second job of registered psychologist cluster](#) Health, Standard 10/12/2009

Surgical specialty

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – surgical specialty (of scheduled doctor), code NN
<i>METeOR identifier:</i>	270146
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The area of clinical expertise held by the doctor who will perform the elective surgery, as represented by a code.
Data Element Concept:	Elective surgery waiting list episode – surgical specialty (of scheduled doctor)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																								
<i>Data type:</i>	String																								
<i>Format:</i>	NN																								
<i>Maximum character length:</i>	2																								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Cardio-thoracic surgery</td></tr><tr><td>02</td><td>Ear, nose and throat surgery</td></tr><tr><td>03</td><td>General surgery</td></tr><tr><td>04</td><td>Gynaecology</td></tr><tr><td>05</td><td>Neurosurgery</td></tr><tr><td>06</td><td>Ophthalmology</td></tr><tr><td>07</td><td>Orthopaedic surgery</td></tr><tr><td>08</td><td>Plastic surgery</td></tr><tr><td>09</td><td>Urology</td></tr><tr><td>10</td><td>Vascular surgery</td></tr><tr><td>11</td><td>Other</td></tr></tbody></table>	Value	Meaning	01	Cardio-thoracic surgery	02	Ear, nose and throat surgery	03	General surgery	04	Gynaecology	05	Neurosurgery	06	Ophthalmology	07	Orthopaedic surgery	08	Plastic surgery	09	Urology	10	Vascular surgery	11	Other
Value	Meaning																								
01	Cardio-thoracic surgery																								
02	Ear, nose and throat surgery																								
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05	Neurosurgery																								
06	Ophthalmology																								
07	Orthopaedic surgery																								
08	Plastic surgery																								
09	Urology																								
10	Vascular surgery																								
11	Other																								

Collection and usage attributes

<i>Comments:</i>	The above classifications are consistent with the Recommended Medical Specialties and Qualifications agreed by the National Specialist Qualification Advisory Committee of Australia, September 1993. Vascular surgery is a subspecialty of general surgery. The Royal Australian College of Surgeons has a training program for vascular surgeons. The specialties listed above refer to the surgical component of these specialties - ear, nose and throat surgery refers to the surgical component of the specialty otolaryngology; gynaecology refers to the gynaecological surgical component of obstetrics and gynaecology; ophthalmology refers to the surgical component of the specialty (patients awaiting argon laser phototherapy are not included).
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Data element attributes

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 [Surgical specialty, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005 .pdf](#) (15.7 KB)

Implementation in Data Set Specifications: [Elective surgery waiting times \(census data\) NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(census data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

[Elective surgery waiting times \(census data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(removals data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Surgical treatment procedure for cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – surgical procedure for cancer, procedure code (ACHI 7th edn) NNNNNN-NN
<i>METeOR identifier:</i>	391347
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	The surgical procedure used in the primary treatment of the cancer, as represented by a code.
Data Element Concept:	Cancer treatment – surgical procedure for cancer

Value domain attributes

Representational attributes

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

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Each surgical treatment procedure used in the initial treatment of the cancer should be recorded. Surgical procedures performed for palliative purposes only should not be included.</p> <p>For surgical procedures involved in the administration of another modality (e.g. implantation of infusion pump, isolated limb perfusion/infusion, intra-operative radiotherapy) record both the surgery and the other modality.</p> <p>Any systemic treatment which can be coded as a procedure through ACHI should be so coded (e.g. stem cell or bone marrow infusion).</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National Cancer Control Initiative
<i>Origin:</i>	National Centre for Classification in Health New South Wales Department of Health, Public Health Division
<i>Reference documents:</i>	NSW Department of Health NSW Clinical Cancer Data Collection for Outcomes and Quality. Data Dictionary Version 1 (2001).

Relational attributes

<i>Related metadata references:</i>	Supersedes Cancer treatment – surgical procedure for cancer ,
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*Implementation in Data Set
Specifications:*

[procedure code \(ACHI 6th edn\) NNNNN-NN](#) Health,
Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Systemic therapy agent name

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Cancer treatment – systemic therapy agent name (primary cancer), antineoplastic drug code (Self-Instructional Manual for Tumour Registrars Book 8 3rd edn) X[X(39)]
<i>METeOR identifier:</i>	288446
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The chemotherapeutic agent or anti-cancer drug used for treatment of the primary cancer, as represented by a code.
Data Element Concept:	Cancer treatment – systemic therapy agent name (primary cancer)

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	Self-Instructional Manual for Tumour Registrars Book 8 Antineoplastic Drugs, 3rd edition
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	X[X(39)]
<i>Maximum character length:</i>	40

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The purpose of collecting specific treatment information is to account for all treatment types, which may assist in evaluation of effectiveness of different treatment patterns. The actual agents used will sometimes be of interest.</p> <p>Systemic therapy often involves treatment with a combination of agents. These may be known by acronyms but since details of drugs and acronyms may vary it is recommended that each agent be recorded separately.</p> <p>Oral chemotherapy normally given on an outpatient basis should also be included.</p> <p>New codes and names will need to be added as new agents become available for clinical use.</p> <p>Hormone therapy agents and immunotherapy agents should be recorded under this data element.</p>
<i>Collection methods:</i>	The full name of the agent(s) should be recorded if the coding manual is not available.
<i>Comments:</i>	Collecting dates for systemic therapy will allow evaluation of treatments delivered and of time intervals from diagnosis to treatment, from treatment to recurrence and from treatment to death.

Source and reference attributes

Origin: National Cancer Institute Surveillance, Epidemiology and End Results (SEER) Program

Reference documents: Surveillance, Epidemiology and End Results (SEER) Program Self-instructional manual for tumour registrars: Book 8 - Antineoplastic drugs 3rd Edition National Cancer Institute.

Relational attributes

Related metadata references: Supersedes [Systemic therapy agent name, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.5 KB)

Implementation in Data Set [Cancer \(clinical\) DSS Health, Superseded 07/12/2005](#)

Specifications:

[Cancer \(clinical\) DSS Health, Superseded 06/03/2009](#)

[Cancer \(clinical\) DSS Health, Superseded 22/12/2009](#)

[Cancer \(clinical\) DSS Health, Standard 22/12/2009](#)

Teaching status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Establishment – teaching status (university affiliation), code N
<i>METeOR identifier:</i>	270148
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator to identify the non-direct patient care activity of teaching for a particular establishment, as represented by a code.
Data Element Concept:	Establishment – teaching status (university affiliation)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Unknown</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Unknown
Value	Meaning								
1	Yes								
2	No								
9	Unknown								
<i>Supplementary values:</i>									

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	In this context, teaching relates to teaching hospitals affiliated with universities providing undergraduate medical education as advised by the relevant state health authority.
<i>Comments:</i>	<p>The initial intention based on the Taskforce on National Hospital Statistics approach had been to have non-direct care activity indicators for all of the following non-direct patient care activities:</p> <ul style="list-style-type: none">• teaching• research• group or community contacts• public health activities• mobile centre and/or part-time service. <p>However, the Resources Working Party decided to delete 2, 3, 4 and 5 and place the emphasis on teaching where teaching (associated with a university) was a major program activity of the hospital. The working party took the view that it was extremely difficult to identify research activities in health institutions because many staff consider that they do research as part of their</p>

usual duties. The research indicator was thus deleted and the teaching indicator was agreed to relate to teaching hospitals affiliated with universities providing undergraduate medical education, as advised by the relevant state health authority. If a teaching hospital is identified by a Yes/no indicator then it is not necessary to worry about research (based on the assumption that if you have teaching, you have research).

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Teaching status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.1 KB)

Implementation in Data Set Specifications: [Public hospital establishments NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Public hospital establishments NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Public hospital establishments NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Public hospital establishments NMDS 2008-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Public hospital establishments NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

[Public hospital establishments NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Telephone number

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – telephone number, text [X(40)]
<i>METeOR identifier:</i>	270266
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	The person's contact telephone number, as represented by text.
Data Element Concept:	Person – telephone number

Value domain attributes

Representational attributes

<i>Representation class:</i>	Text
<i>Data type:</i>	String
<i>Format:</i>	[X(40)]
<i>Maximum character length:</i>	40

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	More than one phone number may be recorded as required. Each phone number should have an appropriate telephone number type code assigned. Record the full phone number (including any prefixes) with no punctuation (hyphens or brackets).
<i>Collection methods:</i>	Prefix plus telephone number: Record the prefix plus telephone number. The default should be the local prefix with an ability to overtype with a different prefix. For example, 08 8226 6000 or 0417 123456. Punctuation: Do not record punctuation. For example, (08) 8226 6000 or 08-8226 6000 would not be correct. Unknown: Leave the field blank.
<i>Comments:</i>	Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
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Origin:

National Health Data Committee
National Community Services Data Committee
Standards Australia 2002. Australian Standard AS5017-2002
Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes [Telephone number, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf](#) (15.4 KB)

Implementation in Data Set Specifications:

[Health care client identification](#) Health, Superseded 04/05/2005

Telephone number type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person (telephone) – telephone number type, code A
<i>METeOR identifier:</i>	270299
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	The type of telephone number recorded for a person, as represented by a code.
Data Element Concept:	Person (telephone) – telephone number type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	String														
<i>Format:</i>	A														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>B</td><td>Business or work</td></tr><tr><td>H</td><td>Home</td></tr><tr><td>M</td><td>Personal mobile</td></tr><tr><td>N</td><td>Contact number (not own)</td></tr><tr><td>O</td><td>Business or work mobile</td></tr><tr><td>T</td><td>Temporary</td></tr></tbody></table>	Value	Meaning	B	Business or work	H	Home	M	Personal mobile	N	Contact number (not own)	O	Business or work mobile	T	Temporary
Value	Meaning														
B	Business or work														
H	Home														
M	Personal mobile														
N	Contact number (not own)														
O	Business or work mobile														
T	Temporary														

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Where more than one telephone number has been recorded, then each telephone number should have the appropriate telephone number type code assigned.
<i>Comments:</i>	Concerned with the use of person identification data. For organisations that create, use or maintain records on people. Organisations should use this standard, where appropriate, for collecting data when registering people. The positive and unique identification of people is a critical event in service delivery, with direct implications for the safety and quality of care delivered by health and community services.

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
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Origin:

National Health Data Committee

National Community Services Data Committee

Reference documents:

Standards Australia 2002. Australian Standard AS5017-2002
Health Care Client Identification. Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes [Telephone number type, version 2, DE, Int. NCSDD & NHDD, NCSIMG & NHIMG, Superseded 01/03/2005.pdf](#)
(15.5 KB)

Implementation in Data Set Specifications:

[Health care client identification](#) Health, Superseded 04/05/2005

Time C-reactive protein level measured

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – C-reactive protein level measured time, hhmm
<i>Synonymous names:</i>	CRP measured time
<i>METeOR identifier:</i>	343853
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time the person's C-reactive protein (CRP) level is measured.
<i>Data Element Concept:</i>	Person – C-reactive protein level measured time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	The time C-reactive protein (CRP) is measured should be recorded from the laboratory report.
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Relational attributes

<i>Related metadata references:</i>	See also Person – C-reactive protein level (measured), total milligrams per litre N[NN].N Health, Standard 01/10/2008 See also Person – C-reactive protein level measured date, DDMMYYYY Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time creatine kinase MB isoenzyme measured

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – creatine kinase myocardial band isoenzyme measured time, hhmm
<i>METeOR identifier:</i>	285179
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The time at which the person's creatine kinase myocardial band (CK-MB) isoenzyme was measured.
Data Element Concept:	Person – creatine kinase myocardial band isoenzyme measured time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the time in 24-hour clock format.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Time creatine kinase MB isoenzyme (CK-MB) measured, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.2 KB)
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Superseded 07/12/2005
	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Time of acute coronary syndrome related clinical event

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with acute coronary syndrome – acute coronary syndrome related clinical event time, hhmm
<i>METeOR identifier:</i>	349809
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time a person experienced an acute coronary syndrome related clinical event.
Data Element Concept:	Person with acute coronary syndrome – acute coronary syndrome related clinical event time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	A time should be recorded for each of the specified clinical events that the person experiences.
<i>Comments:</i>	<p>An acute coronary syndrome (ACS) related clinical event is a clinical event which can affect the health outcomes of a person with ACS.</p> <p>Information on the occurrence of these clinical events in people with ACS is required due to an emerging appreciation of their relationship with late mortality.</p>

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome clinical event cluster Health, Standard 01/10/2008
	<i>Conditional obligation:</i> If a clinical event has occurred, record the time when it was experienced by the person.

Time of diagnostic cardiac catheterisation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – diagnostic cardiac catheterisation time, hhmm
<i>Synonymous names:</i>	Time of coronary angiography
<i>METeOR identifier:</i>	359777
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when cardiac catheterisation is performed for diagnostic purposes.
Data Element Concept:	Person – diagnostic cardiac catheterisation time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This metadata item includes coronary angiography which is performed using a catheter.
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Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Time of electrocardiogram

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Electrocardiogram – electrocardiogram time, hhmm
<i>Synonymous names:</i>	Time of ECG
<i>METeOR identifier:</i>	343831
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time at which an electrocardiogram (ECG) is performed for a person.
Data Element Concept:	Electrocardiogram – electrocardiogram time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	The time of ECG should be recorded irrespective of the setting (e.g. pre-hospital setting, emergency department or inpatient ward). The time of ECG should be recorded each time an ECG is performed.
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Electrocardiogram cluster Health, Standard 01/10/2008
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Time of implantable cardiac defibrillator procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – implantable cardiac defibrillator procedure time, hhmm
<i>Synonymous names:</i>	ICD procedure time
<i>METeOR identifier:</i>	359678
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when a procedure is performed for insertion of an implantable cardiac defibrillator (ICD).
Data Element Concept:	Person – implantable cardiac defibrillator procedure time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Time of intra-aortic balloon pump procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – intra-aortic balloon pump procedure time, hhmm
<i>METeOR identifier:</i>	359691
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when a procedure is performed for insertion of an intra-aortic balloon pump.
Data Element Concept:	Person – intra-aortic balloon pump procedure time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Time of intravenous fibrinolytic therapy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – intravenous fibrinolytic therapy time, hhmm
<i>METeOR identifier:</i>	360949
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time intravenous (IV) fibrinolytic therapy was first administered to a person.
Data Element Concept:	Person – intravenous fibrinolytic therapy time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	If initiated by a bolus dose whether in a pre-hospital setting, emergency department or inpatient unit/ward, the time the initial bolus was administered should be recorded.
<i>Comments:</i>	This is used to calculate the time between initial presentation and reperfusion.

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Person – intravenous fibrinolytic therapy time, hhmm Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome pharmacotherapy data cluster Health, Standard 01/10/2008
	<i>Conditional obligation:</i> If prescribed, provide the time when the fibrinolytic therapy is administered.

Time of non-invasive ventilation administration

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – non-invasive ventilation administration time, hhmm
<i>METeOR identifier:</i>	359647
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time of administration of non-invasive ventilation.
Data Element Concept:	Person – non-invasive ventilation administration time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Time of onset of acute coronary syndrome symptoms

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – acute coronary syndrome symptoms onset time, hhmm
<i>METeOR identifier:</i>	321211
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time at which a person experienced acute coronary syndrome symptoms that prompted a person to seek medical attention, either at the hospital or from a general practitioner.
Data Element Concept:	Person – acute coronary syndrome symptoms onset time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Acute coronary syndrome symptoms may include:</p> <ul style="list-style-type: none">• tightness, pressure, heaviness, fullness or squeezing in the chest which may spread to the neck and throat, jaw, shoulders, the back, upper abdomen, either or both arms and even into the wrists and hands• dyspnoea, nausea/vomiting, cold sweat or syncope. <p>Seeking medical attention could include the person presenting to their GP who then refers them to hospital or the person presenting directly to hospital (via ambulance or own form of transport).</p> <p>If the person is already a patient at the hospital for another reason then the time recorded would be when they advised hospital staff of their symptoms.</p>
<i>Collection methods:</i>	Record the time of onset of the most significant acute coronary syndrome symptom/s that prompted the person to seek medical attention (from the person's perspective).

Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

See also [Person – acute coronary syndrome symptoms onset date, DDMMYYYY](#) Health, Standard 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Time of pacemaker insertion

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – pacemaker insertion time, hhmm
<i>METeOR identifier:</i>	359662
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when a procedure is performed for insertion of a pacemaker.
Data Element Concept:	Person – pacemaker insertion time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Time of primary percutaneous coronary intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – primary percutaneous coronary intervention time, hhmm
<i>Synonymous names:</i>	Primary PCI time
<i>METeOR identifier:</i>	359201
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time of the primary percutaneous coronary intervention (PCI).
Data Element Concept:	Person – primary percutaneous coronary intervention time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Primary PCI relates to the first balloon angioplasty inflation and/or stent implantation for reperfusion therapy of a ST-segment-elevation myocardial infarction (STEMI). The time of the first balloon inflation should be recorded, even if this includes the implantation of a stent.
<i>Comments:</i>	This is used to calculate the time between initial presentation and reperfusion.

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Person – first angioplasty balloon inflation or stenting time, hhmm Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Coronary artery cluster Health, Standard 01/10/2008
	<i>Conditional obligation:</i> Record when a primary percutaneous coronary intervention is performed.

Time of rescue percutaneous coronary intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – rescue percutaneous coronary intervention time, hhmm
<i>Synonymous names:</i>	Rescue PCI time
<i>METeOR identifier:</i>	359569
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when rescue percutaneous coronary intervention (PCI) is performed.
Data Element Concept:	Person – rescue percutaneous coronary intervention time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Rescue PCI relates to balloon angioplasty inflation and/or stent implantation performed following failed fibrinolysis in patients with continuing or recurrent myocardial ischaemia.
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Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Coronary artery cluster Health, Standard 01/10/2008
	<i>Conditional obligation:</i> Record when a rescue percutaneous coronary intervention is performed.

Time of revascularisation percutaneous coronary intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – revascularisation percutaneous coronary intervention time, hhmm
<i>Synonymous names:</i>	Revascularisation PCI time
<i>METeOR identifier:</i>	359738
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when a percutaneous coronary intervention (PCI) is performed for revascularisation.
Data Element Concept:	Person – revascularisation percutaneous coronary intervention time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Revascularisation PCI relates to balloon angioplasty inflation and/or stent implantation performed for subsequent restoration of blood flow.
<i>Comments:</i>	Routine revascularisation PCI may be performed after ST-segment-elevation myocardial infarction for people with objective evidence of recurrent myocardial infarction in whom there is spontaneous or inducible ischaemia or haemodynamic instability. Revascularisation PCI may also be performed for treatment of high-risk non-ST-segment-elevation acute coronary syndrome.

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
<i>Reference documents:</i>	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of

acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specifications:

[Coronary artery cluster](#) Health, Standard 01/10/2008

Conditional obligation:

Record when a percutaneous coronary intervention is performed for revascularisation.

Time of triage

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – triage time, hhmm
<i>METeOR identifier:</i>	313817
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	The time at which the patient is triaged .
<i>Context:</i>	Emergency Department care.
<i>Data Element Concept:</i>	Non-admitted patient emergency department service episode – triage time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Collected in conjunction with non-admitted patient emergency department service episode – triage date.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Government Department of Health and Ageing
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Relational attributes

<i>Related metadata references:</i>	Supersedes Triage – triage time, hhmm Health, Superseded 07/12/2005
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Superseded 01/10/2008
	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
	Non-admitted patient emergency department care NMDS Health, Superseded 24/03/2006
	<i>Implementation start date:</i> 01/07/2005
	<i>Implementation end date:</i> 30/06/2006

[Non-admitted patient emergency department care NMDS](#)
Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Time of ventricular ejection fraction test

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Ventricular ejection fraction test – test time, hhmm
<i>Synonymous names:</i>	Time EF measured
<i>METeOR identifier:</i>	349817
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when a person's ventricular ejection fraction is measured.
Data Element Concept:	Ventricular ejection fraction – test time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Ventricular ejection fraction cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> To be provided when the ventricular ejection fraction is measured.
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Time patient presents

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Health service event – presentation time, hhmm
<i>METeOR identifier:</i>	270080
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time at which the patient presents for the delivery of a service.
Data Element Concept:	Health service event – presentation time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>For community health care, outreach services and services provided via telephone or telehealth, this may be the time at which the service provider presents to the patient or the telephone/ telehealth session commences.</p> <p>The time of patient presentation at the emergency department is the earliest occasion of being registered clerically or triaged.</p> <p>The time that the patient presents is not necessarily:</p> <ul style="list-style-type: none">• the listing time for care (see listing date for care for an analogous concept), nor• the time at which care is scheduled to be provided, nor• the time at which commencement of care actually occurs (for admitted patients see admission time, for hospital non-admitted patient care and community health care see service commencement time).
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Source and reference attributes

<i>Submitting organisation:</i>	National Institution Based Ambulatory Model Reference Group
<i>Origin:</i>	National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Time patient presents, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.2 KB)

Is used in the formation of [Non-admitted patient emergency department service episode – waiting time \(to service delivery\), total minutes NNNNN](#) Health, Superseded 22/12/2009

Is used in the formation of [Non-admitted patient emergency department service episode – service episode length, total minutes NNNNN](#) Health, Standard 01/03/2005

Is used in the formation of [Non-admitted patient emergency department service episode – waiting time \(to hospital admission\), total hours and minutes NNNN](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Time troponin measured

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – troponin level measured time, hhmm
<i>METeOR identifier:</i>	359427
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time at which the troponin (T or I) was measured.
<i>Data Element Concept:</i>	Person – troponin level measured time

Value domain attributes

Representational attributes

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

Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This metadata item pertains to the measuring of troponin at any time point during this current event.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Person – troponin level measured time, hhmm Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Timing of ACE-inhibitor prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – timing of ACE-inhibitor prescription, code N
<i>METeOR identifier:</i>	349385
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when an ACE-inhibitor is prescribed to a person, as represented by a code.
Data Element Concept:	Person – timing of ACE-inhibitor prescription

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Prior to presentation at hospital</td></tr><tr><td>2</td><td>First 24 hours of presentation</td></tr><tr><td>3</td><td>After 24 hours and before discharge</td></tr><tr><td>4</td><td>At discharge</td></tr></tbody></table>	Value	Meaning	1	Prior to presentation at hospital	2	First 24 hours of presentation	3	After 24 hours and before discharge	4	At discharge
Value	Meaning										
1	Prior to presentation at hospital										
2	First 24 hours of presentation										
3	After 24 hours and before discharge										
4	At discharge										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Prior to presentation at hospital Use this code when the person has been previously prescribed an ACE-inhibitor prior to presentation at the hospital and the person is still following the prescription.</p> <p>CODE 2 First 24 hours of presentation Use this code when an ACE-inhibitor is prescribed within the first 24 hours following presentation to the hospital.</p> <p>CODE 3 After 24 hours and before discharge Use this code when an ACE-inhibitor is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.</p> <p>CODE 4 At discharge Use this code when an ACE-inhibitor is prescribed at discharge from the hospital.</p>
<i>Collection methods:</i>	Record each time an ACE-inhibitor is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Conditional obligation:

If prescribed, provide a phase for each time ACE-inhibitor therapy is prescribed.

Timing of angiotensin II receptor blocker prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – timing of angiotensin II receptor blocker prescription, code N
<i>METeOR identifier:</i>	350421
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when an angiotensin II receptor blocker is prescribed to a person, as represented by a code.
Data Element Concept:	Person – timing of angiotensin II receptor blocker prescription

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Prior to presentation at hospital</td></tr><tr><td>2</td><td>First 24 hours of presentation</td></tr><tr><td>3</td><td>After 24 hours and before discharge</td></tr><tr><td>4</td><td>At discharge</td></tr></tbody></table>	Value	Meaning	1	Prior to presentation at hospital	2	First 24 hours of presentation	3	After 24 hours and before discharge	4	At discharge
Value	Meaning										
1	Prior to presentation at hospital										
2	First 24 hours of presentation										
3	After 24 hours and before discharge										
4	At discharge										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Prior to presentation at hospital Use this code when the person has been previously prescribed an angiotensin II receptor blocker prior to presentation at the hospital and the person is still following the prescription.</p> <p>CODE 2 First 24 hours of presentation Use this code when an angiotensin II receptor blocker is prescribed within the first 24 hours following presentation to the hospital.</p> <p>CODE 3 After 24 hours and before discharge Use this code when an angiotensin II receptor blocker is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.</p> <p>CODE 4 At discharge Use this code when an angiotensin II receptor blocker is prescribed at discharge from the hospital.</p>
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Collection methods:

Record each time an angiotensin II receptor blocker is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Conditional obligation:

If prescribed, provide a phase for each time angiotensin II receptor blocker therapy is prescribed.

Timing of antithrombin therapy prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – timing of antithrombin therapy prescription, code N
<i>METeOR identifier:</i>	350510
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when antithrombin therapy is prescribed to a person, as represented by a code.
Data Element Concept:	Person – timing of antithrombin therapy prescription

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Initial medical management: preceding reperfusion therapy</td></tr><tr><td>2</td><td>During reperfusion therapy</td></tr><tr><td>3</td><td>Following reperfusion therapy</td></tr></tbody></table>	Value	Meaning	1	Initial medical management: preceding reperfusion therapy	2	During reperfusion therapy	3	Following reperfusion therapy
Value	Meaning								
1	Initial medical management: preceding reperfusion therapy								
2	During reperfusion therapy								
3	Following reperfusion therapy								
<i>Supplementary values:</i>	9 Not stated/inadequately described								

Source and reference attributes

<i>Reference documents:</i>	National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand, Guidelines for the management of acute coronary syndromes 2006, Med J Aust; 184; S1-S32. © MJA2006.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Reperfusion therapy includes percutaneous coronary intervention and fibrinolytic therapy. CODE 1 Initial medical management: preceding reperfusion therapy Use this code when antithrombin therapy is prescribed before reperfusion therapy is to be performed. CODE 2 During reperfusion therapy Use this code when antithrombin therapy is prescribed while reperfusion therapy is being performed.
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CODE 3 Following reperfusion therapy

Use this code when antithrombin therapy is prescribed after reperfusion therapy has been performed.

Collection methods:

Record for each time antithrombin therapy is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Conditional obligation:

If prescribed, provide a phase for each time antithrombin therapy is prescribed

Timing of aspirin prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – timing of aspirin prescription, code N
<i>METeOR identifier:</i>	347829
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when aspirin is prescribed to a person, as represented by a code.
Data Element Concept:	Person – timing of aspirin prescription

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Prior to presentation at hospital</td></tr><tr><td>2</td><td>First 24 hours of presentation</td></tr><tr><td>3</td><td>After 24 hours and before discharge</td></tr><tr><td>4</td><td>At discharge</td></tr></tbody></table>	Value	Meaning	1	Prior to presentation at hospital	2	First 24 hours of presentation	3	After 24 hours and before discharge	4	At discharge
Value	Meaning										
1	Prior to presentation at hospital										
2	First 24 hours of presentation										
3	After 24 hours and before discharge										
4	At discharge										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Prior to presentation at hospital Use this code when the person has been previously prescribed aspirin prior to presentation at the hospital and the person is still following the prescription.</p> <p>CODE 2 First 24 hours of presentation Use this code when aspirin is prescribed within the first 24 hours following presentation to the hospital.</p> <p>CODE 3 After 24 hours and before discharge Use this code when aspirin is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.</p> <p>CODE 4 At discharge Use this code when aspirin is prescribed at discharge from the hospital.</p>
<i>Collection methods:</i>	Record each time aspirin is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Conditional obligation:

If prescribed, provide a phase for each time aspirin therapy is prescribed.

Timing of beta-blocker prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – timing of beta-blocker prescription, code N
<i>METeOR identifier:</i>	349400
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when a beta-blocker is prescribed to a person, as represented by a code.
Data Element Concept:	Person – timing of beta-blocker prescription

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Prior to presentation at hospital</td></tr><tr><td>2</td><td>First 24 hours of presentation</td></tr><tr><td>3</td><td>After 24 hours and before discharge</td></tr><tr><td>4</td><td>At discharge</td></tr></tbody></table>	Value	Meaning	1	Prior to presentation at hospital	2	First 24 hours of presentation	3	After 24 hours and before discharge	4	At discharge
Value	Meaning										
1	Prior to presentation at hospital										
2	First 24 hours of presentation										
3	After 24 hours and before discharge										
4	At discharge										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Prior to presentation at hospital Use this code when the person has been previously prescribed a beta-blocker prior to presentation at the hospital and the person is still following the prescription.</p> <p>CODE 2 First 24 hours of presentation Use this code when a beta-blocker is prescribed within the first 24 hours following presentation to the hospital.</p> <p>CODE 3 After 24 hours and before discharge Use this code when a beta-blocker is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.</p> <p>CODE 4 At discharge Use this code when a beta-blocker is prescribed at discharge from the hospital.</p>
<i>Collection methods:</i>	Record each time a beta-blocker is prescribed for a person.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Conditional obligation:

If prescribed, provide a phase for each time beta-blocker therapy is prescribed.

Timing of clopidogrel prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – timing of clopidogrel prescription, code N
<i>METeOR identifier:</i>	350431
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when clopidogrel is prescribed to a person, as represented by a code.
Data Element Concept:	Person – timing of clopidogrel prescription

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Prior to presentation at hospital</td></tr><tr><td>2</td><td>First 24 hours of presentation</td></tr><tr><td>3</td><td>After 24 hours and before discharge</td></tr><tr><td>4</td><td>At discharge</td></tr></tbody></table>	Value	Meaning	1	Prior to presentation at hospital	2	First 24 hours of presentation	3	After 24 hours and before discharge	4	At discharge
Value	Meaning										
1	Prior to presentation at hospital										
2	First 24 hours of presentation										
3	After 24 hours and before discharge										
4	At discharge										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Prior to presentation at hospital Use this code when the person has been previously prescribed clopidogrel prior to presentation at the hospital and the person is still following the prescription.</p> <p>CODE 2 First 24 hours of presentation Use this code when clopidogrel is prescribed within the first 24 hours following presentation to the hospital.</p> <p>CODE 3 After 24 hours and before discharge Use this code when clopidogrel is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.</p> <p>CODE 4 At discharge Use this code when clopidogrel is prescribed at discharge from the hospital.</p>
<i>Collection methods:</i>	Record each time clopidogrel is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Conditional obligation:

If prescribed, provide a phase for each time clopidogrel therapy is prescribed.

Timing of glycoprotein IIb/IIIa inhibitor prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – timing of glycoprotein IIb/IIIa inhibitor prescription, code N
<i>METeOR identifier:</i>	349367
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when a glycoprotein IIb/IIIa inhibitor is prescribed to a person, as represented by a code.
Data Element Concept:	Person – timing of glycoprotein IIb/IIIa inhibitor prescription

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Initial medical management: preceding invasive management</td></tr><tr><td>2</td><td>During invasive management</td></tr><tr><td>3</td><td>Following invasive management</td></tr></tbody></table>	Value	Meaning	1	Initial medical management: preceding invasive management	2	During invasive management	3	Following invasive management
Value	Meaning								
1	Initial medical management: preceding invasive management								
2	During invasive management								
3	Following invasive management								
<i>Supplementary values:</i>	9 Not stated/inadequately described								

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Invasive management includes angiography, percutaneous coronary intervention and coronary artery bypass graft.</p> <p>CODE 1 Initial medical management: preceding invasive management</p> <p>Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed before invasive management is to be performed.</p> <p>CODE 2 During invasive management</p> <p>Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed while invasive management is being performed.</p> <p>CODE 2 Following invasive management</p> <p>Use this code when a glycoprotein IIb/IIIa inhibitor is prescribed after invasive management has been performed.</p>
<i>Collection methods:</i>	Record each time a glycoprotein IIb/IIIa inhibitor is prescribed for a person.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Conditional obligation:

If prescribed, provide a phase for each time glycoprotein IIb/IIIa inhibitor therapy is prescribed.

Timing of statin prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – timing of statin prescription, code N
<i>METeOR identifier:</i>	350445
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when a statin is prescribed to a person, as represented by a code.
Data Element Concept:	Person – timing of statin prescription

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Prior to presentation at hospital</td></tr><tr><td>2</td><td>First 24 hours of presentation</td></tr><tr><td>3</td><td>After 24 hours and before discharge</td></tr><tr><td>4</td><td>At discharge</td></tr></tbody></table>	Value	Meaning	1	Prior to presentation at hospital	2	First 24 hours of presentation	3	After 24 hours and before discharge	4	At discharge
Value	Meaning										
1	Prior to presentation at hospital										
2	First 24 hours of presentation										
3	After 24 hours and before discharge										
4	At discharge										
<i>Supplementary values:</i>	9 Not stated/inadequately described										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Prior to presentation at hospital Use this code when the person has been previously prescribed a statin prior to presentation at the hospital and the person is still following the prescription.</p> <p>CODE 2 First 24 hours of presentation Use this code when a statin is prescribed for within the first 24 hours following presentation to the hospital.</p> <p>CODE 3 After 24 hours and before discharge Use this code when an ACE-inhibitor is prescribed following the first 24 hours after presentation to the hospital and before discharge from the hospital.</p> <p>CODE 4 At discharge Use this code when a statin is prescribed at discharge from the hospital.</p>
<i>Collection methods:</i>	Record each time a statin is prescribed for the person.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome pharmacotherapy data cluster](#) Health, Standard 01/10/2008

Conditional obligation:

If prescribed, provide a phase for each time statin therapy is prescribed.

Tobacco smoking indicator, after 20 weeks of pregnancy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female (pregnant) – tobacco smoking indicator (after twenty weeks of pregnancy), yes/no code N
<i>METeOR identifier:</i>	365417
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	A self-reported indicator of whether a pregnant woman smoked tobacco at any time after the first 20 weeks of her pregnancy until the birth, as represented by a code
<i>Context:</i>	Perinatal Statistics
<i>Data Element Concept:</i>	Female (pregnant) – tobacco smoking indicator (after twenty weeks of pregnancy)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	9	Not stated/inadequately described				
9	Not stated/inadequately described						

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes Record if a woman smoked tobacco at any time after the first 20 weeks of pregnancy. CODE 2 No Record if a woman did not smoke tobacco at any time after the first 20 weeks of pregnancy.
<i>Collection methods:</i>	Recommended question: 'Did the woman smoke at all after 20 weeks of pregnancy?', where after 20 weeks of pregnancy is defined as greater than or equal to 20 weeks + 0 days. To ensure consistency of results, data should be collected after delivery.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also [Female \(pregnant\) – tobacco smoking indicator \(first twenty weeks of pregnancy\), yes/no code N](#) Health, Standard 03/12/2008

Implementation in Data Set Specifications: [Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009
Implementation start date: 01/07/2010

Tobacco smoking indicator, first 20 weeks of pregnancy

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Female (pregnant) – tobacco smoking indicator (first twenty weeks of pregnancy), yes/no code N
<i>METeOR identifier:</i>	365404
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	A self-reported indicator of whether a pregnant woman smoked tobacco at any time during the first 20 weeks of her pregnancy, as represented by a code
<i>Context:</i>	Perinatal Statistics
<i>Data Element Concept:</i>	Female (pregnant) – tobacco smoking indicator (first twenty weeks of pregnancy)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	9	Not stated/inadequately described				
9	Not stated/inadequately described						

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes Record if a woman smoked tobacco at any time during the first 20 weeks of pregnancy. CODE 2 No Record if a woman did not smoke tobacco at any time during the first 20 weeks of pregnancy.
<i>Collection methods:</i>	Recommended question: 'Did the woman smoke at all during the first 20 weeks of pregnancy?', where the first 20 weeks of pregnancy is defined as less than or equal to 19 weeks + 6 days. To ensure consistency of results, data should be collected after the first 20 weeks of pregnancy.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: See also [Female \(pregnant\) – number of cigarettes smoked \(per day after 20 weeks of pregnancy\), number N\[NN\]](#) Health, Standard 03/12/2008

See also [Female \(pregnant\) – tobacco smoking indicator \(after twenty weeks of pregnancy\), yes/no code N](#) Health, Standard 03/12/2008

Implementation in Data Set Specifications:

[Perinatal NMDS 2010-2011](#) Health, Standard 02/12/2009

Implementation start date: 01/07/2010

Tobacco smoking status

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – tobacco smoking status, code N
<i>METeOR identifier:</i>	270311
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's current and past smoking behaviour, as represented by a code.
<i>Context:</i>	Public health and health care
<i>Data Element Concept:</i>	Person – tobacco smoking status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Daily smoker</td></tr><tr><td>2</td><td>Weekly smoker</td></tr><tr><td>3</td><td>Irregular smoker</td></tr><tr><td>4</td><td>Ex-smoker</td></tr><tr><td>5</td><td>Never smoked</td></tr></tbody></table>	Value	Meaning	1	Daily smoker	2	Weekly smoker	3	Irregular smoker	4	Ex-smoker	5	Never smoked
Value	Meaning												
1	Daily smoker												
2	Weekly smoker												
3	Irregular smoker												
4	Ex-smoker												
5	Never smoked												

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Daily smoker A person who smokes daily
	CODE 2 Weekly smoker A person who smokes at least weekly but not daily
	CODE 3 Irregular smoker A person who smokes less than weekly
	CODE 4 Ex-smoker A person who does not smoke at all now, but has smoked at least 100 cigarettes or a similar amount of other tobacco products in his/her lifetime.
	CODE 5 Never-smoker A person who does not smoke now and has smoked fewer than 100 cigarettes or similar amount of other tobacco products in his/her lifetime.

Source and reference attributes

Reference documents: Standard Questions on the Use of Tobacco Among Adults (1998)

Data element attributes

Collection and usage attributes

Collection methods: The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults - interviewer administered (Questions 1 and 4) and self-administered (Questions 1 and 1a) versions. The questionnaires are designed to cover persons aged 18 years and over.

Comments: There are two other ways of categorising this information:

- Regular and irregular smokers where a regular smoker includes someone who is a daily smoker or a weekly smoker. 'Regular' smoker is the preferred category to be reported in prevalence estimates.
- Daily and occasional smokers where an occasional smoker includes someone who is a weekly or irregular smoker. The category of 'occasional' smoker can be used when the aim of the study is to draw contrast between daily smokers and other smokers.

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

Smoker type is used to define subpopulations of adults (age 18+ years) based on their smoking behaviour.

Smoking has long been known as a health risk factor. Population studies indicate a relationship between smoking and increased mortality/morbidity.

This data element can be used to estimate smoking prevalence. Other uses are:

- To evaluate health promotion and disease prevention programs (assessment of interventions)
- To monitor health risk factors and progress towards National Health Goals and Targets

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references: Supersedes [Tobacco smoking status, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (18.5 KB)

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS Health, Superseded 01/10/2008](#)

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded
07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard
01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard
22/12/2009

Tobacco smoking status (diabetes mellitus)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – regular tobacco smoking indicator (last 3 months), code N
<i>METeOR identifier:</i>	302467
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	Whether an individual has been a regular smoker (daily or weekly) of any tobacco material over the previous 3 months, as represented by a code.
Data Element Concept:	Person – regular tobacco smoking indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No	9	Not stated/inadequately described
Value	Meaning								
1	Yes								
2	No								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Yes: Record if the person has smoked daily or weekly over the previous 3 months. CODE 2 No: Record if the person has not smoked daily or weekly over the previous 3 months or has been an irregular smoker.
<i>Collection methods:</i>	Ask the individual if he/she has regularly smoked (daily or weekly) any tobacco material over the past 3 months.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary.

Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Person – tobacco smoking status \(previous three months\), code N](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Tobacco smoking—consumption/quantity (cigarettes)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – number of cigarettes smoked (per day), total N[N]
<i>METeOR identifier:</i>	270332
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total number of cigarettes (manufactured or roll-your-own) smoked per day by a person.
<i>Context:</i>	Public health and health care
<i>Data Element Concept:</i>	Person – number of cigarettes smoked

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total	
<i>Data type:</i>	Number	
<i>Format:</i>	N[N]	
<i>Maximum character length:</i>	2	
<i>Supplementary values:</i>	Value	Meaning
	99	Not stated/inadequately described

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item is relevant only for persons who currently smoke cigarettes daily or at least weekly. Daily consumption should be reported, rather than weekly consumption. Weekly consumption is converted to daily consumption by dividing by 7 and rounding to the nearest whole number.</p> <p>Quantities greater than 98 (extremely rare) should be recorded as 98.</p>
<i>Collection methods:</i>	<p>The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Questions 3a and 3b) and self-administered (Questions 2a and 2b) versions.</p> <p>The questions cover persons aged 18 and over.</p>
<i>Comments:</i>	<p>The number of cigarettes smoked is an important measure of the magnitude of the tobacco problem for an individual.</p> <p>Research shows that of Australians who smoke, the overwhelming majority smoke cigarettes (manufactured or roll-your-own) rather than other tobacco products.</p> <p>From a public health point of view, consumption level is relevant only for regular smokers (those who smoke daily or at least weekly).</p>

Data on quantity smoked can be used to:

- evaluate health promotion and disease prevention programs (assessment of interventions)
- monitor health risk factors and progress towards National Health Goals and Targets
- ascertain determinants and consequences of smoking
- assess a person's exposure to tobacco smoke.

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Tobacco smoking - consumption/quantity \(cigarettes\), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.7 KB)

[Cardiovascular disease \(clinical\) DSS Health, Superseded 15/02/2006](#)

[Cardiovascular disease \(clinical\) DSS Health, Superseded 04/07/2007](#)

[Cardiovascular disease \(clinical\) DSS Health, Superseded 22/12/2009](#)

[Cardiovascular disease \(clinical\) DSS Health, Standard 22/12/2009](#)

Tobacco smoking—duration (daily smoking)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – tobacco smoking duration (daily smoking), total years N[N]
<i>METeOR identifier:</i>	270330
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The total duration in years, of daily smoking for a person who is now a daily smoker or has been a daily smoker in the past.
<i>Context:</i>	Public health and health care
<i>Data Element Concept:</i>	Person – tobacco smoking duration

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[N]
<i>Maximum character length:</i>	2
<i>Supplementary values:</i>	Value Meaning
	99 Not stated/inadequately described
<i>Unit of measure:</i>	Year

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	In order to estimate duration of smoking the person's date of birth or current age should also be collected. If a person reports that they smoke daily now then duration is the difference between the start-age and the person's current age. If a person reports that they smoked daily in the past but do not smoke daily now then duration is the difference between the quit age and the start age. Record duration of less than one year as 0.
<i>Collection methods:</i>	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1, 5, 6, 7) and self-administered (Question 1, 3, 3a, 4) versions. The questions cover persons aged 18 years and over.
<i>Comments:</i>	Duration of daily smoking is an indicator of exposure to increased risk to health. In this data element, duration is measured as the years elapsed from the time the person first started smoking daily and when they most recently quit smoking daily (or the present for those persons who still smoke daily). There may have been intervening periods when the person did not smoke daily. However, as the negative health effects of

smoking accumulate over time, the information on duration of daily smoking, as measured in this data element, remains useful, despite any intervening periods of non-daily smoking.

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes [Tobacco smoking - duration \(daily smoking\), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.7 KB)

Is formed using [Person – tobacco smoking start age \(daily smoking\), total years NN](#) Health, Standard 01/03/2005

Is formed using [Person – tobacco smoking quit age \(daily smoking\), total years NN](#) Health, Standard 01/03/2005

Tobacco smoking—ever daily use

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – tobacco smoking daily use status, code N
<i>METeOR identifier:</i>	270329
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of whether a person has ever smoked tobacco in any form on a daily basis in their lifetime, as represented by a code.
Data Element Concept:	Person – tobacco smoking daily use status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Ever-daily</td></tr><tr><td>2</td><td>Never-daily</td></tr></tbody></table>	Value	Meaning	1	Ever-daily	2	Never-daily
Value	Meaning						
1	Ever-daily						
2	Never-daily						

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Ever-daily</p> <p>If a person reports that they now smoke cigarettes, cigars, pipes or any other tobacco products daily OR if they report that in the past they have been a daily smoker, they are coded to 1 (ever-daily).</p> <p>CODE 2 Never-daily</p> <p>If a person reports that they have never smoked cigarettes, cigars, pipes or any other tobacco products daily AND they have never in the past been a daily smoker then they are coded to 2 (never-daily).</p>
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1 and 5) and self-administered (Question 1 and 3) versions. The questions cover persons aged 18 years and over.
<i>Comments:</i>	Whether a person has ever smoked on a daily basis can be used to assess an individual's health risk from smoking and to monitor population trends in smoking behaviour.

It can also be used to:

- evaluate health promotion and disease prevention programs (assessment of interventions);
- monitor health risk factors;
- ascertain determinants and consequences of smoking.

Where the information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes [Tobacco smoking - ever daily use, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.0 KB)

Tobacco smoking—frequency

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – tobacco smoking frequency, code N
<i>METeOR identifier:</i>	270328
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	How often a person now smokes a tobacco product, as represented by a code.
Data Element Concept:	Person – tobacco smoking frequency

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Smokes daily</td></tr><tr><td>2</td><td>Smokes at least weekly, but not daily</td></tr><tr><td>3</td><td>Smokes less often than weekly</td></tr><tr><td>4</td><td>Does not smoke at all</td></tr></tbody></table>	Value	Meaning	1	Smokes daily	2	Smokes at least weekly, but not daily	3	Smokes less often than weekly	4	Does not smoke at all
Value	Meaning										
1	Smokes daily										
2	Smokes at least weekly, but not daily										
3	Smokes less often than weekly										
4	Does not smoke at all										

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.
<i>Collection methods:</i>	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 1) and self-administered (Question 1) versions. The questions relate to smoking of manufactured cigarettes, roll-your-own cigarettes, cigars, pipes and other tobacco products and are designed to cover persons aged 18 years and over.
<i>Comments:</i>	The frequency of smoking helps to assess a person's exposure to tobacco smoke which is a known risk factor for cardiovascular disease and cancer. From a public health point of view, the level of consumption of tobacco as measured by frequency of smoking tobacco products is only relevant for regular smokers (persons who smoke daily or at least weekly).

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes [Tobacco smoking - frequency, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.7 KB)

Tobacco smoking—product

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – tobacco product smoked, code N
<i>METeOR identifier:</i>	270327
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of tobacco product smoked by a person, as represented by a code.
Data Element Concept:	Person – tobacco product smoked

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Cigarettes - manufactured</td></tr><tr><td>2</td><td>Cigarettes - roll-your-own</td></tr><tr><td>3</td><td>Cigars</td></tr><tr><td>4</td><td>Pipes</td></tr><tr><td>5</td><td>Other tobacco product</td></tr><tr><td>6</td><td>None</td></tr></tbody></table>	Value	Meaning	1	Cigarettes - manufactured	2	Cigarettes - roll-your-own	3	Cigars	4	Pipes	5	Other tobacco product	6	None
Value	Meaning														
1	Cigarettes - manufactured														
2	Cigarettes - roll-your-own														
3	Cigars														
4	Pipes														
5	Other tobacco product														
6	None														

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	To record multiple use data, repeat the data field as many times as necessary, viz: product1, product2 etc. In most instances, data on both product and frequency are needed. In such situations, repeat both fields as many times as necessary, viz: product1, frequency1, product2, frequency2 etc.
<i>Collection methods:</i>	The recommended standard for collecting information about smoking the above tobacco products is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer or self-administered versions.
<i>Comments:</i>	Tobacco smoking is a known risk factor for cardiovascular disease and cancer. The type of tobacco product smoked by a person in conjunction with information about the frequency of smoking assists with establishing a profile of smoking behaviour at the individual or population level and with monitoring shifts from cigarette smoking to other types of tobacco products and vice versa.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes [Tobacco smoking - product, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.1 KB)

Tobacco smoking—quit age (daily smoking)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – tobacco smoking quit age (daily smoking), total years NN
<i>METeOR identifier:</i>	270323
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The age in years at which a person who has smoked daily in the past and is no longer a daily smoker most recently stopped smoking daily.
<i>Context:</i>	Public health and health care
<i>Data Element Concept:</i>	Person – tobacco smoking quit age

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	String
<i>Format:</i>	NN
<i>Maximum character length:</i>	2
<i>Supplementary values:</i>	Value Meaning
	99 Not stated/inadequately described
<i>Unit of measure:</i>	Year

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>In order to estimate quit-age, the person's date of birth or current age should also be collected. Quit-age may be directly reported, or derived from the date the person quit smoking or the length of time since quitting, once the person's date of birth (or current age) is known.</p> <p>Quit-age is relevant only to persons who have been daily smokers in the past and are not current daily smokers.</p>
<i>Collection methods:</i>	<p>The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults - interviewer administered (Question 6) and self-administered (Question 3a) versions. The questions cover persons aged 18 years and over.</p> <p>The relevant question in each version of the questionnaires refers to when the person finally stopped smoking daily, whereas the definition for this metadata item refers to when the person most recently stopped smoking daily. However, in order to provide information on when the person most recently stopped smoking daily, the most appropriate question to ask at the time of</p>

collecting the information is when the person finally stopped smoking daily.

Comments:

Quit-age and start-age provide information on the duration of daily smoking and exposure to increased risk to health.

Where the information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes [Tobacco smoking - quit age \(daily smoking\), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.8 KB)

Is used in the formation of [Person – time since quitting tobacco smoking \(daily smoking\), code NN](#) Health, Standard 01/03/2005

Is used in the formation of [Person – tobacco smoking duration \(daily smoking\), total years N\[N\]](#) Health, Standard 01/03/2005

Tobacco smoking—start age (daily smoking)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – tobacco smoking start age (daily smoking), total years NN
<i>METeOR identifier:</i>	270324
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The age in years at which a person who has ever been a daily smoker, first started to smoke daily.
<i>Context:</i>	Public health and health care
<i>Data Element Concept:</i>	Person – tobacco smoking start age

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	String
<i>Format:</i>	NN
<i>Maximum character length:</i>	2
<i>Supplementary values:</i>	Value Meaning
	99 Not stated/inadequately described
<i>Unit of measure:</i>	Year

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record age in completed years. This information is relevant only if a person currently smokes daily or has smoked daily in the past.
<i>Collection methods:</i>	The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 7) and self-administered (Question 4) versions. The questions cover persons aged 18 years and over.
<i>Comments:</i>	Start-age may be used to derive duration of smoking, which is a much stronger predictor of the risks associated with smoking than is the total amount of tobacco smoked over time. Where the information is collected by survey and the sample permits, population estimates should be presented by sex and age groups. The recommended age groups are: It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status,

physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes [Tobacco smoking - start age \(daily smoking\), version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.7 KB)

Is used in the formation of [Person – tobacco smoking duration \(daily smoking\), total years N\[N\]](#) Health, Standard 01/03/2005

Tobacco smoking—time since quitting (daily smoking)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – time since quitting tobacco smoking (daily smoking), code NN
<i>METeOR identifier:</i>	270356
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time since a person most recently quit daily smoking, as represented by a code.
<i>Context:</i>	Public health and health care
<i>Data Element Concept:</i>	Person – time since quitting tobacco smoking

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																						
<i>Data type:</i>	String																																						
<i>Format:</i>	NN																																						
<i>Maximum character length:</i>	2																																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>12 months (1 year)</td></tr><tr><td>02</td><td>2 years etc. to 78</td></tr><tr><td>79</td><td>79+ years</td></tr><tr><td>80</td><td>Less than 1 month</td></tr><tr><td>81</td><td>1 month</td></tr><tr><td>82</td><td>2 months</td></tr><tr><td>83</td><td>3 months</td></tr><tr><td>84</td><td>4 months</td></tr><tr><td>85</td><td>5 months</td></tr><tr><td>86</td><td>6 months</td></tr><tr><td>87</td><td>7 months</td></tr><tr><td>88</td><td>8 months</td></tr><tr><td>89</td><td>9 months</td></tr><tr><td>90</td><td>10 months</td></tr><tr><td>91</td><td>11 months</td></tr><tr><td>92</td><td>months, not specified</td></tr><tr><td>93</td><td>years, not specified</td></tr><tr><td><i>Supplementary values:</i></td><td>99 not stated</td></tr></tbody></table>	Value	Meaning	01	12 months (1 year)	02	2 years etc. to 78	79	79+ years	80	Less than 1 month	81	1 month	82	2 months	83	3 months	84	4 months	85	5 months	86	6 months	87	7 months	88	8 months	89	9 months	90	10 months	91	11 months	92	months, not specified	93	years, not specified	<i>Supplementary values:</i>	99 not stated
Value	Meaning																																						
01	12 months (1 year)																																						
02	2 years etc. to 78																																						
79	79+ years																																						
80	Less than 1 month																																						
81	1 month																																						
82	2 months																																						
83	3 months																																						
84	4 months																																						
85	5 months																																						
86	6 months																																						
87	7 months																																						
88	8 months																																						
89	9 months																																						
90	10 months																																						
91	11 months																																						
92	months, not specified																																						
93	years, not specified																																						
<i>Supplementary values:</i>	99 not stated																																						

Data element attributes

Collection and usage attributes

Guide for use:

In order to estimate time since quitting for all respondents, the person's date of birth or current age should also be collected.

For optimal flexibility of use, the time since quitting is coded as months or years. However, people may report the time that they quit smoking in various ways (e.g. age, a date, or a number of days or weeks ago). When the information is reported in weeks and is less than 4, or in days and is less than 28, then code 80.

When the person reports the time since quitting as weeks ago, convert into months by dividing by 4 (rounded down to the nearest month).

If days reported are between 28 and 59, then code 81.

Where the information is about age only, time since quitting (daily use) is the difference between quit-age and age at survey.

Collection methods:

The recommended standard for collecting this information is the Standard Questions on the Use of Tobacco Among Adults (1998) - interviewer administered (Question 6) and self-administered (Question 3) versions.

Comments:

Time since quitting daily smoking may give an indication of improvement in the health risk profile of a person. It is also useful in evaluating health promotion campaigns.

Where this information is collected by survey and the sample permits, population estimates should be presented by sex and 5-year age groups. Summary statistics may need to be adjusted for age and other relevant variables.

It is recommended that in surveys of smoking, data on age, sex and other socio-demographic variables should be collected. It is also recommended that when smoking is investigated in relation to health, data on other risk factors including pregnancy status, physical activity, overweight and obesity, and alcohol consumption should be collected.

Relational attributes

Related metadata references:

Supersedes [Tobacco smoking - time since quitting \(daily smoking\), version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.0 KB)

Is formed using [Person – tobacco smoking quit age \(daily smoking\), total years NN](#) Health, Standard 01/03/2005

Total blood units transfused

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – units of blood transfused, total N[NNN]
<i>METeOR identifier:</i>	344798
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The total number of units of blood that a person has received, either whole blood or packed red blood cells.
Data Element Concept:	Person – units of blood transfused

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[NNN]				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	9999	Not stated/inadequately described
Value	Meaning				
9999	Not stated/inadequately described				

Collection and usage attributes

<i>Guide for use:</i>	1 blood unit (or one bag of blood) = approx 500ml of blood
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Platelet transfusions or transfusions of fresh frozen plasma (FFP) should not be included in the total.
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Relational attributes

<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008
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Conditional obligation:
Record the total number of blood units (either whole blood or packed red blood cells) that the person has received following a haemorrhagic event.

Total contract patient days

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Admitted patient hospital stay – number of patient days (of contracted care), total N[NN]
<i>METeOR identifier:</i>	270301
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Sum of the number of contract patient days for all periods within the hospital stay.
Data Element Concept:	Admitted patient hospital stay – number of patient days (of contracted care)

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Count number of days.</p> <p>A day is measured from midnight to 2359 hours.</p> <p>Contract patient days are included in the total count of patient days. If necessary, contract patient days can be distinguished from other patient days by using the following rules:</p> <ul style="list-style-type: none">• The day the contract commences is counted as a contract patient day.• If the patient is on contract from midnight to 2359 count as a contract patient day.• The day a contract is completed is not counted as a contract patient day.• If the patient is admitted and commences a contract on the same day, this is not counted as a contract patient day.• If a contract is completed and the patient is separated on the same day, the day should not be counted as a contract or other patient day.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Total contract patient days, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.9 KB)
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Total leave days

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – number of leave days, total N[NN]
<i>METeOR identifier:</i>	270251
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.
Data Element Concept:	Episode of admitted patient care – number of leave days

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NN]
<i>Maximum character length:</i>	3
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A day is measured from midnight to midnight.</p> <p>The following rules apply in the calculation of leave days for both overnight and same-day patients:</p> <ul style="list-style-type: none">• The day the patient goes on leave is counted as a leave day.• The day the patient is on leave is counted as a leave day.• The day the patient returns from leave is counted as a patient day.• If the patient is admitted and goes on leave on the same day, this is counted as a patient day, not a leave day.• If the patient returns from leave and then goes on leave again on the same day, this is counted as a leave day.• If the patient returns from leave and is separated on the same day, the day should not be counted as either a patient day or a leave day.
<i>Comments:</i>	<p>It should be noted that for private patients in public and private hospitals, s.3 (12) of the Health Insurance Act 1973 (Cwlth) currently applies a different leave day count, Commonwealth Department of Human Services and Health HBF Circular 354 (31 March 1994). This metadata item was modified in July 1996 to exclude the previous differentiation between the psychiatric and other patients.</p>

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Total leave days, version 3, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.6 KB)

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v 6\) NN](#) Health, Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v 6\) ANNA](#) Health, Standard 22/12/2009

Is used in the formation of [Episode of admitted patient care – diagnosis related group, code \(AR-DRG v5.1\) ANNA](#) Health, Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – major diagnostic category, code \(AR-DRG v5.1\) NN](#) Health, Superseded 22/12/2009

Is used in the formation of [Episode of admitted patient care – length of stay \(excluding leave days\), total N\[NN\]](#) Health, Standard 01/03/2005

Is used in the formation of [Episode of care – number of psychiatric care days, total N\[NNNN\]](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Total psychiatric care days

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of care – number of psychiatric care days, total N[NNNN]
<i>METeOR identifier:</i>	270300
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The sum of the number of days or part days of stay that the person received care as an admitted patient or resident within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.
Data Element Concept:	Episode of care – number of psychiatric care days

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNNN]
<i>Maximum character length:</i>	5
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Designated psychiatric units are staffed by health professionals with specialist mental health qualifications or training and have as their principal function the treatment and care of patients affected by mental disorder. The unit may or may not be recognised under relevant State and Territory legislation to treat patients on an involuntary basis. Patients are admitted patients in the acute and psychiatric hospitals and residents in community based residences.</p> <p>Public acute care hospitals: Designated psychiatric units in public acute care hospitals are normally recognised by the State/Territory health authority in the funding arrangements applying to those hospitals.</p> <p>Private acute care hospitals: Designated psychiatric units in private acute care hospitals normally require license or approval by the State/Territory health authority in order to receive benefits from health funds for the provision of psychiatric care.</p> <p>Psychiatric hospitals: Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received</p>
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specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Psychiatric hospitals are establishments devoted primarily to the treatment and care of admitted patients with psychiatric, mental or behavioural disorders. Private hospitals formerly approved by the Commonwealth Department of Health under the Health Insurance Act 1973 (Commonwealth) (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Community-based residential services:

Designated psychiatric units refers to 24-hour staffed community-based residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Special psychiatric units for the elderly are covered by this category, including psychogeriatric hostels or psychogeriatric nursing homes. Note that residences occupied by admitted patients located on hospital grounds, whether on the campus of a general or stand-alone psychiatric hospital, should be counted in the category of admitted patient services and not as community-based residential services.

Counting of patient days and leave days in designated psychiatric units should follow the standard definitions applying to these items.

For each period of care in a designated psychiatric unit, total days is calculated by subtracting the date on which care commenced within the unit from the date on which the specialist unit care was completed, less any leave days that occurred during the period.

Total psychiatric care days in 24-hour community-based residential care are calculated by counting those days the patient received specialist psychiatric care. Leave days and days on which the patient was receiving other care (e.g. specialised intellectual ability or drug and alcohol care) should be excluded.

Admitted patients in acute care:

Commencement of care within a designated psychiatric unit may be the same as the date the patient was admitted to the hospital, or occur subsequently, following transfer of the patient from another hospital ward. Where commencement of psychiatric care occurs by transfer from another ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type). Completion of care within a designated psychiatric unit may be the same as the date the patient was discharged from the hospital, or occur prior to this on transfer of the patient to another hospital ward. Where completion of psychiatric care is followed by transfer to another hospital ward, a new episode of care may be recorded, depending on whether the care type has changed (see metadata item Care type). Total psychiatric care days may cover one or more periods in a designated psychiatric unit within the overall

Collection methods:

hospital stay.

Accurate counting of total days in psychiatric care requires periods in designated psychiatric units to be identified in the person-level data collected by state or territory health authorities. Several mechanisms exist for this data field to be implemented:

- Ideally, the new data field should be collected locally by hospitals and added to the unit record data provided to the relevant state/territory health authority.
- Acute care hospitals in most states and territories include details of the wards in which the patient was accommodated in the unit record data provided to the health authority. Local knowledge should be used to identify designated psychiatric units within each hospital's ward codes, to allow total psychiatric care days to be calculated for each episode of care.
- Acute care hospitals and 24-hour staffed community-based residential services should be identified separately at the level of the establishment.

Comments:

This metadata item was originally designed to monitor trends in the delivery of psychiatric admitted patient care in acute care hospitals. It has been modified to enable collection of data in the community-based residential care sector. The metadata item is intended to improve understanding in this area and contribute to the ongoing evaluation of changes occurring in mental health services.

Source and reference attributes

Submitting organisation:

National Mental Health Information Strategy Committee

Reference documents:

Health Insurance Act 1973 (Commonwealth)

Relational attributes

Related metadata references:

Supersedes [Total psychiatric care days, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (23.8 KB)

Is formed using [Establishment – establishment type, sector and services provided code AN.N{.N}](#) Health, Standard 01/03/2005

Is formed using [Hospital service – care type, code N\[N\].N](#) Health, Standard 01/03/2005

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 – admission date, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Episode of admitted patient care – separation date, DDMMYYYY](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded
05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded
04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded
22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

[Admitted patient mental health care NMDS](#) Health, Superseded
23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded
07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health,
Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health,
Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health,
Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health,
Standard 05/01/2010

Implementation start date: 01/07/2010

Treatment delivery setting for alcohol and other drugs

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of treatment for alcohol and other drugs – service delivery setting, code N
<i>METeOR identifier:</i>	270068
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The main physical setting in which the type of treatment that is the principal focus of a client's alcohol and other drug treatment episode is actually delivered irrespective of whether or not this is the same as the usual location of the service provider, as represented by a code.
Data Element Concept:	Episode of treatment for alcohol and other drugs – service delivery setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Non-residential treatment facility</td></tr><tr><td>2</td><td>Residential treatment facility</td></tr><tr><td>3</td><td>Home</td></tr><tr><td>4</td><td>Outreach setting</td></tr><tr><td>8</td><td>Other</td></tr></tbody></table>	Value	Meaning	1	Non-residential treatment facility	2	Residential treatment facility	3	Home	4	Outreach setting	8	Other
Value	Meaning												
1	Non-residential treatment facility												
2	Residential treatment facility												
3	Home												
4	Outreach setting												
8	Other												

Collection and usage attributes

<i>Guide for use:</i>	<p>Only one code to be selected at the end of the alcohol and other drug treatment episode. Agencies should report the setting in which most of the main type of treatment was received by the client during the treatment episode.</p> <p>CODE 1 Non-residential treatment facility</p> <p>This code refers to any non-residential centre that provides alcohol and other drug treatment services, including hospital outpatient services and community health centres.</p> <p>CODE 2 Residential treatment facility</p> <p>This code refers to community-based settings in which clients reside either temporarily or long-term in a facility that is not their home or usual place of residence to receive alcohol and other drug treatment. This does not include ambulatory situations, but does include therapeutic community settings.</p>
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CODE 3 Home

This code refers to the client's own home or usual place of residence.

CODE 4 Outreach setting

This code refers to an outreach environment, excluding a client's home or usual place of residence, where treatment is provided. An outreach environment may be any public or private location that is not covered by Codes 1-3. Mobile/outreach alcohol and other drug treatment service providers would usually provide treatment within this setting.

Data element attributes

Source and reference attributes

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

Relational attributes

Related metadata references: Supersedes [Treatment delivery setting for alcohol and other drugs, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.8 KB)

Implementation in Data Set Specifications: [Alcohol and other drug treatment services NMDS](#) Health, Superseded 21/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Alcohol and other drug treatment services NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Alcohol and other drug treatment services NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Alcohol and other drug treatment services NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Alcohol and other drug treatment services NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Triage category

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – triage category, code N
<i>METeOR identifier:</i>	390392
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	The urgency of the patient's need for medical and nursing care as assessed at triage, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode – triage category

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Resuscitation: immediate (within seconds)</td></tr><tr><td>2</td><td>Emergency: within 10 minutes</td></tr><tr><td>3</td><td>Urgent: within 30 minutes</td></tr><tr><td>4</td><td>Semi-urgent: within 60 minutes</td></tr><tr><td>5</td><td>Non-urgent: within 120 minutes</td></tr></tbody></table>	Value	Meaning	1	Resuscitation: immediate (within seconds)	2	Emergency: within 10 minutes	3	Urgent: within 30 minutes	4	Semi-urgent: within 60 minutes	5	Non-urgent: within 120 minutes
Value	Meaning												
1	Resuscitation: immediate (within seconds)												
2	Emergency: within 10 minutes												
3	Urgent: within 30 minutes												
4	Semi-urgent: within 60 minutes												
5	Non-urgent: within 120 minutes												

Data element attributes

Collection and usage attributes

Collection methods: This triage classification is to be used in the emergency departments of hospitals. Patients will be triaged into one of five categories on the National Triage Scale according to the triageur's response to the question: 'This patient should wait for medical care no longer than ...?'.
The triage category is allocated by an experienced **registered nurse** or medical practitioner. If the triage category changes, both triage categories can be captured, but the original category must be reported in this data element.

Source and reference attributes

Origin: National Triage Scale, Australasian College for Emergency Medicine

Relational attributes

Related metadata references:

Supersedes [Non-admitted patient emergency department service episode – triage category, code N](#) Health, Superseded
22/12/2009

Implementation in Data Set Specifications:

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Triglyceride level (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – triglyceride level (measured), total millimoles per litre N[N].N
<i>METeOR identifier:</i>	359411
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's triglyceride level measured in millimoles per litre.
<i>Data Element Concept:</i>	Person – triglyceride level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[N].N				
<i>Maximum character length:</i>	3				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>99.9</td><td>Not stated/inadequately described.</td></tr></tbody></table>	Value	Meaning	99.9	Not stated/inadequately described.
Value	Meaning				
99.9	Not stated/inadequately described.				
<i>Unit of measure:</i>	Millimole per litre (mmol/L)				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the absolute result of the total triglyceride measurement.
<i>Collection methods:</i>	<p>Measurement of lipid levels should be carried out by laboratories, or practices, which have been accredited to perform these tests by the National Association of Testing Authorities.</p> <ul style="list-style-type: none">To be collected as a single venous blood sample, preferably following a 12-hour fast where only water and medications have been consumed. <p>Note that to calculate the low-density lipoprotein - cholesterol (LDL-C) from the Friedwald Equation (Friedwald et al, 1972):</p> <ul style="list-style-type: none">a fasting level of plasma triglyceride and knowledge of the levels of plasma total cholesterol and high-density lipoprotein - cholesterol (HDL-C) is required,the Friedwald equation becomes unreliable when the plasma triglyceride exceeds 4.5 mmol/L, andthat while levels are reliable for the first 24 hours after the onset of acute coronary syndromes, they may be unreliable for the subsequent 8 weeks after an event.

Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular Data Working Group
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Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Person – triglyceride level \(measured\), total millimoles per litre N\[N\].N](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Troponin assay type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – troponin assay type, code N
<i>METeOR identifier:</i>	356929
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of troponin assay (I or T) used to assess the person's troponin levels, as represented by a code.
Data Element Concept:	Person – troponin assay type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Cardiac troponin T (cTnT)</td></tr><tr><td>2</td><td>Cardiac troponin I (cTnI)</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Cardiac troponin T (cTnT)	2	Cardiac troponin I (cTnI)	9	Not stated/inadequately described
Value	Meaning								
1	Cardiac troponin T (cTnT)								
2	Cardiac troponin I (cTnI)								
9	Not stated/inadequately described								
<i>Supplementary values:</i>									

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group.
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	Supersedes Person – troponin assay type, code N Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Troponin assay—upper limit of normal range (micrograms per litre)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Laboratory standard – upper limit of normal range for troponin assay, total micrograms per litre N[NNN]
<i>METeOR identifier:</i>	359315
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Laboratory standard for the value of ‘troponin T’ or ‘troponin I’ measured in micrograms per litre that is the upper boundary of the normal reference range.
Data Element Concept:	Laboratory standard – upper limit of normal range of troponin assay

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	N[NNN]						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>9998</td><td>Not measured</td></tr><tr><td>9999</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	9998	Not measured	9999	Not stated/inadequately described
Value	Meaning						
9998	Not measured						
9999	Not stated/inadequately described						
<i>Unit of measure:</i>	Microgram per litre (µg/L)						

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the upper limit of normal (usually the ninety-ninth percentile of a normal population) for the individual laboratory.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Laboratory standard – upper limit of normal range for troponin assay, total micrograms per litre N[NNN] Health, Superseded 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Acute coronary syndrome (clinical) DSS Health, Standard 01/10/2008

Troponin level (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – troponin level (measured), total micrograms per litre NN.NN
<i>METeOR identifier:</i>	356934
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's troponin measured in micrograms per litre.
<i>Data Element Concept:</i>	Person – troponin level

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	NN.NN						
<i>Maximum character length:</i>	4						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>88.88</td><td>Not measured</td></tr><tr><td>99.99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	88.88	Not measured	99.99	Not stated/inadequately described
Value	Meaning						
88.88	Not measured						
99.99	Not stated/inadequately described						
<i>Unit of measure:</i>	Microgram per litre (µg/L)						

Collection and usage attributes

<i>Guide for use:</i>	CODE 88.88 Not measured This code is used if test for troponin (T or I) was not done.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Measured in different assays dependant upon laboratory methodology. When only one troponin level is recorded, this should be the peak level.
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Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand

Relational attributes

<i>Related metadata references:</i>	See also Laboratory standard – upper limit of normal range for troponin assay, total micrograms per litre N[NNN] Health, Superseded 01/10/2008
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*Implementation in Data Set
Specifications:*

Supersedes [Person – troponin level \(measured\), total micrograms per litre NN.NN](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Tumour size at diagnosis (solid tumours)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – solid tumour size (at diagnosis), total millimetres NNN
<i>METeOR identifier:</i>	370042
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The largest dimension of a solid tumour, measured in millimetres.
Data Element Concept:	Person with cancer – solid tumour size

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	String
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3
<i>Supplementary values:</i>	Value Meaning 999 Unknown
<i>Unit of measure:</i>	Millimetre (mm)

Collection and usage attributes

Guide for use: Size in millimetres with valid values 001 to 997.

Data element attributes

Collection and usage attributes

Guide for use: The reporting standard for the size of solid tumours is:
Breast cancer or other solid neoplasms - the largest tumour dimension, measured to a precision of 1mm.
Round to the nearest millimetre, rounding up if size is $\geq .5$ mm (e.g. 1.50mm, 1.54mm recorded as 2mm, 1.47mm recorded as 1mm).
General coding rules:
Recorded size:
Only record measured size if stated, otherwise record size as unknown. Do not attempt to estimate size from descriptions of the tumour, such as 'tumour occupying three quarters of tissue'.
Do not take values for size from sources other than histopathology (such as imaging, mammography or clinical examination).
Size reported for multiple specimens:

If tumour is removed in more than one procedure (e.g. biopsy and excision, local excision and re-excision) do not sum the sizes across multiple pathology reports but rather use the larger of the measured sizes from the separate pathology reports.

If tumour is divided into several parts (in the same pathology report), do not sum sizes together but rather use the larger of the measured sizes. However, if the pathologist states an aggregate or composite size, record that size.

Multifocal tumour:

If the tumour is multifocal, record the size of the largest measured focus. Do not attempt to sum sizes of different foci.

Macroscopic size:

If only macroscopic size is given, record this value.

If the macroscopic and microscopic measurements differ, the microscopic measurement should be recorded.

Exclusions:

Size is not recorded for Phyllodes tumours, sarcomas, or lymphomas.

Invasive breast cancer coding rules:

Note: These rules are to be used only when the record pertains to an invasive breast cancer (as per Person with cancer-primary site of cancer, code (ICDO-3), ANN{.N[N]}).

Invasive tumours with an in situ component:

When an invasive tumour contains an in situ component, only record the size of the invasive component as stated.

If the size of the invasive tumour is not recorded separately to the in-situ component, then record the total size of the tumour without any attempt to estimate the invasive component using percentage or size of the in situ component.

Microinvasive tumour:

For microinvasive tumours, record size in millimetres if stated. If microinvasion is stated but no size is recorded, enter 990 in size field to enable these very small tumours to be differentiated from other tumours without measured sizes.

Bilateral breasts tumours:

Bilateral tumours are recorded as two separate primary tumours each having their own size (and other data elements).

Multifocal tumours with different morphology:

Foci with different morphology should be considered to be separate primary tumours each having their own size (and other data elements). The coder needs to ascertain whether two foci with differing morphology are separate primaries with different morphology or a single multifocal primary with a mixed histology. In the latter case the rule of taking the size from the larger focus would apply as stated.

Collection methods:

This data item is collected for the size of tumours as specified in pathology reports.

Source and reference attributes

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.

National Breast and Ovarian Cancer Centre and Australian Cancer Network. The Pathology reporting of breast cancer. A guide for pathologists, surgeons, radiologists and oncologists (3rd edition). National Breast and Ovarian Cancer Centre, Surry Hills, NSW, 2008.

Relational attributes

Related metadata references:

Supersedes [Person with cancer – solid tumour size \(at diagnosis\), total millimetres NNN](#) Health, Superseded 06/03/2009

Is used in the formation of [Person with cancer – primary tumour status, T stage \(UICC TNM Classification of Malignant Tumours, 6th ed\) code XX\[X\]](#) Health, Standard 06/03/2009

Implementation in Data Set Specifications:

[Breast cancer \(Cancer registries\) DSS](#) Health, Standard 06/03/2009

[Cancer \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cancer \(clinical\) DSS](#) Health, Standard 22/12/2009

Tumour thickness at diagnosis (melanoma)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person with cancer – melanoma thickness (at diagnosis), total millimetres NNN.NN
<i>METeOR identifier:</i>	270185
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The measured thickness of a melanoma in millimetres.
<i>Data Element Concept:</i>	Person with cancer – melanoma thickness

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	String				
<i>Format:</i>	NNN.NN				
<i>Maximum character length:</i>	5				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999.99</td><td>Unknown</td></tr></tbody></table>	Value	Meaning	999.99	Unknown
Value	Meaning				
999.99	Unknown				
<i>Unit of measure:</i>	Millimetre (mm)				

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The reporting standard for the thickness of melanoma is: Primary cutaneous melanoma - the depth of penetration of tumour cells below the basal layer of the skin; measured to a precision of 0.01mm. Size in millimetres - valid values are: 000.01 to 997.99
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Relational attributes

<i>Related metadata references:</i>	Supersedes Tumour thickness at diagnosis - melanoma, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.3 KB)
<i>Implementation in Data Set Specifications:</i>	Cancer (clinical) DSS Health, Superseded 07/12/2005 Cancer (clinical) DSS Health, Superseded 06/03/2009 Cancer (clinical) DSS Health, Superseded 22/12/2009 Cancer (clinical) DSS Health, Standard 22/12/2009

Type of accommodation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – accommodation type (usual), code N[N]
<i>METeOR identifier:</i>	270088
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of accommodation setting in which a person usually lives/lived, as represented by a code.
<i>Context:</i>	Admitted patient mental health care: Permits analysis of the usual residential accommodation type of people prior to admission to institutional health care. The setting in which the person usually lives can have a bearing on the types of treatment and support required by the person and the outcomes that result from their treatment.
Data Element Concept:	Person – accommodation type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																						
<i>Data type:</i>	Number																						
<i>Format:</i>	N[N]																						
<i>Maximum character length:</i>	2																						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Private residence (e.g. house, flat, bedsitter, caravan, boat, independent unit in retirement village), including privately and publicly rented homes</td></tr><tr><td>2</td><td>Psychiatric hospital</td></tr><tr><td>3</td><td>Residential aged care service</td></tr><tr><td>4</td><td>Specialised alcohol/other drug treatment residence</td></tr><tr><td>5</td><td>Specialised mental health community-based residential support service</td></tr><tr><td>6</td><td>Domestic-scale supported living facility (e.g. group home for people with disability)</td></tr><tr><td>7</td><td>Boarding/rooming house/hostel or hostel type accommodation, not including aged persons' hostel</td></tr><tr><td>8</td><td>Homeless persons' shelter</td></tr><tr><td>9</td><td>Shelter/refuge (not including homeless persons' shelter)</td></tr><tr><td>10</td><td>Other supported accommodation</td></tr></tbody></table>	Value	Meaning	1	Private residence (e.g. house, flat, bedsitter, caravan, boat, independent unit in retirement village), including privately and publicly rented homes	2	Psychiatric hospital	3	Residential aged care service	4	Specialised alcohol/other drug treatment residence	5	Specialised mental health community-based residential support service	6	Domestic-scale supported living facility (e.g. group home for people with disability)	7	Boarding/rooming house/hostel or hostel type accommodation, not including aged persons' hostel	8	Homeless persons' shelter	9	Shelter/refuge (not including homeless persons' shelter)	10	Other supported accommodation
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10	Other supported accommodation																						

	11	Prison/remand centre/youth training centre
	12	Public place (homeless)
	13	Other accommodation, not elsewhere classified
<i>Supplementary values:</i>	14	Unknown/unable to determine

Collection and usage attributes

Guide for use:

CODE 3 Residential aged care service

Includes nursing home beds in acute care hospitals.

CODE 4 Specialised alcohol/other drug treatment residence

Includes alcohol/other drug treatment units in psychiatric hospitals.

CODE 5 Specialised mental health community-based residential support service

Specialised mental health community-based residential support services are defined as community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.

CODE 6 Domestic-scale supported living facility (e.g. group home for people with disability)

Domestic-scale supported living facilities include group homes for people with disability, cluster apartments where a support worker lives on-site, community residential apartments (except mental health), congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care.

CODE 10 Other supported accommodation

Includes other supported accommodation facilities such as hostels for people with disability and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

Data element attributes

Collection and usage attributes

Guide for use:

'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to admission to institutional health care or first contact with a community service setting. If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation. In practice, receiving an answer to questioning about a person's usual accommodation setting may be difficult to achieve. The place the person perceives as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.

Comments:

The changes made to this metadata item are in accordance with

the requirements of the National Mental Health Information Strategy Committee and take into consideration corresponding definitions in other data dictionaries (e.g. Home and Community Care Data Dictionary Version 1 and National Community Services Data Dictionary Version 1).

Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Type of accommodation, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.4 KB)

[Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Type of augmentation of labour

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – labour augmentation type, code N
<i>METeOR identifier:</i>	270036
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Methods used to assist progress of labour, as represented by a code.
Data Element Concept:	Birth event – labour augmentation type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>None</td></tr><tr><td>1</td><td>Oxytocin</td></tr><tr><td>2</td><td>Prostaglandins</td></tr><tr><td>3</td><td>Artificial rupture of membranes (ARM)</td></tr><tr><td>4</td><td>Other</td></tr><tr><td>5</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	0	None	1	Oxytocin	2	Prostaglandins	3	Artificial rupture of membranes (ARM)	4	Other	5	Not stated
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4	Other														
5	Not stated														
<i>Supplementary values:</i>															

Collection and usage attributes

<i>Comments:</i>	Prostaglandin is listed as a method of augmentation in the data domain. Advice from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the manufacturer indicates that vaginal prostaglandin use is not recommended or supported as a method of augmentation of labour as it may significantly increase the risk of uterine hyperstimulation. In spite of this, the method is being used and it is considered important to monitor its use for augmentation.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	More than one method of augmentation can be recorded, except where 0=none applies. Collection units need to edit carefully the use of prostaglandins as an augmentation method. Results from checking records have shown that either the onset of labour was incorrect or that the augmentation method was incorrectly selected.
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Comments: Type of augmentation determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Source and reference attributes

Submitting organisation: National Perinatal Data Development Committee

Relational attributes

Related metadata references: [Supersedes Type of augmentation of labour, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf \(15.4 KB\)](#)

Type of health or health related function

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Organisation – type of health or health related function, code NNN
<i>METeOR identifier:</i>	352187
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Describes the type of activities or programs with a health or health-related function provided by an organisation, as represented by a code.
Data Element Concept:	Organisation – type of health or health related function

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																										
<i>Data type:</i>	Number																																										
<i>Format:</i>	NNN																																										
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404	Public health – Environmental health
405	Public health – Food standards and hygiene
406	Public health – Breast cancer screening
407	Public health – Cervical screening
408	Public health – Bowel cancer screening
409	Public health – Prevention of hazardous and harmful drug use
410	Public health – Public health research
488	Public health – Other public health
499	Public health – Not further defined
501	Health related care – Patient transport
502	Health related care – Patient transport subsidies
503	Health related care – Medications
504	Health related care – Aids and appliances
505	Health related care – Health administration
506	Health related care – Health research
588	Health related care – Other
599	Health related care – Not further defined
601	Other function – Home and Community Care
602	Other function – Aged care
603	Other function – Other welfare
688	Other function – Other
699	Other function – Not further defined

Collection and usage attributes

Guide for use:

CODE 101 Admitted patient care – Mental health program

An **admission** to a mental health program includes:

The component of the mental health program that provides admitted patient care. These services are delivered through specialised psychiatric hospitals and designated psychiatric units located within hospitals that are not specialised psychiatric hospitals.

NOTE: This is the admitted patient component of the mental health care program reported to the Mental Health Establishments NMDS.

Excludes residential care mental health programs, **ambulatory care** mental health programs which are provided as **outpatient** and **emergency department** care to non-admitted patients, and community-based (non-hospital) mental health programs.

CODE 102 Admitted patient care – Non-mental health program

An admitted patient non-mental health program includes:

All services, excluding mental health services, provided to admitted patients, including acute care, rehabilitative care, palliative care, geriatric evaluation and management, psychogeriatric care, maintenance care, newborn care and any

other admitted patient care e.g. organ procurement – posthumous. Also includes admitted patient services where service delivery is contracted to private hospitals or treatment facilities and **hospital in the home** services.

Excludes emergency department and outpatient care provided to non-admitted patients, and community-based (non hospital) care.

CODE 199 Admitted patient care – Not further defined

Comprises admitted patient care services that could be a combination of categories 101 and 102 but which could not be further disaggregated.

State and territory health authorities are only to report admitted patient care under codes 101 or 102.

CODE 201 Residential care – Mental health program

A residential mental health care program includes:

The component of the specialised mental health program that provides residential care. A **resident** in one **residential mental health service** cannot be concurrently a resident in another residential mental health service. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.

Comprises the residential component of the mental health care program reported to the Mental Health Establishments NMDS.

Excludes residential aged care services, residential disability, alcohol and other drug treatment health care services and residential type care provided to admitted patients in hospitals. Also excludes mental health programs provided to admitted patients, emergency and outpatient care patients, and community health (non-hospital) and other ambulatory care patients.

CODE 202 Residential care – Non-mental health program

A residential non-mental health care program includes alcohol and other drug treatment health care services.

Excludes residential mental health care program services, residential aged care services, residential disability services and residential type care provided to admitted patients in hospitals. Also excludes services provided to admitted patients and patients receiving ambulatory care.

CODE 299 Residential care – Not further defined

Comprises residential care services that could be a combination of categories 201 and 202 but which could not be further disaggregated.

State and territory health authorities are only to report residential care under codes 201 or 202.

CODE 301 Ambulatory care – Mental health program

The component of a specialised mental health program supplied by a specialised mental health service that provides **ambulatory health care**.

Comprises the ambulatory component of the mental health care program reported to the Mental Health Establishments NMDS,

i.e. specialised mental health program services provided by emergency departments, outpatient clinics and community-based (non-hospital) services.

Excludes specialised mental health care provided to admitted and residential patients.

CODE 302 Ambulatory care – Emergency department

Comprises emergency department services provided in an **emergency department**.

Excludes specialised mental health services provided by emergency departments, outpatient clinics and community-based (non-hospital) services. Also excludes residential and admitted patient services.

CODE 303 Ambulatory care – General practitioner

This item is not currently required to be reported by state and territory health authorities.

The definition relates to the broad type of non-referred general practitioner services as specified on the Medicare Benefits Schedule website. These services comprise general practitioner attendances, including General Practitioner, Vocationally Registered General Practitioner (GP/VRGP) and other non-referred attendances, to non-admitted patients, and services provided by a practice nurse or registered Aboriginal Health Worker on behalf of a general practitioner.

This category is not limited to services funded by Medicare Australia. It also includes services funded from other sources such as Motor Vehicle Third Party Insurance and Workers Compensation Insurance, among others. Therefore, general or nurse practitioner services such as vaccinations for overseas travel are included regardless of their funding source. These non-referred general practitioner services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Excludes mental health care services reported under code 301 and services provided to non-admitted patients in an emergency department.

CODE 304 Ambulatory care – Medical specialist

This item is not currently required to be reported by state and territory health authorities.

Specialist attendances, obstetrics, anaesthetics, radiotherapy, operations and assistance at operations care. These services are defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Includes salaried medical officers.

Excludes mental health care services reported under code 301 and services provided to non-admitted patients in an emergency department.

CODE 305 Ambulatory care – Imaging/pathology service.

This item is not currently required to be reported by state and territory health authorities.

Pathology and diagnostic imaging services as defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are provided in private or group practices in medical clinics, community health care centres or hospital outpatient clinics.

Excludes services provided to admitted or residential care patients and non-admitted patients in an emergency department.

CODE 306 Ambulatory care – Dental service

Includes any non-admitted patient and community dental services, including dental assessments, preventative services and treatments, regardless of funding source. Oral and maxillofacial services and cleft lip and palate services, as defined in the current Medicare Benefits Schedule, are also included in this category.

Includes dental services funded from a range of sources such as Medicare Benefits Scheme, Motor Vehicle Third Party Insurance and dental services funded by vouchers for dental care.

These dental services are provided in private or group practices in dental clinics, community health care centres or hospital outpatient clinics.

Excludes dental care provided to admitted patients in hospitals (same day or overnight) or to non-admitted patients in an emergency department.

CODE 307 Ambulatory care – Optometry service

This item is not currently required to be reported by state and territory health authorities.

Optometry services as defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments. These services are mainly provided in private or group practices, but may be provided in hospital outpatient centres.

Excludes optometry services provided to admitted or residential care patients or to non-admitted patients in an emergency department.

CODE 308 Ambulatory care – Allied health service

Includes services provided by the following allied health items. Aboriginal health worker, diabetes educator, audiologists, exercise physiologist, dietician, mental health worker, occupational therapist, physiotherapist, podiatrist or chiroprapist, chiropractor, osteopath, psychologist and speech pathologist. These services are defined in the current Medicare Benefits Schedule. Includes services funded by Medicare Benefits Scheme, Motor Vehicle Third Party Insurance, Workers Compensation Insurance and from patient out-of-pocket payments.

Excludes allied health services provided to admitted or residential care patients or to non-admitted patients in an emergency department.

CODE 309 Ambulatory care – Community health services

Includes community health services such as family, maternal, child and youth health (including well baby clinics) as well as Aboriginal and Torres Strait Islander and migrant health services. Also includes health care for people with acute, post-acute, chronic and end of life illnesses, alcohol and drug treatment services, child psychology services, community midwifery, community nursing, school and district nursing, community rehabilitation, continence services, telehealth, dietetics, family planning and correctional health services.

Excludes mental health services reported under code 301 and services provided to admitted and residential care patients and non-admitted patients in an emergency department. Also excludes services already reported under codes 303 to 308.

CODE 388 Ambulatory care – Other

Comprises ambulatory care services other than those reported under codes 301 to 309.

CODE 399 Ambulatory care – Not further defined

Comprises ambulatory care services that could be a combination of categories 301 to 309 and 388, but which could not be further disaggregated, such as public outpatient services.

CODE 401 Public health – Communicable disease control

This category includes all activities associated with the development and implementation of programs to prevent the spread of communicable diseases.

Communicable disease control is recorded using three sub-categories:

HIV/AIDS, hepatitis C and sexually transmitted infections

Needle and syringe programs

Other communicable disease control.

The **public health** component of the HIV/AIDS, hepatitis C and STI strategies includes all activities associated with the development and implementation of prevention and education programs to prevent the spread of HIV/AIDS, hepatitis C and sexually transmitted infections.

CODE 402 Public health – Selected health promotion

This category includes those activities fostering healthy lifestyle and a healthy social environment overall, and health promotion activities targeted at health risk factors which lead to injuries, skin cancer and cardiovascular disease (for example diet, inactivity) that are delivered on a population-wide basis. The underlying criterion for the inclusion of health promotion programs within this category was that they are population health programs promoting health and wellbeing.

The Selected health promotion programs are:

Healthy settings (for example municipal health planning)

Public health nutrition

Exercise and physical activity

Personal hygiene

Mental health awareness promotion

Sun exposure and protection

Injury prevention including suicide prevention and female genital mutilation.

CODE 403 Public health – Organised immunisation

This category includes immunisation clinics, school immunisation programs, immunisation education, public awareness, immunisation databases and information systems.

Organised immunisation is recorded using three sub-categories:

Organised childhood immunisation (as defined by the National Health and Medical Research Council Schedule/ Australian Standard Vaccination Schedule)

Organised pneumococcal and influenza immunisation – the target groups for pneumococcal immunisation are Indigenous people over 50 years and high-risk Indigenous younger people aged 15–49 years. Influenza vaccine is available free to all Australians 65 years of age and over, Indigenous people over 50 years and high-risk Indigenous younger people aged 15–19 years.

All other organised immunisation (for example tetanus) – as opposed to ad hoc or opportunistic immunisation.

CODE 404 Public health – Environmental health

This category relates to health protection education (for example safe chemical storage, water pollutants), expert advice on specific issues, development of standards, risk management and public health aspects of environmental health protection. The costs of monitoring and regulating are to be included where costs are borne by a regulatory agency and principally have a public health focus (for example radiation safety, and pharmaceutical regulation and safety).

CODE 405 Public health – Food standards and hygiene

This category includes the development, review and implementation of food standards, regulations and legislation as well as the testing of food by the regulatory agency.

CODE 406 Public health – Breast cancer screening

This category relates to Breast cancer screening and includes the complete breast cancer screening pathway through organised programs.

The breast cancer screening pathway includes such activities as recruitment, screen taking, screen reading, assessment (this includes fine needle biopsy), core biopsy, open biopsy, service management and program management.

CODE 407 Public health – Cervical screening

This category relates to organised cervical screening programs

such as the state cervical screening programs and rural access programs, including coordination, provision of screens and assessment services.

Cervical screening, funded through Medicare, for both screening and diagnostic services is also included. The methodology used in deriving the estimates is set out in the Jurisdictions' technical notes (section 11.2 of NPHER 2004-05).

CODE 408 Public health – Bowel screening

This category relates to organised bowel screening programs, such as the National Bowel Cancer Screening Program (NBCSP) and the Bowel Cancer Screening Pilot program. The screening pathway includes self administered home based tests by persons turning 55 years or 65 years of age across Australia who mail results in for analysis, the assessment/diagnostic service and program management.

CODE 409 Public health – Prevention of hazardous and harmful drug use

This category includes activities targeted at the general population with the aim of reducing the overuse or abuse of alcohol, tobacco, illicit and other drugs of dependence, and mixed drugs. The Australian Standard Classification of Drugs of Concern includes analgesics, sedatives and hypnotics, stimulants and hallucinogens, anabolic agents and selected hormones, antidepressants and anti-psychotics, and also miscellaneous drugs of concern.

Report for each sub-category as below, the aggregate of which will be total expenditure on Prevention of hazardous and harmful drug use:

Alcohol

Tobacco

Illicit and other drugs of dependence

Mixed.

CODE 410 Public health – Public health research

The basic criterion for distinguishing public health research and development from other public health activities is the presence in research and development of an appreciable element of novelty and resolution of scientific and/or technical uncertainty.

Includes mainly new or one-off research in the 8 core public health functions listed under codes 401 to 409.

General research and development work relating to the running of ongoing public health programs is included under the other relevant public health activities in codes 401 to 409.

CODE 488 Public health – Other public health

Comprises public health functions not reported to the National Public Health Expenditure Project.

CODE 499 Public health – Not further defined

Comprises public health services that could be a combination of categories 401 to 410 but which could not be further disaggregated.

State and territory health authorities are only to report public health services under codes 401 to 409.

CODE 501 Health related care – Patient transport

This item comprises transportation in a specially-equipped surface vehicle or in a designated air ambulance to and from facilities for the purposes of receiving medical and surgical care.

Includes all government ambulance services and transport provided by the Royal Flying Doctors Service, care flight and similar services, emergency transport services of public fire rescue departments or defence that operate on a regular basis for civilian emergency services (not only for catastrophe medicine).

Includes transport between hospitals or other medical facilities and transport to or from a hospital or other medical facility and a private residence or other non-hospital/medical services location.

The provider of this service could be a public or private hospital or an ambulance service.

CODE 502 Health related care – Patient transport subsidies

Government subsidies to private ambulance services e.g. patient transport vouchers, support programs to assist isolated patients with travel to obtain specialised health care.

It also includes transportation in conventional vehicles, such as taxi, when the latter is authorised and the costs are reimbursed to the patient (e.g. for patients undergoing renal dialysis or chemotherapy).

CODE 503 Health related care – Medications

This item is not currently required to be reported by state and territory health authorities.

Includes pharmaceuticals and other medical non-durables, prescribed medicines and over-the-counter pharmaceuticals. Included within these categories are: medicinal preparations, branded and generic medicines, drugs, patent medicines, serums and vaccines, vitamins and minerals and oral contraceptives, prescribed medicines exclusively sold to customers with a medical voucher, irrespective of whether it is covered by public or private funding. Includes branded and generic products, private households' non-prescription medicines and a wide range of medical non-durables such as bandages, condoms and other mechanical contraceptive devices, elastic stockings, incontinence articles and toothbrushes, toothpastes and therapeutic mouth washes.

CODE 504 Health related care – Aids and appliances

This item is not currently required to be reported by state and territory health authorities.

This item comprises glasses and other vision products, orthopaedic appliances & other prosthetics, hearing aids, medico-technical devices including wheelchairs and all other miscellaneous medical durables not elsewhere classified such as blood pressure instruments.

CODE 505 Health related care – Health administration

Administrative services which cannot be allocated to a specific health good and service. Those unallocatable services might include, for example, maintaining an office of the Chief Medical Officer; a Departmental liaison officer in the office of the Minister; or a number of other agency-wide items for which it is not possible to derive appropriate or meaningful allocations to particular health programs.

CODE 506 Health related care – Health research

Includes all research on health topics that is not included in public health research (code 410). That is, it includes all research classified under ABS Australian Standard Research Classification code 320000, excluding code 321200.

Excludes public health research and non-health related research.

CODE 588 Health related care – Other

Includes for example, services provided by health and health-related call centres and e-health information services.

Excludes health related care reported under codes 501 to 506 and health assessments provided under the Aged Care Assessment Program which are reported under code 602.

CODE 599 Health related care – Not further defined

Comprises health related care that could be a combination of categories 501 to 506 but which could not be further disaggregated.

State and territory health authorities are only to report health related care under codes 501 to 506.

CODE 601 Other function – Home and community care

This item is not currently required to be reported by state and territory health authorities.

Comprises Home and Community Care services reported under the HACC NMDS.

Information on these service categories is available in the following report:

National classifications of community services. Version 2.0. AIHW Cat. No. HWI 40. Canberra: Australian Institute of Health and Welfare, 2003.

Excludes services reported under codes 602 to 604.

CODE 602 Other function – Aged care

This item is not currently required to be reported by state and territory health authorities.

Includes residential care aged care programs, aged care assessment programs and other non-health aged care programs, such as respite care and day care activities.

Excludes services provided under the HACC program.

CODE 603 Other function – Other welfare

This item is not currently required to be reported by state and territory health authorities.

Includes services delivered to clients, or groups of clients with special needs such as the young or the disabled. Excludes aged care services reported under code 602.

CODE 688 Other function – Other

This item is not currently required to be reported by state and territory health authorities. Includes for example, car parking, accommodation for staff or for patients' relatives, or non-health related research.

CODE 699 Other function – Not further defined

This item is not currently required to be reported by state and territory health authorities.

Comprises other functions that could be a combination of categories 601 to 603 but which could not be further disaggregated.

Source and reference attributes

Submitting organisation:

Health Expenditure Advisory Committee

Reference documents:

Australian Bureau of Statistics 1998. Australian Standard Research Classification. Cat. no. 1297.0. Canberra: ABS.

Australian Government Department of Health and Ageing Medicare Benefits Schedule Book, 1 November 2006 available from <http://www.health.gov.au/mbsonline>

Australian Institute of Health and Welfare 2003. National classifications of community services. Version 2.0. AIHW cat. no. HWI 40. Canberra: AIHW.

Australian Institute of Health and Welfare 2007. National public health expenditure report 2004–05. Health and welfare series expenditure series no. 29. cat. no. HWE 36. Canberra: AIHW.

Data element attributes

Relational attributes

Implementation in Data Set Specifications:

[Government health expenditure function revenue data cluster](#) Health, Superseded 03/12/2008

[Government health expenditure function revenue data element cluster](#) Health, Standard 03/12/2008

[Government health expenditure organisation expenditure capital consumption data element cluster](#) Health, Superseded 01/04/2009

[Government health expenditure organisation expenditure capital consumption data element cluster](#) Health, Standard 01/04/2009

[Government health expenditure organisation expenditure data cluster](#) Health, Superseded 03/12/2008

[Government health expenditure organisation expenditure data element cluster](#) Health, Superseded 01/04/2009

[Government health expenditure organisation expenditure data element cluster](#) Health, Standard 01/04/2009

[Government health expenditure organisation expenditure](#)

[employee related data element cluster](#) Health, Superseded
01/04/2009

[Government health expenditure organisation expenditure
employee related data element cluster](#) Health, Standard
01/04/2009

[Government health expenditure organisation expenditure
purchase of goods and services data element cluster](#) Health,
Superseded 01/04/2009

[Government health expenditure organisation expenditure
purchase of goods and services data element cluster](#) Health,
Standard 01/04/2009

Type of labour induction

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Birth event – labour induction type, code N
<i>METeOR identifier:</i>	270037
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Method used to induce labour, as represented by a code.
Data Element Concept:	Birth event – labour induction type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>0</td><td>None</td></tr><tr><td>1</td><td>Oxytocin</td></tr><tr><td>2</td><td>Prostaglandins</td></tr><tr><td>3</td><td>Artificial rupture of membranes (ARM)</td></tr><tr><td>4</td><td>Other</td></tr></tbody></table>	Value	Meaning	0	None	1	Oxytocin	2	Prostaglandins	3	Artificial rupture of membranes (ARM)	4	Other
Value	Meaning												
0	None												
1	Oxytocin												
2	Prostaglandins												
3	Artificial rupture of membranes (ARM)												
4	Other												

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	More than one method of induction can be recorded, except where 0=none applies.
<i>Comments:</i>	Type of induction determines the progress and duration of labour and may influence the method of delivery and the health status of the baby at birth.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Type of labour induction, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
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Type of usual accommodation

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – accommodation type (prior to admission), code N
<i>METeOR identifier:</i>	270079
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of physical accommodation the person lived in prior to admission .
<i>Context:</i>	Admitted patient mental health care: Permits analysis of the prior residential accommodation type of people admitted to residential aged care services or other institutional care.
Data Element Concept:	Person – accommodation type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>House or flat</td></tr><tr><td>2</td><td>Independent unit as part of retirement village or similar</td></tr><tr><td>3</td><td>Hostel or hostel type accommodation</td></tr><tr><td>4</td><td>Psychiatric hospital</td></tr><tr><td>5</td><td>Acute hospital</td></tr><tr><td>6</td><td>Other accommodation</td></tr><tr><td>7</td><td>No usual residence</td></tr></tbody></table>	Value	Meaning	1	House or flat	2	Independent unit as part of retirement village or similar	3	Hostel or hostel type accommodation	4	Psychiatric hospital	5	Acute hospital	6	Other accommodation	7	No usual residence
Value	Meaning																
1	House or flat																
2	Independent unit as part of retirement village or similar																
3	Hostel or hostel type accommodation																
4	Psychiatric hospital																
5	Acute hospital																
6	Other accommodation																
7	No usual residence																

Collection and usage attributes

<i>Collection methods:</i>	The above classifications have been based on Question 16 of Form NH5. The Australian Government Department of Health and Aged Care has introduced a new Aged Care Application and Approval form which replaces the NH5.
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Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	This metadata item is not available for New South Wales State nursing homes. As this item includes only details of physical
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accommodation before admission it was decided to have details of the relational basis of accommodation before admission collected as a separate metadata item (see metadata item Admission mode).

Source and reference attributes

Submitting organisation: National minimum data set working parties

Relational attributes

Related metadata references: Supersedes [Type of usual accommodation, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.1 KB)

Implementation in Data Set Specifications: [Admitted patient mental health care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient mental health care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient mental health care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient mental health care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient mental health care NMDS 2009-2010](#) Health, Superseded 05/01/2010

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient mental health care NMDS 2010-2011](#) Health, Standard 05/01/2010

Implementation start date: 01/07/2010

Type of visit to emergency department

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Non-admitted patient emergency department service episode – type of visit to emergency department, code N
<i>METeOR identifier:</i>	270362
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The reason the patient presents to an emergency department, as represented by a code.
Data Element Concept:	Non-admitted patient emergency department service episode – type of visit to emergency department

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Emergency presentation: attendance for an actual or suspected condition which is sufficiently serious to require acute unscheduled care.</td></tr><tr><td>2</td><td>Return visit, planned: presentation is planned and is a result of a previous emergency department presentation or return visit.</td></tr><tr><td>3</td><td>Pre-arranged admission: a patient who presents at the emergency department for either clerical, nursing or medical processes to be undertaken, and admission has been pre-arranged by the referring medical officer and a bed allocated.</td></tr><tr><td>4</td><td>Patient in transit: the emergency department is responsible for care and treatment of a patient awaiting transport to another facility.</td></tr><tr><td>5</td><td>Dead on arrival: a patient who is dead on arrival at the emergency department.</td></tr></tbody></table>	Value	Meaning	1	Emergency presentation: attendance for an actual or suspected condition which is sufficiently serious to require acute unscheduled care.	2	Return visit, planned: presentation is planned and is a result of a previous emergency department presentation or return visit.	3	Pre-arranged admission: a patient who presents at the emergency department for either clerical, nursing or medical processes to be undertaken, and admission has been pre-arranged by the referring medical officer and a bed allocated.	4	Patient in transit: the emergency department is responsible for care and treatment of a patient awaiting transport to another facility.	5	Dead on arrival: a patient who is dead on arrival at the emergency department.
Value	Meaning												
1	Emergency presentation: attendance for an actual or suspected condition which is sufficiently serious to require acute unscheduled care.												
2	Return visit, planned: presentation is planned and is a result of a previous emergency department presentation or return visit.												
3	Pre-arranged admission: a patient who presents at the emergency department for either clerical, nursing or medical processes to be undertaken, and admission has been pre-arranged by the referring medical officer and a bed allocated.												
4	Patient in transit: the emergency department is responsible for care and treatment of a patient awaiting transport to another facility.												
5	Dead on arrival: a patient who is dead on arrival at the emergency department.												

Data element attributes

Collection and usage attributes

Comments: Required for analysis of emergency department services.

Source and reference attributes

Submitting organisation: National Institution Based Ambulatory Model Reference Group
Origin: National Health Data Committee

Relational attributes

Related metadata references:

Implementation in Data Set Specifications:

Supersedes [Type of visit to emergency department, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.6 KB)

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 24/03/2006

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Non-admitted patient emergency department care NMDS](#) Health, Superseded 07/12/2005

[Non-admitted patient emergency department care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Non-admitted patient emergency department care NMDS 2008-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2010

[Non-admitted patient emergency department care NMDS 2010-2011](#) Health, Standard 22/12/2009

Implementation start date: 01/07/2010

Underlying cause of death

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – underlying cause of death, code (ICD-10 2nd edn) ANN-ANN
<i>Synonymous names:</i>	UCOD code
<i>METeOR identifier:</i>	307931
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The disease or injury which initiated the train of morbid events leading directly to a person's death or the circumstances of the accident or violence which produced the fatal injury, as represented by a code. (WHO 2004)
Data Element Concept:	Person – underlying cause of death

Value domain attributes

Representational attributes

<i>Classification scheme:</i>	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, (2nd edition)
<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	ANN-ANN
<i>Maximum character length:</i>	6

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Underlying cause of death is central to mortality coding and comparable international mortality reporting.
<i>Comments:</i>	<p>The Australian Bureau of Statistics (ABS) codes and classifies the underlying cause of death (UCOD) according to the rules and guidelines for mortality coding adopted by the World Health Assembly and set out in the World Health Organisation's International Classification of Diseases and Related Health Problems (ICD).</p> <p>The ABS uses the Mortality Medical Data System (MMDS) to process and code cause-of-death information reported on death certificates.</p>

Source and reference attributes

<i>Submitting organisation:</i>	Australian Bureau of Statistics
<i>Origin:</i>	Australian Bureau of Statistics 2004. Information Paper: Cause of death certification. Catalogue no. 1205.0.55.001 . Canberra: Australian Bureau of Statistics. Viewed 31 August 2005. National Center for Health Statistics 2005. About the Mortality

Medical Data System. [U.S. Department of Health and Human Services, Centers for Disease Control and Prevention](#). Viewed 31 August 2005.

World Health Organisation 2004. The International statistical classification of diseases and related health problems, tenth revision, (2nd edn). Geneva: World Health Organisation.

Reference documents:

Australian Bureau of Statistics 2004. [Information Paper: Cause of death certification. Catalogue no. 1205.0.55.001](#). Canberra: Australian Bureau of Statistics. Viewed 31 August 2005.

World Health Organisation 2004. The International statistical classification of diseases and related health problems, tenth revision, (2nd edn). Geneva: World Health Organisation.

Relational attributes

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Conditional obligation:

If a date of death is recorded, the cause of death must also be recorded. These data are recorded regardless of the cause of death.

Urgency of admission

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Episode of admitted patient care – admission urgency status, code N
<i>METeOR identifier:</i>	269986
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether the admission has an urgency status assigned and, if so, whether admission occurred on an emergency basis, as represented by a code.
Data Element Concept:	Episode of admitted patient care – admission urgency status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Urgency status assigned - emergency</td></tr><tr><td>2</td><td>Urgency status assigned - elective</td></tr><tr><td>3</td><td>Urgency status not assigned</td></tr></tbody></table>	Value	Meaning	1	Urgency status assigned - emergency	2	Urgency status assigned - elective	3	Urgency status not assigned
Value	Meaning								
1	Urgency status assigned - emergency								
2	Urgency status assigned - elective								
3	Urgency status not assigned								
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not known/not reported</td></tr></tbody></table>	9	Not known/not reported						
9	Not known/not reported								

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Urgency status assigned - emergency</p> <p>Emergency admission:</p> <p>The following guidelines may be used by health professionals, hospitals and health insurers in determining whether an emergency admission has occurred. These guidelines should not be considered definitive.</p> <p>An emergency admission occurs if one or more of the following clinical conditions are applicable such that the patient required admission within 24 hours.</p> <p>Such a patient would be:</p> <ul style="list-style-type: none">• at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation; or• suffering from suspected acute organ or system failure; or• suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
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- suffering from a drug overdose, toxic substance or toxin effect; or
- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- suffering acute significant haemorrhage and requiring urgent assessment and treatment; or
- suffering gynaecological or obstetric complications; or
- suffering an acute condition which represents a significant threat to the patient's physical or psychological wellbeing; or
- suffering a condition which represents a significant threat to public health.

If an admission meets the definition of emergency above, it is categorised as emergency, regardless of whether the admission occurred within 24 hours of such a categorisation being made, or after 24 hours or more.

CODE 2 Urgency status assigned - Elective

Elective admissions:

If an admission meets the definition of elective above, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission could be delayed by at least 24 hours.

Scheduled admissions:

A patient who expects to have an elective admission will often have that admission scheduled in advance. Whether or not the admission has been scheduled does not affect the categorisation of the admission as emergency or elective, which depends only on whether it meets the definitions above. That is, patients both with and without a scheduled admission can be admitted on either an emergency or elective basis.

Admissions from elective surgery waiting lists:

Patients on waiting lists for elective surgery are assigned a Clinical urgency status which indicates the clinical assessment of the urgency with which a patient requires elective hospital care. On admission, they will also be assigned an urgency of admission category, which may or may not be elective:

- Patients who are removed from elective surgery waiting lists on admission as an elective patient for the procedure for which they were waiting (see code 1 in metadata item Reason for removal from an elective surgery waiting list code N) will be assigned an Admission urgency status code N code of 2. In that case, their clinical urgency category could be regarded as further detail on how urgent their admission was.
- Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting (see code 2 in metadata item Reason for removal from an elective surgery waiting list code N), will be assigned an Admission urgency status code N code of 1.

CODE 3 Urgency status not assigned

Admissions for which an urgency status is usually not assigned are:

- admissions for normal delivery (obstetric)
- admissions which begin with the birth of the patient, or when it was intended that the birth occur in the hospital, commence shortly after the birth of the patient
- statistical admissions
- planned readmissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.

An urgency status can be assigned for admissions of the types listed above for which an urgency status is not usually assigned. For example, a patient who is to have an obstetric admission may have one or more of the clinical conditions listed above and be admitted on an emergency basis.

CODE 9 Not known/not reported

This code is used when it is not known whether or not an urgency status has been assigned, or when an urgency status has been assigned but is not known.

Source and reference attributes

Submitting organisation:

Emergency definition working party

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Urgency of admission, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (21.4 KB)

Implementation in Data Set Specifications:

[Admitted patient care NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2005

Implementation end date: 30/06/2006

[Admitted patient care NMDS 2006-2007](#) Health, Superseded 23/10/2006

Implementation start date: 01/07/2006

Implementation end date: 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded 05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded 04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded 22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

Vascular history

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – vascular condition status (history), code NN
<i>METeOR identifier:</i>	269958
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether the person has had a history of vascular conditions, as represented by a code.
<i>Context:</i>	<p>The vascular history of the patient is important as an element in defining future risk for a cardiovascular event and as a factor in determining best practice management for various cardiovascular risk factor(s).</p> <p>It may be used to map vascular conditions, assist in risk stratification and link to best practice management.</p>
Data Element Concept:	Person – vascular condition status

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																		
<i>Data type:</i>	String																																		
<i>Format:</i>	NN																																		
<i>Maximum character length:</i>	2																																		
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Myocardial infarction</td></tr><tr><td>02</td><td>Unstable angina pectoris</td></tr><tr><td>03</td><td>Angina</td></tr><tr><td>04</td><td>Heart failure</td></tr><tr><td>05</td><td>Atrial fibrillation</td></tr><tr><td>06</td><td>Other dysrhythmia or conductive disorder</td></tr><tr><td>07</td><td>Rheumatic heart disease</td></tr><tr><td>08</td><td>Non-rheumatic valvular heart disease</td></tr><tr><td>09</td><td>Left ventricular hypertrophy</td></tr><tr><td>10</td><td>Stroke</td></tr><tr><td>11</td><td>Transient ischaemic attack</td></tr><tr><td>12</td><td>Hypertension</td></tr><tr><td>13</td><td>Peripheral vascular disease (includes abdominal aortic aneurism)</td></tr><tr><td>14</td><td>Deep vein thrombosis</td></tr><tr><td>15</td><td>Other atherosclerotic disease</td></tr><tr><td>16</td><td>Carotid stenosis</td></tr></tbody></table>	Value	Meaning	01	Myocardial infarction	02	Unstable angina pectoris	03	Angina	04	Heart failure	05	Atrial fibrillation	06	Other dysrhythmia or conductive disorder	07	Rheumatic heart disease	08	Non-rheumatic valvular heart disease	09	Left ventricular hypertrophy	10	Stroke	11	Transient ischaemic attack	12	Hypertension	13	Peripheral vascular disease (includes abdominal aortic aneurism)	14	Deep vein thrombosis	15	Other atherosclerotic disease	16	Carotid stenosis
Value	Meaning																																		
01	Myocardial infarction																																		
02	Unstable angina pectoris																																		
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04	Heart failure																																		
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06	Other dysrhythmia or conductive disorder																																		
07	Rheumatic heart disease																																		
08	Non-rheumatic valvular heart disease																																		
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11	Transient ischaemic attack																																		
12	Hypertension																																		
13	Peripheral vascular disease (includes abdominal aortic aneurism)																																		
14	Deep vein thrombosis																																		
15	Other atherosclerotic disease																																		
16	Carotid stenosis																																		

	17	Vascular renal disease
	18	Vascular retinopathy (hypertensive)
	19	Vascular retinopathy (diabetic)
	97	Other vascular
	98	No vascular history
<i>Supplementary values:</i>	99	Unknown/not stated / not specified

Collection and usage attributes

Comments: Can be mapped to the current version of ICD-10-AM.

Source and reference attributes

Origin: International Classification of Diseases - Tenth Revision - Australian Modification (3rd Edition 2000), National Centre for Classification in Health, Sydney

Data element attributes

Collection and usage attributes

Guide for use: More than one code can be recorded.

Collection methods: Ideally, vascular history information is derived from and substantiated by clinical documentation.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group

Origin: National Centre for Classification in Health

National Data Standards for Injury Surveillance Advisory Group

Relational attributes

Related metadata references: Supersedes [Vascular history, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.8 KB)

Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 01/10/2008

[Acute coronary syndrome \(clinical\) DSS](#) Health, Superseded 07/12/2005

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Vascular procedures

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – vascular procedures (history), code NN
<i>METeOR identifier:</i>	269962
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The vascular procedures the person has undergone, as represented by a code.
Data Element Concept:	Person – vascular procedure

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																			
<i>Data type:</i>	String																																			
<i>Format:</i>	NN																																			
<i>Maximum character length:</i>	2																																			
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>Amputation for arterial vascular insufficiency</td></tr><tr><td>02</td><td>Carotid endarterectomy</td></tr><tr><td>03</td><td>Carotid angioplasty/stenting</td></tr><tr><td>04</td><td>Coronary angioplasty/stenting</td></tr><tr><td>05</td><td>Coronary artery bypass grafting</td></tr><tr><td>06</td><td>Renal artery angioplasty/stenting</td></tr><tr><td>07</td><td>Heart transplant</td></tr><tr><td>08</td><td>Heart valve surgery</td></tr><tr><td>09</td><td>Abdominal aortic aneurism repair/bypass graft/stenting</td></tr><tr><td>10</td><td>Cerebral circulation angioplasty/stenting</td></tr><tr><td>11</td><td>Femoral/popliteal bypass/graft/stenting</td></tr><tr><td>12</td><td>Congenital heart and blood vessel defect surgery</td></tr><tr><td>13</td><td>Permanent pacemaker implantation</td></tr><tr><td>14</td><td>Implantable cardiac defibrillator</td></tr><tr><td>98</td><td>Other</td></tr><tr><td><i>Supplementary values:</i></td><td>99</td><td>Unknown/not recorded</td></tr></tbody></table>	Value	Meaning	01	Amputation for arterial vascular insufficiency	02	Carotid endarterectomy	03	Carotid angioplasty/stenting	04	Coronary angioplasty/stenting	05	Coronary artery bypass grafting	06	Renal artery angioplasty/stenting	07	Heart transplant	08	Heart valve surgery	09	Abdominal aortic aneurism repair/bypass graft/stenting	10	Cerebral circulation angioplasty/stenting	11	Femoral/popliteal bypass/graft/stenting	12	Congenital heart and blood vessel defect surgery	13	Permanent pacemaker implantation	14	Implantable cardiac defibrillator	98	Other	<i>Supplementary values:</i>	99	Unknown/not recorded
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98	Other																																			
<i>Supplementary values:</i>	99	Unknown/not recorded																																		

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Ideally, Vascular procedure information is derived from and substantiated by clinical documentation.
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Comments: In settings where the monitoring of a person's health is ongoing and where a history can change over time (such as general practice), the Service contact – service contact date, DDMMYYYY should be recorded.

Source and reference attributes

Submitting organisation: Cardiovascular Data Working Group
Origin: Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases - Australian facts 2001. AIHW Cat. No. CVD 13. Canberra: AIHW, National Heart foundation of Australia, National Stroke Foundation of Australia (CVD Series No. 14)

Relational attributes

Related metadata references: Supersedes [Vascular procedures, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (16.5 KB)
Implementation in Data Set Specifications: [Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006
[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007
[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009
[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

Ventricular ejection fraction measurement indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – ventricular ejection fraction test performed indicator, yes/no code N
<i>Synonymous names:</i>	EF measurement indicator
<i>METeOR identifier:</i>	347672
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An indicator of whether a person’s ventricular ejection fraction was measured, as represented by a code.
Data Element Concept:	Person – ventricular ejection fraction test performed indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						
<i>Supplementary values:</i>	<table><tbody><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	9	Not stated/inadequately described				
9	Not stated/inadequately described						

Collection and usage attributes

<i>Guide for use:</i>	CODE 9 Not stated/inadequately described This code is not for use in primary data collections.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Code 1 Yes Record if a test was performed to measure the person’s ventricular ejection fraction. Code 2 No Record if no test was performed to measure the person’s ventricular ejection fraction.
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Relational attributes

<i>Related metadata references:</i>	See also Ventricular ejection fraction test – test type, code N Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Ventricular ejection fraction cluster Health, Standard 01/10/2008

Ventricular ejection fraction test result (percentage)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Ventricular ejection fraction—test result, percentage N[N].N
<i>Synonymous names:</i>	EF result (percentage)
<i>METeOR identifier:</i>	347002
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A person's ventricular ejection fraction result expressed as a percentage.
Data Element Concept:	Ventricular ejection fraction—test result

Value domain attributes

Representational attributes

<i>Representation class:</i>	Percentage	
<i>Data type:</i>	Number	
<i>Format:</i>	N[N].N	
<i>Maximum character length:</i>	3	
<i>Supplementary values:</i>	Value	Meaning
	99.9	Not stated/inadequately described

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	The person's ejection fraction result recorded should be between 0 and 80%.
<i>Comments:</i>	The patient is not alive or is in Pulseless Electrical Activity (PEA) if the result is 0%.

Relational attributes

<i>Related metadata references:</i>	See also Ventricular ejection fraction—test result, code N Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Ventricular ejection fraction cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> To be provided when the ventricular ejection fraction is measured.

Ventricular ejection fraction test result (code)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Ventricular ejection fraction—test result, code N
<i>Synonymous names:</i>	EF result (code)
<i>METeOR identifier:</i>	346993
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The person's ventricular ejection fraction result, as represented by a code.
Data Element Concept:	Ventricular ejection fraction—test result

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Normal</td></tr><tr><td>2</td><td>Mild</td></tr><tr><td>3</td><td>Moderate</td></tr><tr><td>4</td><td>Severe</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Normal	2	Mild	3	Moderate	4	Severe	9	Not stated/inadequately described
Value	Meaning												
1	Normal												
2	Mild												
3	Moderate												
4	Severe												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Collection and usage attributes

<i>Guide for use:</i>	CODE 1 Normal Use this code when the ejection fraction is greater than 50%
	CODE 2 Mild Use this code when the ejection fraction is greater than or equal to 45% but less than or equal to 50%
	CODE 3 Moderate Use this code when the ejection fraction is greater than or equal to 35% but less than 45%
	CODE 4 Severe Use this code when the ejection fraction is less than 35%
	CODE 9 Not stated/inadequately described Not for use in primary data collections.

Data element attributes

Relational attributes

Related metadata references:

See also [Ventricular ejection fraction – test result, percentage N\[N\].N](#) Health, Standard 01/10/2008

Implementation in Data Set Specifications:

[Ventricular ejection fraction cluster](#) Health, Standard 01/10/2008

Conditional obligation:

To be provided when the ventricular ejection fraction is measured.

Ventricular ejection fraction test type

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Ventricular ejection fraction test – test type, code N
<i>Synonymous names:</i>	EF measurement test
<i>METeOR identifier:</i>	344253
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of test used to measure a person's ventricular ejection fraction, as represented by a code.
Data Element Concept:	Ventricular ejection fraction test – test type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Echocardiography</td></tr><tr><td>2</td><td>Angiography</td></tr><tr><td>3</td><td>Gated blood pool scan</td></tr><tr><td>4</td><td>Magnetic resonance imaging (MRI)</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Echocardiography	2	Angiography	3	Gated blood pool scan	4	Magnetic resonance imaging (MRI)	9	Not stated/inadequately described
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1	Echocardiography												
2	Angiography												
3	Gated blood pool scan												
4	Magnetic resonance imaging (MRI)												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

Data element attributes

Relational attributes

<i>Related metadata references:</i>	See also Person – ventricular ejection fraction test performed indicator, yes/no code N Health, Standard 01/10/2008
<i>Implementation in Data Set Specifications:</i>	Ventricular ejection fraction cluster Health, Standard 01/10/2008 <i>Conditional obligation:</i> To be provided when the ventricular ejection fraction is measured.

Visa type—health professional

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—visa type, code AANNN
<i>METeOR identifier:</i>	381681
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The category of visa (or travel authority) granted by Australia for foreign nationals (excluding New Zealand citizens) who are registered as health professionals in Australia, to travel to, enter and remain in Australia, as represented by a code.
Data Element Concept:	Registered health professional—visa type

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	AANNN
<i>Maximum character length:</i>	5

Collection and usage attributes

<i>Guide for use:</i>	Includes all 2-digit alphabetical classes and 3-digit numeric subclasses as described in the Migration Regulations 1994 of the Migration Act 1958.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Further information regarding visas can be obtained from the Australian Department of Immigration and Citizenship or visit their website www.immi.gov.au
<i>Reference documents:</i>	The Migration Regulations 1994 of the Migration Act 1958 .

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A visa (or travel authority) is permission or authority granted by Australia for foreign nationals to travel to, enter and remain in Australia. Immigration law requires all travellers who are not Australian citizens to obtain authority, in the form of a visa or travel authority, to travel to, and stay in Australia.</p> <p>A temporary visa is the permission or authority granted by the Australian government for foreign nationals to travel to and enter Australia, and stay up to a specified period of time.</p> <p>A permanent visa is the permission or authority granted by the Australian government for foreign nationals to live in Australia permanently.</p>
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All applicants must meet the English language requirements based on their nominated occupation.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Further information regarding visas can be obtained from the Australian Department of Immigration and Citizenship or visit their website www.immi.gov.au
<i>Reference documents:</i>	Registered Health labour force NMDS 2010-2011

Relational attributes

<i>Implementation in Data Set Specifications:</i>	Registered chiropractic labour force DSS Health, Standard 10/12/2009
	Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009
	Registered medical professional labour force DSS Health, Standard 10/12/2009
	Registered midwifery labour force DSS Health, Standard 10/12/2009
	Registered nursing professional labour force DSS Health, Standard 10/12/2009
	Registered optometry labour force DSS Health, Standard 10/12/2009
	Registered osteopathy labour force DSS Health, Standard 10/12/2009
	Registered pharmacy labour force DSS Health, Standard 10/12/2009
	Registered physiotherapy labour force DSS Health, Standard 10/12/2009
	Registered podiatry labour force DSS Health, Standard 10/12/2009
	Registered psychology labour force DSS Health, Standard 10/12/2009

Visual acuity (left eye)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – visual acuity (left eye), code NN
<i>METeOR identifier:</i>	269963
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's left eye visual acuity, as represented by a code.
Data Element Concept:	Person – visual acuity

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																														
<i>Data type:</i>	String																														
<i>Format:</i>	NN																														
<i>Maximum character length:</i>	2																														
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>01</td><td>6/5</td></tr><tr><td>02</td><td>6/6</td></tr><tr><td>03</td><td>6/9</td></tr><tr><td>04</td><td>6/12</td></tr><tr><td>05</td><td>6/18</td></tr><tr><td>06</td><td>6/24</td></tr><tr><td>07</td><td>6/36</td></tr><tr><td>08</td><td>6/60</td></tr><tr><td>09</td><td>CF (count fingers)</td></tr><tr><td>10</td><td>HM (hand movement)</td></tr><tr><td>11</td><td>PL (perceive light)</td></tr><tr><td>12</td><td>BL (blind)</td></tr><tr><td>13</td><td>6/7.5</td></tr><tr><td>99</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	01	6/5	02	6/6	03	6/9	04	6/12	05	6/18	06	6/24	07	6/36	08	6/60	09	CF (count fingers)	10	HM (hand movement)	11	PL (perceive light)	12	BL (blind)	13	6/7.5	99	Not stated/inadequately described
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<i>Supplementary values:</i>																															

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record actual result for both right and left eyes: <ul style="list-style-type: none">• 1st field: Right eye• 2nd field: Left eye. Test wearing distance glasses if prescribed. Use pinhole if vision less than 6/6.
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Collection methods:

One of the most often utilised tests for visual acuity uses the Snellen chart.

- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.
- Both eyes are to be opened and then cover one eye with the ocular occluder.
- The observer has to read out the smallest line of letters that he/she can see from the chart.
- This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

- within five years of **diagnosis** and then every 1-2 years for patients whose diabetes onset was at age under 30 years
- at diagnosis and then every 1-2 years for patients whose diabetes onset was at age 30 years or more.

Source and reference attributes

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Reference documents:

Vision Australia, No 2, 1997/8; University of Melbourne

World Health Organization

US National Library of Medicine

Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Relational attributes

Related metadata references:

Supersedes [Visual acuity, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.3 KB)

See also [Person – visual acuity \(right eye\), code NN](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Visual acuity (right eye)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – visual acuity (right eye), code NN
<i>METeOR identifier:</i>	270381
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's right eye visual acuity, as represented by a code.
Data Element Concept:	Person – visual acuity

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																														
<i>Data type:</i>	String																														
<i>Format:</i>	NN																														
<i>Maximum character length:</i>	2																														
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record actual result for both right and left eyes: <ul style="list-style-type: none">• 1st field: Right eye• 2nd field: Left eye. Test wearing distance glasses if prescribed. Use pinhole if vision less than 6/6.
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Collection methods:

One of the most often utilised tests for visual acuity uses the Snellen chart.

- At a distance of 6 metres all subjects should be able to read the 6/6 line with each eye using the proper refractive correction.
- Both eyes are to be opened and then cover one eye with the ocular occluder.
- The observer has to read out the smallest line of letters that he/she can see from the chart.
- This is to be repeated with the other eye.

Eye examination should be performed by an ophthalmologist or a suitably trained clinician:

- within five years of **diagnosis** and then every 1-2 years for patients whose diabetes onset was at age under 30 years
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Source and reference attributes

Origin:

National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

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Diabetes Control and Complications Trial: DCCT New England Journal of Medicine, 329(14), September 30, 1993

Principles of Care and Guidelines for the Clinical Management of Diabetes Mellitus

Relational attributes

Related metadata references:

See also [Person – visual acuity \(left eye\), code NN](#) Health, Standard 01/03/2005

Supersedes [Visual acuity, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.3 KB)

Implementation in Data Set Specifications:

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Waist circumference (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – waist circumference (measured), total centimetres NN[N].N
<i>METeOR identifier:</i>	270129
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person's waist circumference measured in centimetres.
<i>Data Element Concept:</i>	Person – waist circumference

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	NN[N].N				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999.9</td><td>Not measured</td></tr></tbody></table>	Value	Meaning	999.9	Not measured
Value	Meaning				
999.9	Not measured				
<i>Unit of measure:</i>	Centimetre (cm)				

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity, and without drawing attention to an individual's weight.</p> <p>The measurement protocol described below is that recommended by the World Health Organization (WHO Expert Committee 1995) which was adapted from Lohman et al. (1988) and the International Society for the Advancement of Kinanthropometry as described by Norton et al. (1996).</p> <p>In order to ensure consistency in measurement, the following measurement protocol should be used.</p> <p>Measurement protocol:</p> <p>The measurement of waist circumference requires a narrow (7 mm wide), flexible, inelastic tape measure. The kind of tape used should be described and reported. The graduations on the tape measure should be at 0.1 cm intervals and the tape should have the capacity to measure up to 200 cm. Measurement intervals and labels should be clearly readable under all conditions of use of the tape measure.</p> <p>The subject should remove any belts and heavy outer clothing.</p>
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Measurement of waist circumference should be taken over at most one layer of light clothing. Ideally the measure is made directly over the skin.

The subject stands comfortably with weight evenly distributed on both feet, and the feet separated about 25-30 cm. The arms should hang loosely at the sides. Posture can affect waist circumference. The measurement is taken midway between the inferior margin of the last rib and the crest of the ilium, in the mid-axillary plane. Each landmark should be palpated and marked, and the midpoint determined with a tape measure and marked.

The circumference is measured with an inelastic tape maintained in a horizontal plane, at the end of normal expiration. The tape is snug, but does not compress underlying soft tissues. The measurer is positioned by the side of the subject to read the tape. To ensure contiguity of the two parts of the tape from which the circumference is to be determined, the cross-handed technique of measurement, as described by Norton et al. (1996), should be used. Ideally an assistant will check the position of the tape on the opposite side of the subject's body.

The measurement is recorded at the end of a normal expiration to the nearest 0.1 cm. Take a repeat measurement and record it to the nearest 0.1 cm. If the two measurements disagree by more than 1 cm, take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured waist circumference is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 cm. If so, rounding should be to the nearest even digit to reduce systematic over-reporting (Armitage & Berry 1994). For example, a mean value of 72.25 cm would be rounded to 72.2 cm, while a mean value of 72.35 cm would be rounded to 72.4 cm.

Validation and quality control measures:

Steel tapes should be checked against a 1 metre engineer's rule every 12 months. If tapes other than steel are used they should be checked daily against a steel rule.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement (Pederson & Gore 1996) between observers should not exceed 2% and be less than 1.5% within observers.

Extreme values at the lower and upper end of the distribution of measured waist circumference should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Comments:

Last-digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

This metadata item is recommended for use in population surveys and health care settings.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For reporting purposes, it may be desirable to present waist circumference in categories. It is recommended that 5-cm groupings are used for this purpose. Waist circumference should not be rounded before categorisation. The following categories may be appropriate for describing the waist circumferences of Australian men, women children and adolescents, although the range will depend on the population.

Waist

35 cm = Waist

40 cm = Waist

... in 5 cm categories

105 cm = Waist

Waist => 110 cm

Source and reference attributes

Submitting organisation:

World Health Organization International Society for the Advancement of Kinanthropometry

Relational attributes

Related metadata references:

Supersedes [Waist circumference - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (26.0 KB)

Is used in the formation of [Adult – waist-to-hip ratio, N.NN](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded
22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard
22/12/2009

Waist circumference risk indicator—adults

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Adult – waist circumference risk indicator, Caucasian adult code N
<i>METeOR identifier:</i>	270205
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The sex specific category of risk of metabolic complications associated with excess abdominal adiposity in adult Caucasians, as represented by a code.
<i>Data Element Concept:</i>	Adult – waist circumference risk indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Not at risk (male waist circumference less than 94 cm, female waist circumference less than 80 cm)</td></tr><tr><td>2</td><td>Increased (male waist circumference \geq 94 cm, female waist circumference \geq 80 cm)</td></tr><tr><td>3</td><td>Substantially increased (male waist circumference \geq 102 cm, female waist circumference \geq 88 cm)</td></tr><tr><td>9</td><td>Not stated/inadequately described</td></tr></tbody></table>	Value	Meaning	1	Not at risk (male waist circumference less than 94 cm, female waist circumference less than 80 cm)	2	Increased (male waist circumference \geq 94 cm, female waist circumference \geq 80 cm)	3	Substantially increased (male waist circumference \geq 102 cm, female waist circumference \geq 88 cm)	9	Not stated/inadequately described
Value	Meaning										
1	Not at risk (male waist circumference less than 94 cm, female waist circumference less than 80 cm)										
2	Increased (male waist circumference \geq 94 cm, female waist circumference \geq 80 cm)										
3	Substantially increased (male waist circumference \geq 102 cm, female waist circumference \geq 88 cm)										
9	Not stated/inadequately described										
<i>Supplementary values:</i>											

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	This metadata item cannot be determined if waist circumference measured has not been collected (i.e. is coded to 999.9) and/or sex is not stated (i.e. coded to 9). This metadata item applies to persons aged 18 years or older.
<i>Collection methods:</i>	This metadata item should be derived after the data entry of waist circumference measured. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.
<i>Comments:</i>	This metadata item is recommended for use in population surveys and health care settings. Recent evidence suggests that waist circumference may provide a more practical correlate of abdominal fat distribution and associated ill health.

The identification of risk using waist circumference is population-specific and will depend on levels of obesity and other risk factors for cardiovascular disease and non-insulin dependent diabetes mellitus.

Populations differ in the level of risk associated with a particular waist circumference, so that globally applicable cut-off points cannot be developed. For example, complications associated with abdominal fat in black women and those of South Asian descent are markedly higher for a given level of BMI than in Europeans. Also, although women have almost the same absolute risk of coronary heart disease as men at the same WHR, they show increases in relative risk of coronary heart disease at lower waist circumferences than men. Thus, there is a need to develop sex-specific waist circumference cut-off points appropriate for different populations. Hence, the cut-off points used for this metadata item are associated with obesity in Caucasians. This issue is being investigated further.

Cut-off points for children and adolescents are also being developed. Research shows that a high childhood BMI and high trunk skin fold values are predictive of abdominal obesity as an adult and waist circumference measures in childhood track well into adulthood.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

National health metadata item currently exist for sex, date of birth, country of birth and Indigenous status and smoking. Metadata items are being developed for physical activity.

Source and reference attributes

Origin:

World Health Organization

Reference documents:

Obesity: Preventing and Managing the Global Epidemic: Report of a World Health Organization (WHO) Expert Committee. Geneva: WHO, 2000 as described by Han TS et al (1995)

Relational attributes

Related metadata references:

Supersedes [Waist circumference risk indicator - adults, version 1, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (20.5 KB)

Waist-to-hip ratio

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Adult – waist-to-hip ratio, N.NN
<i>METeOR identifier:</i>	270207
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A ratio calculated by dividing the waist circumference of an adult person by the hip circumference of that same person.
Data Element Concept:	Adult – waist-to-hip ratio

Value domain attributes

Representational attributes

<i>Representation class:</i>	Ratio
<i>Data type:</i>	Number
<i>Format:</i>	N.NN
<i>Maximum character length:</i>	3

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>Formula:</p> <p>WHR = waist circumference (cm) divided by hip circumference (cm).</p> <p>Adult WHR is a continuous variable. Adult WHR cannot be calculated if either component necessary for its calculation (i.e. abdominal circumference or hip circumference) has not been collected (i.e. is coded to 999.9).</p>
<i>Collection methods:</i>	<p>As there are no cut-off points for waist to hip ratio for children and adolescents, it is not necessary to calculate this item for those aged under 18 years.</p> <p>Waist-to-hip ratio (WHR) should be derived after the data entry of waist circumference and hip circumference. It should be stored on the raw data set as a continuous variable and should not be aggregated or rounded.</p>
<i>Comments:</i>	<p>Adult cut-off points for WHR, that may define increased risk of cardiovascular disease and all cause mortality, range from 0.9 to 1.0 for men and 0.8 to 0.9 for women (Croft et al. 1995, Bray 1987, Bjorntorp 1985). These values are based primarily on evidence of increased risk of death in European populations, and may not be appropriate for all age and ethnic groups.</p> <p>In Australia and New Zealand, the cutoffs of >0.9 for males and >0.8 for females were used in the Australian Bureau of Statistics' 1995 National Nutrition Survey.</p> <p>This metadata item applies to persons aged 18 years or older as</p>

no cut off points have been developed for children and adolescents. It is recommended for use in population surveys and health care settings.

More recently it has emerged that waist circumference alone, or in combination with other metabolic measures, is a better indicator of risk and reduces the errors in WHR measurements. WHR is therefore no longer a commonly used measure.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Body fat distribution has emerged as an important predictor of obesity-related morbidity and mortality. Abdominal obesity, which is more common in men than women, has, in epidemiological studies, been closely associated with conditions such as coronary heart disease, stroke, non-insulin dependent diabetes mellitus and high blood pressure.

Waist- to-hip ratio (WHR) can be used:

- to indicate the prevalence of abdominal obesity and its sociodemographic distribution (problem identification)
- to evaluate health promotion and disease prevention programs (assessment of interventions)
- to monitor progress towards national public health policy
- to ascertain determinants and consequences of abdominal obesity - in nutrition and physical activity surveillance and long-term planning.

Presentation of data:

Means, 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

Source and reference attributes

Origin:

National Health Data Committee
National Centre for Monitoring Cardiovascular Disease
Australian Institute of Health and Welfare

Relational attributes

Related metadata references:

Supersedes [Waist-to-hip ratio, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.0 KB)

Is formed using [Person – waist circumference \(measured\), total centimetres NN\[N\].N](#) Health, Standard 01/03/2005

Is formed using [Person – hip circumference \(measured\), total centimetres NN\[N\].N](#) Health, Standard 01/03/2005

Waiting list category

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective care waiting list episode – elective care type, code N
<i>METeOR identifier:</i>	335048
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	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

<i>Classification scheme:</i>	Australian Classification of Health Interventions (ACHI) 5th edition	
<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Elective surgery
	2	Other

Collection and usage attributes

<i>Guide for use:</i>	<p>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.</p> <p>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.</p> <p>CODE 1 Elective surgery</p> <p>All elective surgery, that is excluding procedures listed in exclusion list for Code 2, should be included in this code.</p> <p>CODE 2 Other</p> <p>Patients awaiting the following procedures should be classified as Code 2 - other:</p> <ul style="list-style-type: none">• organ or tissue transplant procedures• procedures associated with obstetrics (e.g. elective caesarean section, cervical suture)• cosmetic surgery, i.e. when the procedure will not attract a Medicare rebate
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- biopsy of:
 - kidney (needle only)
 - lung (needle only)
 - liver and gall bladder (needle only)
- bronchoscopy (including fibre-optic bronchoscopy)
- peritoneal renal dialysis;
- haemodialysis
- colonoscopy
- endoscopic retrograde cholangio-pancreatography (ERCP)
- endoscopy of:
 - biliary tract
 - oesophagus
 - small intestine
 - stomach
- endovascular interventional procedures
- gastroscopy
- miscellaneous cardiac procedures
- oesophagoscopy
- panendoscopy (except when involving the bladder)
- proctosigmoidoscopy
- sigmoidoscopy
- anoscopy
- urethroscopy and associated procedures
- dental procedures not attracting a Medicare rebate
- other diagnostic and non-surgical procedures.

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

Comments:

The table of Australian Classification of Health Interventions (ACHI) (5th 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 facilitate more readily the identification of the exclusions when the list of codes is not used.

ACHI CODES FOR THE EXCLUDED PROCEDURES:

Organ or tissue transplant:

90172-00 [555] 90172-01 [555] 90204-00 [659] 90204-01 [659] 90205-00 [660] 90205-01 [660] 13700-00 [801] 13706-08 [802] 13706-00 [802] 13706-06 [802] 13706-07 [802] 13706-09 [802] 13706-10 [802]

30375-21 [817] 90317-00 [954] 90324-00 [981] 36503-00 [1058]
36503-01 [1058] 14203-01 [1906]

Procedures associated with obstetrics: 16511-00 [1274]

Obstetric Blocks [1330] to [1345] and [1347]

90463-01 [1330] 90488-00 [1330]

Biopsy (needle) of:

- kidney: 36561-00 [1047]
- lung: 38412-00 [550]
- liver and gall bladder: 30409-00 [953] 30412-00 [953] 90319-01 [951] 30094-04 [964]

Bronchoscopy:

41889-00 [543] 41892-00 [544] 41904-00 [546] 41764-02 [416] 41895-00 [544] 41764-04 [532] 41892-01 [545] 41901-00 [545] 41898-00 [543] 41898-01 [544] 41889-01 [543] 41849-00 [520] 41764-03 [520] 41855-00 [520]

Peritoneal renal dialysis:

13100-06 [1061] 13100-07 [1061] 13100-08 [1061] 13100-00 [1060]

Endoscopy of biliary tract:

30484-00 [957] 30484-01 [957] 30484-02 [974] 30494-00 [971] 30452-00 [971] 30491-00 [958] 30491-01 [958] 30485-00 [963] 30485-01 [963] 30452-01 [958] 30450-00 [959] 30452-02 [959] 90349-00 [975]

Endoscopy of oesophagus:

30473-03 [850] 30473-04 [861] 41822-00 [861] 30478-11 [856] 41819-00 [862] 30478-10 [852] 30478-13 [861] 41816-00 [850] 41822-00 [861] 41825-00 [852] 30478-12 [856] 41831-00 [862] 30478-12 [856] 30490-00 [853] 30479-00 [856]

Panendoscopy:

30476-03 [874] 32095-00 [891] 30568-00 [893] 30569-00 [894] 30473-05 [1005] 30473-00 [1005] 30473-02 [1005] 30478-00 [1006] 30478-14 [1006] 30478-01 [1007] 30478-02 [1007] 30478-03 [1007] 30478-15 [1007] 30478-16 [1007] 30478-17 [1007] 30478-20 [1007] 30478-21 [1007] 30473-01 [1008] 30478-04 [1008] 30473-06 [1008] 30478-18 [1008]

Endoscopy of large intestine, rectum and anus:

32075-00 [904] 32090-00 [905] 32084-00 [905] 30479-02 [908] 90308-00 [908] 32075-01 [910] 32078-00 [910] 32081-00 [910] 32090-01 [911] 32093-00 [911] 32084-01 [911] 32087-00 [911] 30479-01 [931] 90315-00 [933]

Miscellaneous cardiac:

38603-00 [642] 38600-00 [642] 38256-00 [647] 38256-01 [647] 38256-02 [647] 38278-00 [648] 38278-01 [648] 38284-00 [648] 90202-00 [649] 38470-00 [649] 38473-00 [649] 38281-01 [650] 38281-02 [650] 38281-03 [650] 38281-04 [650] 38281-05 [650] 38281-06 [650] 38281-07 [651] 38281-07 [651] 38281-08 [651] 38281-09 [651] 38281-10 [651] 38281-00 [652] 38278-02 [654] 38456-07 [654] 90203-00 [654] 38284-01 [654] 90219-00 [663] 38281-11 [655] 38281-12 [655] 38212-00 [665] 38209-00 [665] 38200-00 [667] 38203-00 [667] 38206-00 [667] 35324-00 [740] 35315-00 [758] 35315-01 [758] 90214-00 [648] 90202-01 [649] 38281-13 [652] 38278-03 [654] 38284-02 [654] 90214-01 [654] 90214-02 [654] 90203-01 [654] 38456-08 [654] 38281-14 [655] 38212-01 [665] 38213-00 [665]

Endovascular interventional:

35304-01 [670] 35305-00 [670] 35304-00 [670] 35305-01 [670] 35310-00 [671] 35310-01 [671] 35310-03 [671] 35310-04 [671] 35310-02 [671] 35310-05 [671] 34524-00 [694] 13303-00 [694] 34521-01 [694] 32500-01 [722] 32500-00 [722] 13300-01 [738] 13300-02 [738] 13319-00 [738] 13300-00 [738] 13815-00 [738] 13815-01 [738] 34521-02 [738] 34530-04 [738] 90220-00 [738]

Urethroscopy:

36800-00 [1090] 36800-01 [1090] 37011-00 [1093] 37008-01 [1093] 37008-00 [1093] 37315-00 [1112] 37318-01 [1116] 36815-01 [1116] 37854-00 [1116] 35527-00 [1116] 37318-04 [1117] 36800-03 [1090] 37318-02 [1116] 37318-03 [1116]

Dental:

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]

Other diagnostic and non-surgical:

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] 96207-00 [1921] 96207-01 [1921] 96207-02 [1921] 96207-03 [1921] 96207-04 [1921] 96207-05 [1921] 96207-06 [1921] 96207-07 [1921] 96207-08 [1921] 96207-09 [1921] 96208-00 [1921] 96208-01 [1921] 96208-02 [1921] 96208-03 [1921] 96208-04 [1921] 96208-05 [1921] 96208-06 [1921] 96208-07 [1921] 96208-08 [1921] 96208-09 [1921] 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] 96196-05 [1920] 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] 96197-05 [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] 96198-05 [1920] 96198-06 [1920] 96198-07 [1920] 96198-08 [1920] 96198-09 [1920] 96199-00 [1920] 96199-01 [1920]

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96206-00 [1920] 96206-01 [1920] 96206-02 [1920] 96206-03 [1920]
96206-04 [1920] 96206-05 [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) 2006. The Australian Classification of Health Interventions (ACHI) – Fifth Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.

Data element attributes

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 07/12/2005

Waiting time at a census date

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – waiting time (at a census date), total days N[NNN]
<i>METeOR identifier:</i>	269961
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list to a designated census date.
<i>Context:</i>	Elective surgery
<i>Data Element Concept:</i>	Elective surgery waiting list episode – waiting time

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN]
<i>Maximum character length:</i>	4
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The number of days is calculated by subtracting the Elective care waiting list episode – listing date for care, DDMMYYYY from the Hospital census (of elective surgery waitlist patients) – census date, DDMMYYYY, minus any days when the patient was ‘not ready for care’, and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at the census date.</p> <p>Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as ‘not ready for care’ from the date(s) the person was subsequently recorded as again being ‘ready for care’.</p> <p>If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at the census date, then the number of days waited at the less urgent Elective surgery waiting list episode – clinical urgency, code N category should be subtracted from the total number of days waited.</p> <p>In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at census date) the number of days at the less urgent clinical urgency</p>
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category should be calculated by subtracting the Elective care waiting list episode – listing date for care, DDMMYYYY from the Elective care waiting list episode – category reassignment date, DDMMYYYY. If the patient’s clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at the census date should be calculated by subtracting one Elective care waiting list episode – category reassignment date, DDMMYYYY from the subsequent Elective care waiting list episode – category reassignment date, DDMMYYYY, and then adding the days together.

When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore at the census date the patient’s waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Comments:

Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This metadata item is used to measure waiting times at a designated census date whereas the metadata item Elective surgery waiting list episode – waiting time (at removal), total days N[NNN] measures waiting times at removal.

The calculation of waiting times for patients who are transferred from an elective surgery waiting list managed by one public acute hospital to another will be investigated in the future. In this case, the amount of time waited on previous lists should follow the patient to the next. Therefore at the census date, their waiting time includes the total number of days on all lists (less days not ready for care and days in lower urgency categories).

This is a critical elective surgery waiting times metadata item. It is used to determine whether patients are overdue, or had extended waits at a census date. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Is formed using [Elective surgery waiting list episode – patient listing status, readiness for care code N](#) Health, Standard 01/03/2005

Is formed using [Hospital census \(of elective surgery waitlist patients\) – census date, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Elective care waiting list episode – listing date](#)

Implementation in Data Set Specifications:

[for care, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Elective care waiting list episode – category reassignment date, DDMMYYYY](#) Health, Standard 01/03/2005

Supersedes [Waiting time at a census date, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (18.7 KB)

Is used in the formation of [Elective surgery waiting list episode – overdue patient status, code N](#) Health, Standard 01/03/2005

Is used in the formation of [Elective surgery waiting list episode – extended wait patient indicator, code N](#) Health, Standard 01/03/2005

[Elective surgery waiting times \(census data\) NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 30/09/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(census data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 30/09/2006

Implementation end date: 31/03/2009

[Elective surgery waiting times \(census data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 30/06/2009

Waiting time at removal from elective surgery waiting list

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Elective surgery waiting list episode – waiting time (at removal), total days N[NNN]
<i>METeOR identifier:</i>	269960
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time elapsed (in days) for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were removed from the waiting list.
<i>Context:</i>	Elective surgery
<i>Data Element Concept:</i>	Elective surgery waiting list episode – waiting time

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	N[NNN]
<i>Maximum character length:</i>	4
<i>Unit of measure:</i>	Day

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>The number of days is calculated by subtracting the listing date for care from the removal date, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at removal.</p> <p>Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'.</p> <p>If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at removal, then the number of days waited at the less urgent clinical urgency category should be subtracted from the total number of days waited.</p> <p>In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at removal) the number of days at the less urgent clinical urgency category should be calculated by subtracting the listing date for care from the category reassignment date. If the patient's clinical</p>
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urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one category reassignment date from the subsequent category reassignment date, and then adding the days together.

When a patient is removed from an elective surgery waiting list, for admission on an elective basis for the procedure they were awaiting, but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue.

Therefore at the removal date, the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Comments:

Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This metadata item is used to measure waiting times at removal whereas the metadata item waiting time at a census date measures waiting times at a designated census date.

The calculation of waiting times for patients, who are transferred from an elective surgery waiting list managed by one public acute hospital to another, will be investigated in the future. In this case, the amount of time waited on previous lists would follow the patient to the next. Therefore when the patient is removed from the waiting list (for admission or other reason), their waiting time would include the total number of days on all lists (less days not ready for care and days in lower urgency categories).

This is a critical elective surgery waiting times metadata item. It is used to determine whether patients were overdue, or had extended waits when they were removed from the waiting list. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Origin:

National Health Data Committee

Relational attributes

Related metadata references:

Supersedes [Waiting time at removal from elective surgery waiting list, version 2, Derived DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (19.0 KB)

Is formed using [Elective care waiting list episode – category reassignment date, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Elective surgery waiting list episode – waiting list removal date, DDMMYYYY](#) Health, Standard 01/03/2005

Is formed using [Episode of admitted patient care – admission date, DDMMYYYY](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

Is formed using [Elective care waiting list episode – listing date for care, DDMMYYYY](#) Health, Standard 01/03/2005

Is used in the formation of [Elective surgery waiting list episode – overdue patient status, code N](#) Health, Standard 01/03/2005

Is used in the formation of [Elective surgery waiting list episode – extended wait patient indicator, code N](#) Health, Standard 01/03/2005

[Elective surgery waiting times \(removals data\) NMDS](#) Health, Superseded 07/12/2005

Implementation start date: 01/07/2002

Implementation end date: 30/06/2006

[Elective surgery waiting times \(removals data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Implementation start date: 01/07/2006

Implementation end date: 30/06/2009

[Elective surgery waiting times \(removals data\) NMDS 2009-](#) Health, Standard 03/12/2008

Implementation start date: 01/07/2009

Weight (self-reported)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – weight (self-reported), total kilograms NN[N]
<i>METeOR identifier:</i>	302365
<i>Registration status:</i>	Health, Standard 14/07/2005
<i>Definition:</i>	A person's self-reported weight (body mass).
Data Element Concept:	Person – weight

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total						
<i>Data type:</i>	Number						
<i>Format:</i>	NN[N]						
<i>Maximum character length:</i>	3						
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>888</td><td>Unknown</td></tr><tr><td>999</td><td>Not stated</td></tr></tbody></table>	Value	Meaning	888	Unknown	999	Not stated
Value	Meaning						
888	Unknown						
999	Not stated						
<i>Unit of measure:</i>	Kilogram (Kg)						

Collection and usage attributes

<i>Guide for use:</i>	CODE 888 Unknown Use this code if self-reported body mass (weight) is unknown.
	CODE 999 Not stated Use this code if self-reported body mass (weight) is not responded to.

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	<p>The method of data collection, e.g. face to face interview, telephone interview or self-completion questionnaire, can affect survey estimates and should be reported.</p> <p>The data collection form should include a question asking the respondent what their weight is. For example, the ABS National Health Survey 1989-90 included the question 'How much do you weigh without clothes and shoes?'. The data collection form should allow for both metric (to the nearest 1 kg) and imperial (to the nearest 1 lb) units to be recorded.</p> <p>If practical, it is preferable to enter the raw data into the data base before conversion of measures in imperial units to metric. However, if this is not possible, weight reported in imperial units can be converted to metric prior to data entry using a conversion factor of 0.454 kg to the lb.</p>
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Rounding to the nearest 1 kg will be required for measures converted to metric prior to data entry, and may be required for data reported in metric units to a greater level of precision than the nearest 1 kg. The following rounding conventions are desirable to reduce systematic over reporting (Armitage and Berry 1994):

nnn.x where x

nnn.x where $x > 5$ - round up, e.g. 72.7 kg would be rounded to 73 kg.

nnn.x where $x = 5$ - round to the nearest even number, e.g. 72.5 kg would be rounded to 72 kg, while 73.5 kg would be rounded to 74 kg.

Comments:

This metadata item is recommended for persons aged 18 years or older. It is recommended for use in population surveys when it is not possible to measure weight.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables. Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following categories may be appropriate for describing the weights of Australian men and women, although the range will depend on the population. The World Health Organization's range for weight is 30-140 kg.

Weight

30 kg = Weight

35 kg = Weight

... in 5 kg categories

135 kg = Weight

Weight => 140 kg

On average, body mass (weight) tends to be underestimated when self-reported by respondents. Data for men and women

aged 20-69 years in 1989 indicated that men underestimated by an average of 0.2 kg (sem of 0.05 kg) and women by an average of 0.4 kg (sem of 0.04 kg) (Waters 1993). The extent of underestimation varied with age.

Source and reference attributes

Origin: National Centre for Monitoring Cardiovascular Disease
Australian Institute of Health and Welfare
National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Weight - self-reported, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (20.5 KB)
Supersedes [Adult – weight \(self-reported\), total kilograms NN\[N\] Health, Superseded 14/07/2005](#)
Is used in the formation of [Child – body mass index \(self-reported\), ratio NN\[N\].N\[N\] Health, Standard 01/03/2005](#)
Is used in the formation of [Adult – body mass index \(self-reported\), ratio NN\[N\].N\[N\] Health, Standard 01/03/2005](#)
Implementation in Data Set Specifications: [Acute coronary syndrome \(clinical\) DSS Health, Superseded 01/10/2008](#)
[Acute coronary syndrome \(clinical\) DSS Health, Superseded 07/12/2005](#)

Weight in grams (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – weight (measured), total grams NNNN
<i>Synonymous names:</i>	Infant weight, neonate, stillborn
<i>METeOR identifier:</i>	310245
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The weight (body mass) of a person measured in grams.
Data Element Concept:	Person – weight

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4
<i>Unit of measure:</i>	Gram (g)

Data element attributes

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Is used in the formation of Episode of admitted patient care – major diagnostic category, code (AR-DRG v 6) NN Health, Standard 22/12/2009
	Is used in the formation of Episode of admitted patient care – diagnosis related group, code (AR-DRG v 6) ANNA Health, Standard 22/12/2009
	Is used in the formation of Episode of admitted patient care – diagnosis related group, code (AR-DRG v5.1) ANNA Health, Superseded 22/12/2009
	Is used in the formation of Episode of admitted patient care – major diagnostic category, code (AR-DRG v5.1) NN Health, Superseded 22/12/2009
<i>Implementation in Data Set Specifications:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005
	<i>Implementation start date:</i> 01/07/2005
	<i>Implementation end date:</i> 30/06/2006
	Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006
	<i>Implementation start date:</i> 01/07/2006
	<i>Implementation end date:</i> 30/06/2007

[Admitted patient care NMDS 2007-2008](#) Health, Superseded
05/02/2008

Implementation start date: 01/07/2007

Implementation end date: 30/06/2008

[Admitted patient care NMDS 2008-2009](#) Health, Superseded
04/02/2009

Implementation start date: 01/07/2008

Implementation end date: 30/06/2009

[Admitted patient care NMDS 2009-2010](#) Health, Superseded
22/12/2009

Implementation start date: 01/07/2009

Implementation end date: 30/06/2010

[Admitted patient care NMDS 2010-2011](#) Health, Standard
22/12/2009

Implementation start date: 01/07/2010

Conditional obligation:

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

Weight in kilograms (measured)

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – weight (measured), total kilograms N[NN].N
<i>Synonymous names:</i>	Infant weight, neonate, stillborn
<i>METeOR identifier:</i>	270208
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The weight (body mass) of a person measured in kilograms.
<i>Data Element Concept:</i>	Person – weight

Value domain attributes

Representational attributes

<i>Representation class:</i>	Total				
<i>Data type:</i>	Number				
<i>Format:</i>	N[NN].N				
<i>Maximum character length:</i>	4				
<i>Supplementary values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>999.9</td><td>Not collected</td></tr></tbody></table>	Value	Meaning	999.9	Not collected
Value	Meaning				
999.9	Not collected				
<i>Unit of measure:</i>	Kilogram (Kg)				
<i>Unit of measure precision:</i>	1				

Collection and usage attributes

<i>Guide for use:</i>	A continuous variable measured to the nearest 0.1 kg. CODE 999.9 Not collected Use this code if measured weight is not collected.
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Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	In order to ensure consistency in measurement, the measurement protocol described under Collection methods should be used.
<i>Collection methods:</i>	<p>The collection of anthropometric measurements, particularly in those who are overweight or obese or who are concerned about their weight, should be performed with great sensitivity and without drawing attention to an individual's weight.</p> <p>The measurement protocol described below is that recommended by the WHO Expert Committee (1995).</p> <p>Measurement protocol:</p> <p>Equipment used should be described and reported. Scales should have a resolution of at least 0.1kg and should have the capacity to weigh up to at least 200 kg. Measurement intervals and labels should be clearly readable under all conditions of use of the</p>

instrument. Scales should be capable of being calibrated across the entire range of measurements. Precision error should be no more than 0.1kg. Scales should be calibrated on each day of use. Manufacturers' guidelines should be followed with regard to the transportation of the scales.

Adults and children who can stand:

The subject stands over the centre of the weighing instrument, with the body weight evenly distributed between both feet.

Heavy jewellery should be removed and pockets emptied. Light indoor clothing can be worn, excluding shoes, belts, and sweater. Any variations from light indoor clothing (e.g. heavy clothing, such as kaftans or coats worn because of cultural practices) should be noted on the data collection form. Adjustments for non-standard clothing (i.e. other than light indoor clothing) should only be made in the data checking/cleaning stage prior to data analysis.

If the subject has had one or more limbs amputated, record this on the data collection form and weigh them as they are. If they are wearing an artificial limb, record this on the data collection form but do not ask them to remove it. Similarly, if they are not wearing the limb, record this but do not ask them to put it on.

The measurement is recorded to the nearest 0.1 kg. If the scales do not have a digital readout, take a repeat measurement. If the two measurements disagree by more than 0.5 kg, then take a third measurement. All raw measurements should be recorded on the data collection form. If practical, it is preferable to enter the raw data into the database as this enables intra-observer and, where relevant, inter-observer errors to be assessed. The subject's measured weight is subsequently calculated as the mean of the two observations, or the mean of the two closest measurements if a third is taken, and recorded on the form. If only a mean value is entered into the database then the data collection forms should be retained.

It may be necessary to round the mean value to the nearest 0.1 kg. If so, rounding should be to the nearest even digit to reduce systematic over reporting (Armitage and Berry 1994). For example, a mean value of 72.25 kg would be rounded to 72.2 kg, while a mean value of 72.35 kg would be rounded to 72.4 kg.

Infants:

Birth weight and gender should be recorded with gestational age. During infancy a levelled pan scale with a bean and movable weights or digital scales capable of measuring to two decimal places of a kilogram are acceptable. Birth weight should be determined within 12 hours of birth. The infant, with or without a nappy or diaper is placed on the scales so that the weight is distributed equally about the centre of the pan. When the infant is lying or suspended quietly, weight is recorded to the nearest 10 grams. If the nappy or diaper is worn, its weight is subtracted from the observed weight i.e. reference data for infants are based on nude weights.

Validation and quality control measures:

If practical, equipment should be checked daily using one or more objects of known weight in the range to be measured. It is recommended that the scale be calibrated at the extremes and in the mid range of the expected weight of the population being studied.

Within- and, if relevant, between-observer variability should be reported. They can be assessed by the same (within-) or different (between-) observers repeating the measurement of weight, on the same subjects, under standard conditions after a short time interval. The standard deviation of replicate measurements (technical error of measurement) between observers should not exceed 0.5 kg and be less than 0.5 kg within observers.

Extreme values at the lower and upper end of the distribution of measured height should be checked both during data collection and after data entry. Individuals should not be excluded on the basis of true biological difference.

Last digit preference, and preference or avoidance of certain values, should be analysed in the total sample and (if relevant) by observer, survey site and over time if the survey period is long.

This metadata item applies to persons of all ages. It is recommended for use in population surveys and health care settings.

It is recommended that in population surveys, sociodemographic data including ethnicity should be collected, as well as other risk factors including physiological status (e.g. pregnancy), physical activity, smoking and alcohol consumption. Summary statistics may need to be adjusted for these variables.

Metadata items currently exist for sex, date of birth, country of birth, Indigenous status and smoking. Metadata items are being developed for physical activity.

Presentation of data:

Means and 95% confidence intervals, medians and centiles should be reported to one decimal place. Where the sample permits, population estimates should be presented by sex and 5-year age groups. However 5-year age groups are not generally suitable for children and adolescents. Estimates based on sample surveys may need to take into account sampling weights.

For consistency with conventional practice, and for current comparability with international data sets, recommended centiles are 5, 10, 15, 25, 50, 75, 85, 90 and 95. To estimate the 5th and 95th centiles, a sample size of at least 200 is recommended for each group for which the centiles are being specified.

For some reporting purposes, it may be desirable to present weight data in categories. It is recommended that 5 kg groupings are used for this purpose. Weight data should not be rounded before categorisation. The following categories may be appropriate for describing the weights of Australian men, women, children and adolescents, although the range will depend on the population.

Comments:

Weight
10 kg = Weight
15 kg = Weight
... in 5 kg categories
135 kg = Weight
Weight => 140 kg

Source and reference attributes

Submitting organisation:

World Health Organization The consortium to develop standard methods for the collection and collation of anthropometric data in children as part of the National Food and Nutrition Monitoring and Surveillance Project, funded by the Commonwealth Department of Health and Ageing

Reference documents:

Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults (US National Heart, Lung and Blood Institute (NHLBI) in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases).

Chronic Diseases and Associated Risk Factors in Australia 2001 (AIHW).

Relational attributes

Related metadata references:

Supersedes [Weight - measured, version 2, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (29.3 KB)

Is used in the formation of [Adult – body mass index \(measured\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Is used in the formation of [Child – body mass index \(self-reported\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Is used in the formation of [Child – body mass index \(measured\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Is used in the formation of [Adult – body mass index \(self-reported\), ratio NN\[N\].N\[N\]](#) Health, Standard 01/03/2005

Implementation in Data Set Specifications:

[Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 15/02/2006

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 04/07/2007

[Cardiovascular disease \(clinical\) DSS](#) Health, Superseded 22/12/2009

[Cardiovascular disease \(clinical\) DSS](#) Health, Standard 22/12/2009

[Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

[Diabetes \(clinical\) DSS](#) Health, Standard 21/09/2005

Work sector—health professional

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work sector in health profession, code N
<i>METeOR identifier:</i>	375388
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The sector in which a health professional works in their registered profession, as represented by a code.
Data Element Concept:	Registered health professional—work sector in registered health profession

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Public
	2	Private

Data element attributes

Collection and usage attributes

<i>Comments:</i>	<p>This data element is used to differentiate between establishments run by the government sector (code 1) and establishments that receive some government funding but are run by the non-government sector (code 2).</p> <p>Code 1 Public</p> <p>To be used when the establishment:</p> <ul style="list-style-type: none">operates from the public accounts of a Commonwealth, state or territory government or is part of the executive, judicial or legislative arms of government,is part of the general government sector or is controlled by some part of the general government sector,provides government services free of charge or at nominal prices, andis financed mainly from taxation. <p>Code 2 Private</p> <p>To be used only when the establishment:</p> <ul style="list-style-type: none">is not controlled by government,
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- is directed by a group of officers, an executive committee or a similar body elected by a majority of members, and
- may be an income tax exempt charity.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

[Main job of registered chiropractor cluster](#) Health, Standard 10/12/2009

[Main job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

[Main job of registered medical professional cluster](#) Health, Standard 10/12/2009

[Main job of registered midwife cluster](#) Health, Standard 10/12/2009

[Main job of registered nursing professional cluster](#) Health, Standard 10/12/2009

[Main job of registered optometrist cluster](#) Health, Standard 10/12/2009

[Main job of registered osteopath cluster](#) Health, Standard 10/12/2009

[Main job of registered pharmacist cluster](#) Health, Standard 10/12/2009

[Main job of registered physiotherapist cluster](#) Health, Standard 10/12/2009

[Main job of registered podiatrist cluster](#) Health, Standard 10/12/2009

[Main job of registered psychologist cluster](#) Health, Standard 10/12/2009

[Second job of registered chiropractor cluster](#) Health, Standard 10/12/2009

[Second job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

[Second job of registered medical professional cluster](#) Health, Standard 10/12/2009

[Second job of registered midwife cluster](#) Health, Standard 10/12/2009

[Second job of registered nursing professional cluster](#) Health, Standard 10/12/2009

[Second job of registered optometrist cluster](#) Health, Standard 10/12/2009

[Second job of registered osteopath cluster](#) Health, Standard 10/12/2009

[Second job of registered pharmacist cluster](#) Health, Standard 10/12/2009

[Second job of registered physiotherapist cluster](#) Health, Standard 10/12/2009

[Second job of registered podiatrist cluster](#) Health, Standard
10/12/2009

[Second job of registered psychologist cluster](#) Health, Standard
10/12/2009

[Work setting hours cluster](#) Health, Standard 10/12/2009

Work setting—chiropractor

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, chiropractor code ANN
<i>METeOR identifier:</i>	377909
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service setting or other organisation arrangement in which the work was undertaken by the chiropractor, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																												
<i>Data type:</i>	String																												
<i>Format:</i>	ANN																												
<i>Maximum character length:</i>	3																												
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>A01</td><td>Solo private practice</td></tr><tr><td>A02</td><td>Group private practice</td></tr><tr><td>A03</td><td>Locum private practice</td></tr><tr><td>B00</td><td>Aboriginal health service</td></tr><tr><td>C00</td><td>Community health care service</td></tr><tr><td>D00</td><td>Hospital</td></tr><tr><td>E00</td><td>Residential health care facility</td></tr><tr><td>F00</td><td>Commercial/business service</td></tr><tr><td>G00</td><td>Educational facility</td></tr><tr><td>H00</td><td>Correctional services</td></tr><tr><td>I00</td><td>Defence forces</td></tr><tr><td>J00</td><td>Other government department or agency</td></tr><tr><td>Y00</td><td>Other</td></tr></tbody></table>	Value	Meaning	A01	Solo private practice	A02	Group private practice	A03	Locum private practice	B00	Aboriginal health service	C00	Community health care service	D00	Hospital	E00	Residential health care facility	F00	Commercial/business service	G00	Educational facility	H00	Correctional services	I00	Defence forces	J00	Other government department or agency	Y00	Other
Value	Meaning																												
A01	Solo private practice																												
A02	Group private practice																												
A03	Locum private practice																												
B00	Aboriginal health service																												
C00	Community health care service																												
D00	Hospital																												
E00	Residential health care facility																												
F00	Commercial/business service																												
G00	Educational facility																												
H00	Correctional services																												
I00	Defence forces																												
J00	Other government department or agency																												
Y00	Other																												
<i>Supplementary values:</i>	Z99 Unknown/inadequately described/not stated																												

Collection and usage attributes

<i>Guide for use:</i>	CODE A01 SOLO PRIVATE PRACTICE Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices. CODE A02 GROUP PRIVATE PRACTICE Group private practice includes all private practices owned and
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operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICE

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facilities include schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Main job of registered chiropractor cluster](#) Health, Standard
10/12/2009

[Second job of registered chiropractor cluster](#) Health, Standard
10/12/2009

Work setting—dental

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional – work setting, dental code ANN
<i>METeOR identifier:</i>	377911
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service or other organisation in which the work was undertaken by the dental health professional, as represented by a code.
Data Element Concept:	Registered health professional – work setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																		
<i>Data type:</i>	String																																		
<i>Format:</i>	ANN																																		
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Collection and usage attributes

<i>Guide for use:</i>	CODE A01 SOLO PRIVATE PRACTICE Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.
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CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C05 HEALTH PROMOTION SERVICE

Health promotion service includes those services primarily engaged in the provision of information and education to improve dental health and prevent disease.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICE

Other community health care service includes all non-residential health care services not mentioned above.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE SERVICES

Defence forces include all facilities operated by the Australian

Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications:

[Main job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

[Second job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

Work setting—medical practitioner

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, medical practitioner code ANN
<i>METeOR identifier:</i>	377814
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of service setting or other organisation arrangement in which health care was delivered by the medical practitioner, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																								
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<i>Supplementary values:</i>	Z99 Unknown/inadequately described/not stated																																								

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C02 COMMUNITY MENTAL HEALTH SERVICE

Community mental health service includes all non-residential health care services that engage primarily in mental health care.

CODE C03 COMMUNITY DRUG AND ALCOHOL SERVICE

Community drug and alcohol service includes all non-residential health care services that engage primarily in drug and alcohol treatment.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICES

Other community health care service includes all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICES

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department

CODE E02 RESIDENTIAL MENTAL HEALTH CARE SERVICES

Residential mental health care services include all residential health care services that primarily engage in the delivery of specialist mental health care.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Main job of registered medical professional cluster](#) Health, Standard 10/12/2009
[Second job of registered medical professional cluster](#) Health, Standard 10/12/2009

Work setting—midwife

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, midwife code ANN
<i>METeOR identifier:</i>	380121
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service setting or other organisation arrangement in which the health care was delivered by the midwife, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																		
<i>Data type:</i>	String																		
<i>Format:</i>	ANN																		
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G01	Tertiary educational facility																		
Y00	Other																		
<i>Supplementary values:</i>	Z99 Unknown/inadequately described/not stated																		

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE A03 LOCUM PRIVATE PRACTICE</p> <p>Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.</p> <p>CODE A06 OTHER PRIVATE PRACTICE</p> <p>Other private practice includes all other private practices not included above.</p> <p>CODE B00 ABORIGINAL HEALTH SERVICE</p> <p>Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.</p>
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CODE C00 COMMUNITY HEALTH CARE SERVICE

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department, and aboriginal health services.

CODE D01 OUTPATIENT SERVICES

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Main job of registered midwife cluster](#) Health, Standard 10/12/2009
[Second job of registered midwife cluster](#) Health, Standard 10/12/2009

Work setting—nurse

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, nurse code ANN
<i>METeOR identifier:</i>	377913
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service setting or other organisation arrangement in which the health care was delivered by the nursing professional, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																												
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Collection and usage attributes

Guide for use:

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE A05 GENERAL PRACTITIONER (GP) PRACTICE

General Practitioner (GP) practice includes all solo, group and other GP private practices.

CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C02 COMMUNITY MENTAL HEALTH SERVICE

Community mental health service includes all non-residential health care services that engage primarily in mental health care.

CODE C03 COMMUNITY DRUG AND ALCOHOL SERVICE

Community drug and alcohol service includes all non-residential health care services that engage primarily in drug and alcohol treatment.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICES

Other community health care services include all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICE

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE E01 RESIDENTIAL AGED CARE FACILITIES

Residential aged care facilities include all residential health care facilities that primarily engage in the delivery of aged health care.

CODE E02 RESIDENTIAL MENTAL HEALTH CARE SERVICES

Residential mental health care services include all residential health care services that primarily engage in the delivery of specialist mental health care.

CODE E04 HOSPICE

Hospice includes all residential facilities primarily designed to provide palliative care for terminally ill patients.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F00 COMMERCIAL/BUSINESS

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Guide for use: Nursing professionals include enrolled nurses, registered nurses and nurse practitioners.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Main job of registered nursing professional cluster](#) Health, Standard 10/12/2009

Second job of registered nursing professional cluster Health,
Standard 10/12/2009

Work setting—optometrist

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, optometrist code ANN
<i>METeOR identifier:</i>	377915
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service setting or other organisation arrangement in which the health care was delivered by the optometrist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

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Collection and usage attributes

<i>Guide for use:</i>	CODE A01 SOLO PRIVATE PRACTICE Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices. CODE A02 GROUP PRIVATE PRACTICE Group private practice includes all private practices owned and
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operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Main job of registered optometrist cluster](#) Health, Standard
10/12/2009

[Second job of registered optometrist cluster](#) Health, Standard
10/12/2009

Work setting—osteopath

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, osteopath code ANN
<i>METeOR identifier:</i>	377917
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service setting or other organisation arrangement in which the health care was delivered by the osteopath, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																												
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<i>Format:</i>	ANN																												
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Collection and usage attributes

<i>Guide for use:</i>	CODE A01 SOLO PRIVATE PRACTICE Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices. CODE A02 GROUP PRIVATE PRACTICE Group private practice includes all private practices owned and
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operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department, and Aboriginal health services.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Main job of registered osteopath cluster](#) Health, Standard
10/12/2009

[Second job of registered osteopath cluster](#) Health, Standard
10/12/2009

Work setting—pharmacist

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, pharmacist code ANN
<i>METeOR identifier:</i>	377919
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service setting or other organisation arrangement in which the health care was delivered by the pharmacist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																
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Collection and usage attributes

<i>Guide for use:</i>	CODE A04 MEDICAL PRACTICE Medical practice includes all forms of private medical practice including medical centres.
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CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C00 COMMUNITY HEALTH CARE SERVICES

Community health care services include ambulatory centres, day procedure centres and community health centres. This category excludes non-residential health care provided by private practices and the defence department, and aboriginal health services.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F01 RETAIL PHARMACY

Businesses mainly engaged in retailing prescription drugs or patent medicines, cosmetics and/or toiletries.

CODE F02 WHOLESALE PHARMACY

Businesses mainly engaged in wholesaling prescription drugs or patent medicines, cosmetics or toiletries.

CODE F03 PHARMACEUTICS MANUFACTURING

Businesses mainly engaged in manufacturing pharmaceutical and medicinal products. It also includes businesses mainly engaged in manufacturing diagnostic substances for antibodies, antigens and chemical/diagnostic testing agents.

CODE F05 OTHER COMMERCIAL/BUSINESS

Other commercial/business includes all other commercial/business settings not included above.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all

government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Main job of registered pharmacist cluster](#) Health, Standard 10/12/2009

[Second job of registered pharmacist cluster](#) Health, Standard 10/12/2009

Work setting—physiotherapist

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, physiotherapist code ANN
<i>METeOR identifier:</i>	377921
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service setting or other organisation arrangement in which the health care was delivered by the physiotherapist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																						
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<i>Supplementary values:</i>	Z99 Unknown/inadequately described/not stated																																						

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people

CODE C01 DOMICILIARY SERVICE

Domiciliary service includes all services primarily providing nursing or other professional paramedical care or treatment and non-qualified domestic assistance to people in their own homes.

CODE C06 REHABILITATION/PHYSICAL DEVELOPMENT SERVICE

Rehabilitation/physical development service includes all organisations that primarily engage in specialist rehabilitation and physical development assistance services.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICES

Other community health care services includes all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICE

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE E01 RESIDENTIAL AGED CARE FACILITIES

Residential aged care facilities include all residential health care facilities that primarily engage in the delivery of aged health care.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F04 SPORTS CENTRE/CLINIC

Sports centres/clinics primarily provide professional services for

the prevention and treatment of injuries and diseases related to participation in sports.

CODE F05 OTHER COMMERCIAL/BUSINESS SERVICE

Other commercial/business includes all other commercial/business settings not included above

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Main job of registered physiotherapist cluster](#) Health, Standard 10/12/2009
[Second job of registered physiotherapist cluster](#) Health, Standard 10/12/2009

Work setting—podiatrist

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, podiatrist code ANN
<i>METeOR identifier:</i>	377923
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service setting or other organisation arrangement in which the health care was delivered by the podiatrist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																																								
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Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A03 LOCUM PRIVATE PRACTICE

Locum private practice includes all private practices where the primary business of the practice is the provision of locum or relief services.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C06 REHABILITATION/PHYSICAL DEVELOPMENTAL SERVICE

Rehabilitation/physical development service includes all organisations that primarily engage in specialist rehabilitation and physical development assistance services.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICE

Other community health care service includes all non-residential health care services not mentioned above.

CODE D01 OUTPATIENT SERVICE

Outpatient services include all hospital-based clinics that provide specialist outpatient services to non-admitted, non-emergency department patients.

CODE D02 OTHER HOSPITAL SERVICE

This category includes all other hospital services including acute care, psychiatric and dental hospitals, as well as emergency departments. It excludes hospitals provided by Defence Department.

CODE E01 RESIDENTIAL AGED CARE FACILITY

Residential aged care facilities include all residential health care facilities that primarily engage in the delivery of aged health care.

CODE E03 DISABILITY INSTITUTION

Disability institution includes all residential services that primarily engage in the delivery of disability support services.

CODE E04 HOSPICE

Hospice includes all residential facilities primarily designed to provide palliative care for terminally ill patients.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F04 SPORTS CENTRE/CLINIC

Sports centres/clinics primarily provide professional services for the prevention and treatment of injuries and diseases related to participation in sports.

CODE F05 OTHER COMMERCIAL/BUSINESS

Other commercial/business includes all other commercial/business settings not included above.

CODE G00 EDUCATIONAL FACILITY

Educational facility includes schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Main job of registered podiatrist cluster](#) Health, Standard 10/12/2009
[Second job of registered podiatrist cluster](#) Health, Standard 10/12/2009

Work setting—psychologist

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, psychologist code ANN
<i>METeOR identifier:</i>	377925
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service setting or other organisation arrangement in which the health care was delivered by the psychologist, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

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C02	Community mental health service																																										
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C06	Rehabilitation/physical developmental service																																										
C07	Other community health care service																																										
D00	Hospital																																										
E03	Disability institution																																										
E05	Other residential health care facility																																										
F05	Commercial/business service																																										
G01	Tertiary educational facility																																										
G02	School																																										
G03	Other educational facility																																										
H00	Correctional services																																										
I00	Defence forces																																										
J00	Other government department or agency																																										
Y00	Other																																										
<i>Supplementary values:</i>	Z99 Unknown/inadequately described/not stated																																										

Collection and usage attributes

Guide for use:

CODE A01 SOLO PRIVATE PRACTICE

Solo private practice includes all private practices owned and operated by a single health practitioner, excluding locum practices.

CODE A02 GROUP PRIVATE PRACTICE

Group private practice includes all private practices owned and operated by a partnership of more than one health practitioner excluding locum practices.

CODE A05 GENERAL PRACTITIONER (GP) PRACTICE

General Practitioner (GP) practice includes all solo, group and other GP private practices.

CODE A06 OTHER PRIVATE PRACTICE

Other private practice includes all other private practices not included above.

CODE B00 ABORIGINAL HEALTH SERVICE

Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.

CODE C02 COMMUNITY MENTAL HEALTH

Community mental health service includes all non-residential health care services that engage primarily in mental health care.

CODE C04 DRUG AND ALCOHOL SERVICE

Drug and alcohol service includes all non-residential health care services that engage primarily in drug and alcohol treatment.

CODE C06 REHABILITATION/PHYSICAL DEVELOPMENTAL SERVICE

Rehabilitation/physical development service includes all organisations that primarily engage in specialist rehabilitation and physical development assistance services.

CODE C07 OTHER COMMUNITY HEALTH CARE SERVICE

Other community health care service includes all non-residential health care services not mentioned above.

CODE D00 HOSPITAL

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E03 DISABILITY INSTITUTION

Disability institution includes all residential services that primarily engage in the delivery of disability support services.

CODE E05 OTHER RESIDENTIAL HEALTH CARE FACILITY

This category includes all other residential health care facilities not specified above.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business includes insurance providers, pathology

laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G01 TERTIARY EDUCATIONAL FACILITY

Tertiary educational facility includes all educational institutions mainly engaged in providing undergraduate or postgraduate teaching, or vocational education and training.

CODE G02 SCHOOL

Schools include all pre-primary, primary and secondary schools.

CODE G03 OTHER EDUCATIONAL FACILITY

Other educational facility includes all organisations primarily involved in the delivery of education and training but not mentioned above.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specifications: [Main job of registered psychologist cluster](#) Health, Standard 10/12/2009
[Second job of registered psychologist cluster](#) Health, Standard 10/12/2009

Work setting—registered health professional

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Registered health professional—work setting, code ANN
<i>METeOR identifier:</i>	375402
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of health service setting or other organisation arrangement in which health care was delivered by the registered health professional, as represented by a code.
Data Element Concept:	Registered health professional—work setting

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code																								
<i>Data type:</i>	Number																								
<i>Format:</i>	ANN																								
<i>Maximum character length:</i>	3																								
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>A00</td><td>Private practice</td></tr><tr><td>B00</td><td>Aboriginal health service</td></tr><tr><td>C00</td><td>Community health care service</td></tr><tr><td>D00</td><td>Hospital</td></tr><tr><td>E00</td><td>Residential health care facility</td></tr><tr><td>F00</td><td>Commercial/business services</td></tr><tr><td>G00</td><td>Educational facility</td></tr><tr><td>H00</td><td>Correctional services</td></tr><tr><td>I00</td><td>Defence forces</td></tr><tr><td>J00</td><td>Other government department or agency</td></tr><tr><td>Y00</td><td>Other</td></tr></tbody></table>	Value	Meaning	A00	Private practice	B00	Aboriginal health service	C00	Community health care service	D00	Hospital	E00	Residential health care facility	F00	Commercial/business services	G00	Educational facility	H00	Correctional services	I00	Defence forces	J00	Other government department or agency	Y00	Other
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I00	Defence forces																								
J00	Other government department or agency																								
Y00	Other																								
<i>Supplementary values:</i>	Z99 Unknown/inadequately described/not stated																								

Collection and usage attributes

<i>Guide for use:</i>	<p>CODE A00 PRIVATE PRACTICE</p> <p>Private practice includes private practitioner rooms/ surgeries and 24-hour medical clinics.</p> <p>CODE B00 ABORIGINAL HEALTH SERVICES</p> <p>Aboriginal health services include all non-residential health care services with a primary focus on the delivery of health care to Indigenous people.</p> <p>CODE C00 COMMUNITY HEALTH CARE SERVICES</p> <p>Community health care services include ambulatory centres, day</p>
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procedure centres and community health centres. This category excludes aboriginal health services and non-residential health care provided by private practices and the Australian Government Department of Defence.

CODE D00 HOSPITALS

Hospitals include acute care, psychiatric and dental hospitals as well as emergency departments and outpatient clinics. This category excludes hospitals provided by Defence Department.

CODE E00 RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities include residential aged care, hospices, residential mental health care, residential drug rehabilitation and disability institutions.

CODE F00 COMMERCIAL/BUSINESS SERVICES

Commercial/business services include insurance providers, pathology laboratories, banks and pharmaceutical manufacturers, wholesalers and retailers. This category excludes private practices.

CODE G00 EDUCATIONAL FACILITY

Educational facilities include schools, universities, vocational education and training institutions.

CODE H00 CORRECTIONAL SERVICES

Correctional services include jails and detention centres.

CODE I00 DEFENCE FORCES

Defence forces include all facilities operated by the Australian Government Department of Defence.

CODE J00 OTHER GOVERNMENT DEPARTMENT OR AGENCY

Other government department or agency includes all government facilities not specified above including laboratories and research organisations.

CODE Y00 OTHER

Other includes all organisations not specified above.

Comments:

This data element is used in conjunction with work sector and hours worked to collect data on the distribution of hour worked by registered health professionals.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Data element attributes

Collection and usage attributes

Comments:

This data element is used in conjunction with work sector and hours worked to collect data on the distribution of hours worked by registered health professionals.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: Supersedes [Health professional – establishment type \(employment\), industry code NN](#) Health, Superseded 10/12/2009

Implementation in Data Set Specifications: [Work setting hours cluster](#) Health, Standard 10/12/2009

Working partnership indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Service provider organisation – working partnership indicator, yes/no code N
<i>METeOR identifier:</i>	290696
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Whether a service provider organisation has formal working partnership(s) with other service provider(s) or organisation(s), as represented by a code.
Data Element Concept:	Service provider organisation – working partnership indicator

Value domain attributes

Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Boolean						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table><thead><tr><th>Value</th><th>Meaning</th></tr></thead><tbody><tr><td>1</td><td>Yes</td></tr><tr><td>2</td><td>No</td></tr></tbody></table>	Value	Meaning	1	Yes	2	No
Value	Meaning						
1	Yes						
2	No						

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	<p>A formal working partnership involves arrangements between a service provider organisation and another service provider or organisation, aimed at providing integrated and seamless care, so that clients are able to move smoothly between services and service settings.</p> <p>A formal working partnership is a verbal or written agreement between two or more parties. It specifies the roles and responsibilities of each party, including the expected outcomes of the agreement.</p> <p>Key elements of a formal working partnership are that it is organised, routine, collaborative, and systematic. It excludes ad hoc arrangements. Examples of formal working partnerships include the existence of: written service agreements; formal liaison; referral and discharge planning processes; formal and routine consultation; protocols; partnership working groups; memoranda of understanding with other providers; and case conferencing.</p> <p>CODE 1 Yes The service provider organisation has formal working</p>
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partnership(s) with other service provider(s) or organisation(s) in place.

CODE 2 No

The service provider organisation has no formal working partnership(s) with other service provider(s) or organisation(s) in place.

Collection methods:

Record only one code.

Source and reference attributes

Submitting organisation:

Palliative Care Intergovernmental Forum

Relational attributes

Implementation in Data Set Specifications:

[Palliative care performance indicators DSS](#) Health, Standard 05/12/2007

Year insulin started

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Patient – insulin start date, YYYY
<i>METeOR identifier:</i>	269928
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The year the patient started insulin injections.
<i>Context:</i>	Public health, health care and clinical settings.
<i>Data Element Concept:</i>	Patient – insulin start date

Value domain attributes

Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	YYYY
<i>Maximum character length:</i>	4

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the year that insulin injections were started. This data element has to be completed for all patients who use insulin. It is used to cross check diabetes type assignment.
<i>Collection methods:</i>	Ask the individual the year when he/ she started to use insulin. Alternatively obtain this information from appropriate documentation, if available.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

<i>Related metadata references:</i>	Supersedes Year insulin started, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)
<i>Implementation in Data Set Specifications:</i>	Diabetes (clinical) DSS Health, Superseded 21/09/2005 Diabetes (clinical) DSS Health, Standard 21/09/2005

Year of arrival in Australia

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Person – year of first arrival in Australia, date YYYY
<i>METeOR identifier:</i>	269929
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	The year a person (born outside of Australia) first arrived in Australia, from another country, with the intention of staying in Australia for one year or more.
Data Element Concept:	Person – year of first arrival in Australia

Value domain attributes

Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	YYYY
<i>Maximum character length:</i>	4

Data element attributes

Collection and usage attributes

<i>Collection methods:</i>	Actual year of arrival in Australia. Recommended question: In what year did you/the person first arrive in Australia to live here for one year or more? (Write in the calendar year of arrival or mark the box if here less than one year) Calendar year of arrival Will be here less than one year It is anticipated that for the majority of people their response to the question will be the year of their only arrival in Australia. However, some respondents may have multiple arrivals in Australia. To deal with these cases in self-enumerated collections, an instruction such as 'Please indicate the year of first arrival only' should be included with the question. While agencies are encouraged to use the recommended question described above, it is acknowledged that this is not always possible in practice. For example, where the data collection is a by-product of the provision of a health or community service, the information may be ascertained using different means. However, the recommended question should be used wherever practically possible.
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Source and reference attributes

Origin: The Australian Bureau of Statistics Standard for [Year of Arrival in Australia](#). (last viewed 05/12/2006)

Reference documents: The ABS standard for Year of arrival in Australia appears on the ABS website
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4AD888364A44E87DCA25697E0018FE4C?opendocument> select Other ABS Statistical Standards/Standards for Social, Labour and Demographic Variables/Cultural Diversity Variable.

Relational attributes

Related metadata references: Supersedes [Year of arrival in Australia, version 2, DE, NCSDD, NCSIMG, Superseded 01/03/2005.pdf](#) (15.5 KB)

Implementation in Data Set Specifications: [Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008](#)
[Computer Assisted Telephone Interview demographic module DSS Health, Standard 03/12/2008](#)

Conditional obligation:
Conditional on respondent being from a country that is not Australia.

Year of diagnosis of diabetes mellitus

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Element
<i>Technical name:</i>	Patient – diagnosis date (diabetes mellitus), YYYY
<i>METeOR identifier:</i>	269930
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The year a patient was first diagnosed as having diabetes
<i>Context:</i>	Public health, health care and clinical settings.
<i>Data Element Concept:</i>	Patient – diagnosis date

Value domain attributes

Representational attributes

<i>Representation class:</i>	Date	
<i>Data type:</i>	Date/Time	
<i>Format:</i>	YYYY	
<i>Maximum character length:</i>	4	
<i>Supplementary values:</i>	Value	Meaning
	9999	Not stated/inadequately described

Data element attributes

Collection and usage attributes

<i>Guide for use:</i>	Record the year that the patient was first diagnosed as having diabetes.
<i>Collection methods:</i>	Ask the individual the year when he/ she was diagnosed with diabetes. Alternatively obtain this information from appropriate documentation, if available.

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
<i>Origin:</i>	National Diabetes Outcomes Quality Review Initiative (NDOQRIN) data dictionary

Relational attributes

<i>Related metadata references:</i>	Supersedes Year of diagnosis of diabetes mellitus, version 1, DE, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
<i>Implementation in Data Set Specifications:</i>	Diabetes (clinical) DSS Health, Superseded 21/09/2005
	Diabetes (clinical) DSS Health, Standard 21/09/2005

National minimum data sets

Admitted patient care NMDS 2010–2011

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	386797
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	<p>The purpose of this National Minimum Data Set is to collect information about care provided to admitted patients in Australian hospitals.</p> <p>The scope is episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's off-shore territories may also be included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.</p> <p>Hospital boarders and still births are not included as they are not admitted to hospital. Posthumous organ procurement episodes are also not included.</p>

Collection and usage attributes

<i>Statistical unit:</i>	Episodes of care for admitted patients
<i>Collection methods:</i>	<p>Data are collected at each hospital from patient administrative and clinical record systems. Hospitals forward data to the relevant state or territory health authority on a regular basis (e.g. monthly).</p> <p><i>National reporting arrangements</i></p> <p>State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.</p> <p><i>Periods for which data are collected and nationally collated</i></p> <p>Financial years ending 30 June each year.</p>
<i>Implementation start date:</i>	01/07/2010
<i>Comments:</i>	<p><i>Scope links with other NMDS</i></p> <p>Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:</p> <ul style="list-style-type: none">• Admitted patient mental health care NMDS. <p>Episodes of care for admitted patients where care type is palliative care:</p> <ul style="list-style-type: none">• Admitted patient palliative care NMDS. <p><i>Glossary items</i></p> <p>Some previous Knowledgebase data element concepts are available in the METeOR glossary. Glossary items are available</p>

online through links in the relevant metadata items. In addition links to the glossary terms that are relevant to this National Minimum Data Set are listed below.

Admission

Diagnosis

Episode of acute care

Hospital boarder

Hospital-in-the-home care

Live birth

Neonate

Newborn qualification status

Organ procurement - posthumous

Same-day patient

Separation

Relational attributes

Related metadata references:

Supersedes [Admitted patient care NMDS 2009-2010](#) Health,
Superseded 22/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Activity when injured	Mandatory	99
-	Additional diagnosis	Mandatory	99
-	Admission date	Mandatory	1
-	Admitted patient election status	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Care type	Mandatory	1
-	Condition onset flag	Mandatory	99
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Diagnosis related group	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	External cause	Mandatory	99
-	Funding source for hospital patient	Mandatory	1
-	Hospital insurance status	Mandatory	1
-	Indigenous status	Mandatory	1
-	Intended length of hospital stay	Mandatory	1
-	Inter-hospital contracted patient	Mandatory	1
-	Major diagnostic category	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Mode of admission	Mandatory	1

-	<u>Mode of separation</u>	Mandatory	1
-	<u>Number of days of hospital-in-the-home care</u>	Mandatory	1
-	<u>Number of qualified days for newborns</u>	Conditional	1
-	<u>Person identifier</u>	Mandatory	1
-	<u>Place of occurrence of external cause of injury (ICD-10-AM)</u>	Mandatory	99
-	<u>Principal diagnosis</u>	Mandatory	1
-	<u>Procedure</u>	Mandatory	99
-	<u>Region code</u>	Mandatory	1
-	<u>Separation date</u>	Mandatory	1
-	<u>Sex</u>	Mandatory	1
-	<u>Source of referral to public psychiatric hospital</u>	Conditional	1
-	<u>Total leave days</u>	Mandatory	1
-	<u>Total psychiatric care days</u>	Mandatory	1
-	<u>Urgency of admission</u>	Mandatory	1
-	<u>Weight in grams (measured)</u>	Conditional	1

Admitted patient mental health care NMDS 2010–2011

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	386799
<i>Registration status:</i>	Health, Standard 05/01/2010
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	The scope of this minimum data set is restricted to admitted patients receiving care in psychiatric hospitals or in designated psychiatric units in acute hospitals. The scope does not currently include patients who may be receiving treatment for psychiatric conditions in acute hospitals who are not in psychiatric units.

Collection and usage attributes

<i>Statistical unit:</i>	Episodes of care for admitted patients
<i>Collection methods:</i>	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). <i>National reporting arrangements</i> State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. <i>Periods for which data are collected and nationally collated</i> Financial years ending 30 June each year.
<i>Implementation start date:</i>	01/07/2010
<i>Comments:</i>	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. <i>Scope links with other NMDSs:</i> Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals: <ul style="list-style-type: none">• Admitted patient care NMDS• Admitted patient palliative care NMDS <i>Glossary items</i> 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 2009-2010](#) Health, Superseded 05/01/2010

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Additional diagnosis	Mandatory	1
-	Admission date	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Care type	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Diagnosis related group	Mandatory	1
-	Employment status (admitted patient)	Mandatory	1
-	Employment status – public psychiatric hospital admissions	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Indigenous status	Mandatory	1
-	Major diagnostic category	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	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 2010–11

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	386801
<i>Registration status:</i>	Health, Standard 05/01/2010
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	<p>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.</p> <p>Palliative care patients are identified by the data element <i>Hospital service – care type</i>, code N[N].N.</p>

Collection and usage attributes

<i>Statistical unit:</i>	Episodes of care for admitted patients.
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.</p> <p><i>Periods for which data collected and collated nationally</i></p> <p>Financial years ending 30 June each year.</p>
<i>Implementation start date:</i>	01/07/2010
<i>Comments:</i>	<p><i>Scope links with other NMDSs</i></p> <p>Episodes of care for admitted patients receiving palliative care in all public and private acute hospitals and free standing day hospital facilities:</p> <ul style="list-style-type: none">• Admitted patient care NMDS.• Admitted patient mental health care NMDS.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Admitted patient palliative care NMDS 2009-10 Health, Superseded 05/01/2010
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Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Additional diagnosis	Mandatory	1
-	Admission date	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Care type	Mandatory	1
-	Country of birth	Mandatory	1

-	<u>Date of birth</u>	Mandatory	1
-	<u>Establishment identifier</u>	Mandatory	1
-	<u>Funding source for hospital patient</u>	Mandatory	1
-	<u>Indigenous status</u>	Mandatory	1
-	<u>Mode of admission</u>	Mandatory	1
-	<u>Mode of separation</u>	Mandatory	1
-	<u>Number of days of hospital-in-the-home care</u>	Mandatory	1
-	<u>Person identifier</u>	Mandatory	1
-	<u>Previous specialised treatment</u>	Mandatory	1
-	<u>Principal diagnosis</u>	Conditional	1
-	<u>Separation date</u>	Mandatory	1
-	<u>Sex</u>	Mandatory	1

Alcohol and other drug treatment services NMDS 2010–2011

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	374211
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	<p>This metadata set is nationally mandated for collection and reporting.</p> <p>Publicly funded government and non-government agencies providing alcohol and/or drug treatment services. Including community-based ambulatory services and outpatient services.</p> <p>The following services are currently not included in the coverage:</p> <ul style="list-style-type: none">• 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 National Minimum Data Set and do not provide treatment to non-admitted patients. <p>Clients who are on a methadone maintenance program may be included in the collection where they also receive other types of treatment.</p>

Collection and usage attributes

<i>Statistical unit:</i>	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.
<i>Collection methods:</i>	<p>Data to be reported in each agency on completed treatment episode and then forwarded to state/territory authorities for collation.</p> <p><i>National reporting requirements</i></p> <p>State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.</p> <p><i>Periods for which data are collected and nationally collated</i></p> <p>Financial years ending 30 June each year.</p>
<i>Implementation start date:</i>	01/07/2010

Source and reference attributes

Submitting organisation: National Health Information Group

Relational attributes

Related metadata references: [Supersedes Alcohol and other drug treatment services NMDS 2008-2010 Health, Superseded 22/12/2009](#)

Metadata items in this Data Set Specification

Seq No.	Metadata item	Obligation	Max occurs
-	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
-	Geographical location of service delivery outlet	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
-	Treatment delivery setting for alcohol and other drugs	Mandatory	1

Community mental health care NMDS 2010–2011

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	386803
<i>Registration status:</i>	Health, Standard 05/01/2010
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	This NMDS includes data about service contacts provided by specialised mental health services for patients/clients, other than those admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services.

Collection and usage attributes

<i>Statistical unit:</i>	Mental health service contact
<i>Implementation start date:</i>	01/07/2010

Relational attributes

<i>Related metadata references:</i>	Supersedes Community mental health care NMDS 2009-2010 Health, Superseded 05/01/2010
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Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Area of usual residence	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	Indigenous status	Mandatory	1
-	Marital status	Mandatory	1
-	Mental health legal status	Mandatory	1
-	Mental health service contact date	Mandatory	1
-	Mental health service contact duration	Mandatory	1
-	Mental health service contact – patient/client participation indicator	Mandatory	1
-	Mental health service contact – session type	Mandatory	1
-	Person identifier	Mandatory	1
-	Principal diagnosis	Mandatory	1
-	Region code	Mandatory	1
-	Sex	Mandatory	1

Elective surgery waiting times (census data) NMDS 2009–

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	375331
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	<p>The scope of this minimum data set 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 referred to by the short name '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.</p> <p>Hospitals may also collect information for other care (as defined in the Waiting list category data element), but this is not part of the National Minimum Data Set (NMDS) for Elective surgery waiting times.</p> <p>Patients on waiting lists managed by hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included.</p> <p>Census data:</p> <p>Data are collected for patients on elective surgery waiting lists who are yet to be admitted to hospital or removed for another reason. The scope is patients on elective surgery waiting lists on a census date who are 'ready for care' as defined in the Elective surgery waiting list episode – patient listing status, readiness for care code N data element.</p>

Collection and usage attributes

<i>Statistical unit:</i>	Patients on waiting lists on census dates.
<i>Collection methods:</i>	<p>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].</p> <p>Elective care waiting list episode – elective care type, code N and Elective surgery waiting list episode – patient listing status, readiness for care code N are not required for reporting to the NMDS, but are necessary for determining whether patients are in scope for the NMDS. These data elements should be collected at the local level and reported to state and territory health authorities as required.</p> <p><i>National reporting arrangements</i></p> <p>State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.</p> <p><i>Periods for which data are collected and nationally collated</i></p> <p>Census dates are 30 September, 31 December, 31 March and 30 June.</p>

Implementation start date: 30/06/2009

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: Supersedes [Elective surgery waiting times \(census data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Census date	Mandatory	1
-	Clinical urgency	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Extended wait patient	Mandatory	1
-	Indicator procedure	Mandatory	1
-	Indigenous status	Mandatory	1
-	Listing date for care	Mandatory	1
-	Overdue patient	Mandatory	1
-	Surgical specialty	Mandatory	1
-	Waiting time at a census date	Mandatory	1

Elective surgery waiting times (removals data) NMDS 2009–

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	375336
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	<p>The scope of this minimum data set is patients removed from waiting lists for elective surgery (as defined in the Waiting list category data element) which are managed by public acute hospitals. This will include private patients treated in public hospitals, and may include public patients treated in private hospitals.</p> <p>Hospitals may also collect information for other care (as defined in the Waiting list category data element), but this is not part of the National Minimum Data Set (NMDS) for elective surgery waiting times.</p> <p>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.</p> <p>Removals data:</p> <p>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.</p>

Collection and usage attributes

<i>Statistical unit:</i>	Patients removed from waiting lists (for admission or other reason) during each financial year.
<i>Collection methods:</i>	<p>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].</p> <p>Elective care waiting list episode – elective care type, code N and Elective surgery waiting list episode – patient listing status, readiness for care code N are not required for reporting to the NMDS, but are necessary for determining whether patients are in scope for the NMDS. These data elements should be collected at the local level and reported to state and territory health authorities as required.</p> <p><i>National reporting arrangements</i></p> <p>State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.</p> <p><i>Periods for which data are collected and nationally collated</i></p> <p>Financial years ending 30 June each year for removals data.</p>
<i>Implementation start date:</i>	01/07/2009

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: Supersedes [Elective surgery waiting times \(removals data\) NMDS 2006-2009](#) Health, Superseded 03/12/2008

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Clinical urgency	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Extended wait patient	Mandatory	1
-	Indicator procedure	Mandatory	1
-	Indigenous status	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
-	Listing date for care	Mandatory	1

Government health expenditure NMDS 2009–2010

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	376403
<i>Registration status:</i>	Health, Standard 01/04/2009
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	<p>The scope of this dataset is direct government and government-funded expenditure on health and health-related goods and services.</p> <p>The purpose of this NMDS is to provide an enhanced understanding of the overall financial resources (recurrent and capital) used by the health system, and of unit costs and performance; to enable greater comparability of health expenditure data between jurisdictions and over time; and to provide a more efficient compilation of national reports and analyses on government funded health expenditure.</p>

Collection and usage attributes

<i>Statistical unit:</i>	Providers of health or health related goods and services or non-health services that support the health services industry; health or health related functions; and the sources of funds for these providers or functions.
<i>Guide for use:</i>	<p>The GHE NMDS consists of 5 mandatory data clusters and 1 conditional data cluster.</p> <p>The first two data elements named in each data cluster form one of the two axes of a matrix that combine to provide all data in Australian dollars.</p> <p>Data are to be reported in Australian dollars except when reporting the State/Territory identifier of the Jurisdiction.</p>
<i>Collection methods:</i>	<p>Data are collected by a number of providers from their administrative systems and forwarded to the relevant state or territory health authority on a regular basis (for example, monthly). Hospitals forward data obtained from patient administrative and clinical record systems to the relevant state or territory health authority on a regular basis (for example, monthly). Other data are obtained either directly from annual reports or through surveys.</p> <p>National reporting arrangements</p> <p>State and Territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.</p> <p>Periods for which data are collected and nationally collated:</p> <p>Financial years ending 30 June each year.</p>
<i>Implementation start date:</i>	01/07/2009
<i>Comments:</i>	<p>Scope links with other NMDSs</p> <ul style="list-style-type: none">• National Public Hospital Establishments NMDS• Mental Health Establishments NMDS

Source and reference attributes

Submitting organisation: Health Expenditure Advisory Committee

Relational attributes

Related metadata references: Supersedes [Government health expenditure NMDS 2008-2009 Health](#), Superseded 03/12/2008

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
1	Government health expenditure organisation revenue data element cluster	Mandatory	1
2	Government health expenditure organisation expenditure data element cluster	Mandatory	1
3	Government health expenditure organisation expenditure purchase of goods and services data element cluster	Mandatory	1
4	Government health expenditure organisation expenditure employee related data element cluster	Mandatory	1
5	Government health expenditure organisation expenditure capital consumption data element cluster	Mandatory	1
6	Government health expenditure function revenue data element cluster	Conditional	1
7	Australian State/Territory identifier (jurisdiction)	Mandatory	1

Health labour force NMDS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	273041
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	The scope of this set of data elements is all health occupations. National collections using this data set have been undertaken for the professions of medicine, nursing, dentistry, pharmacy, physiotherapy and podiatry, using labour force questionnaires in the annual renewal of registration to practice.

Collection and usage attributes

<i>Statistical unit:</i>	A health professional's labour force data
<i>Collection methods:</i>	<i>National reporting arrangements</i> State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. <i>Periods for which data are collected and nationally collated</i> Financial years ending 30 June each year.
<i>Implementation start date:</i>	01/07/2005

Source and reference attributes

<i>Submitting organisation:</i>	National Health Information Group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Health labour force, NMDS, NHIMG, Superseded 01/03/2005.pdf (113.4 KB)
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Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Classification of health labour force job	Mandatory	1
-	Date of birth	Mandatory	1
-	Hours on-call (not worked) by medical practitioner	Mandatory	1
-	Hours worked by health professional	Mandatory	1
-	Hours worked by medical practitioner in direct patient care	Mandatory	1
-	Principal area of clinical practice	Mandatory	1
-	Principal role of health professional	Mandatory	1
-	Profession labour force status of health professional	Mandatory	1
-	Total hours worked by a medical practitioner	Mandatory	1
-	Type and sector of employment establishment	Mandatory	1

Mental health establishments NMDS 2010–2011

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	378611
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	<p>The scope of the MHE National Minimum Data Set (NMDS) is all specialised mental health services managed by, or in receipt of funds, from state or territory health authorities.</p> <p>Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.</p> <p>The concept of a specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget.</p> <p>A service is not defined as a specialised mental health service solely because its clients include people affected by a mental illness or psychiatric disability. The definition excludes specialist drug and alcohol services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability.</p> <p>These services can be a sub-unit of a hospital even where the hospital is not a specialised mental health establishment itself (e.g. designated psychiatric units and wards, outpatient clinics etc).</p> <p>The statistical units are specialised mental health services. These are the specialised mental health components of the state and territory health authorities, and of regions within states and territories; specialised mental health service organisations; service units within those organisations; and private hospital and non-government residential service units funded by specialised mental health services.</p> <p>Non-government residential mental health services and specialised mental health services provided by private hospitals that receive state or territory government funding are included as service units for this NMDS.</p> <p>There is a hierarchy of statistical units used within the MHE NMDS. Information is provided at each level: State/Territory; Region; Organisation; Hospital/Service unit cluster; and Service unit (Admitted patient services, Residential services and Ambulatory services). Each level has a unique set of attributes which comprise the NMDS data elements and additional supplementary information.</p>

Collection and usage attributes

<i>Statistical unit:</i>	Specialised mental health services.
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<i>Collection methods:</i>	<i>National reporting arrangements</i> State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. <i>Periods for which data are collected and nationally collated</i> Financial years ending 30 June each year.
<i>Implementation start date:</i>	01/07/2010
<i>Comments:</i>	<i>Glossary items</i> Glossary terms that are relevant to this National minimum data set are included here. Episode of residential care end Episode of residential care start Mental health-funded non-government organisation Residential mental health care service

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Accrued mental health care days	Mandatory	1
-	Australian State/Territory identifier (establishment)	Mandatory	1
-	Average available beds for overnight-stay patients	Mandatory	1
-	Average available beds for residential mental health patients	Mandatory	1
-	Carer participation arrangements – carer consultants employed	Mandatory	1
-	Carer participation arrangements – carer satisfaction surveys	Mandatory	1
-	Carer participation arrangements – formal complaints mechanism	Mandatory	1
-	Carer participation arrangements – formal participation policy	Mandatory	1
-	Carer participation arrangements – regular discussion groups	Mandatory	1
-	Co-location status of mental health service	Mandatory	1
-	Consumer committee representation arrangements	Mandatory	1
-	Consumer participation arrangements – consumer consultants employed	Mandatory	1
-	Consumer participation arrangements – consumer satisfaction surveys	Mandatory	1
-	Consumer participation arrangements – formal complaints mechanism	Mandatory	1
-	Consumer participation arrangements – formal participation policy	Mandatory	1
-	Consumer participation arrangements – regular discussion groups	Mandatory	1
-	Establishment sector	Mandatory	1
-	Full-time equivalent staff – administrative and clerical staff	Mandatory	1
-	Full-time equivalent staff – carer consultants	Conditional	1
-	Full-time equivalent staff – consultant psychiatrists and psychiatrists	Mandatory	1

- Full-time equivalent staff – consumer consultants	Conditional	1
- Full-time equivalent staff – diagnostic and health professionals	Mandatory	1
- Full-time equivalent staff – domestic and other staff	Mandatory	1
- Full-time equivalent staff – enrolled nurses	Mandatory	1
- Full-time equivalent staff – occupational therapists	Mandatory	1
- Full-time equivalent staff – other diagnostic and health professionals	Mandatory	1
- Full-time equivalent staff – other medical officers	Mandatory	1
- Full-time equivalent staff – other personal care staff	Mandatory	1
- Full-time equivalent staff – psychiatry registrars and trainees	Mandatory	1
- Full-time equivalent staff – psychologists	Mandatory	1
- Full-time equivalent staff – registered nurses	Mandatory	1
- Full-time equivalent staff – salaried medical officers	Mandatory	1
- Full-time equivalent staff – social workers	Mandatory	1
- Geographical location of establishment	Mandatory	1
- Grants to non-government organisations – accommodation services	Mandatory	1
- Grants to non-government organisations – advocacy services	Mandatory	1
- Grants to non-government organisations – community awareness/health promotion services	Mandatory	1
- Grants to non-government organisations – counselling services	Mandatory	1
- Grants to non-government organisations – independent living skills support services	Mandatory	1
- Grants to non-government organisations – other and unspecified mental health services	Mandatory	1
- Grants to non-government organisations – pre-vocational training services	Mandatory	1
- Grants to non-government organisations – psychosocial support services	Mandatory	1
- Grants to non-government organisations – recreation services	Mandatory	1
- Grants to non-government organisations – respite services	Mandatory	1
- Grants to non-government organisations – self-help support group services	Mandatory	1
- Mental health services grants to non-government organisations by non-health departments	Mandatory	1
- National standards for mental health services review status	Mandatory	1
- Number of episodes of residential care	Mandatory	1
- Recurrent expenditure (mental health) – non-salary operating costs	Mandatory	1
- Recurrent expenditure (mental health) – salaries and wages	Mandatory	1
- Recurrent expenditure (salaries and wages) – administrative and clerical staff	Mandatory	1
- Recurrent expenditure (salaries and wages) – carer consultants	Mandatory	1
- Recurrent expenditure (salaries and wages) – consultant	Mandatory	1

	<u>psychiatrists and psychiatrists</u>		
-	<u>Recurrent expenditure (salaries and wages) – consumer consultants</u>	Mandatory	1
-	<u>Recurrent expenditure (salaries and wages) – domestic and other staff</u>	Mandatory	1
-	<u>Recurrent expenditure (salaries and wages) – enrolled nurses</u>	Mandatory	1
-	<u>Recurrent expenditure (salaries and wages) – occupational therapists</u>	Mandatory	1
-	<u>Recurrent expenditure (salaries and wages) – other diagnostic and health professionals</u>	Mandatory	1
-	<u>Recurrent expenditure (salaries and wages) – other medical officers</u>	Mandatory	1
-	<u>Recurrent expenditure (salaries and wages) – other personal care staff</u>	Mandatory	1
-	<u>Recurrent expenditure (salaries and wages) – psychiatry registrars and trainees</u>	Mandatory	1
-	<u>Recurrent expenditure (salaries and wages) – psychologists</u>	Mandatory	1
-	<u>Recurrent expenditure (salaries and wages) – registered nurses</u>	Mandatory	1
-	<u>Recurrent expenditure (salaries and wages) – social workers</u>	Mandatory	1
-	<u>Recurrent expenditure – administrative expenses</u>	Mandatory	1
-	<u>Recurrent expenditure – Department of Veterans’ Affairs funded</u>	Mandatory	1
-	<u>Recurrent expenditure – depreciation</u>	Mandatory	1
-	<u>Recurrent expenditure – domestic services</u>	Mandatory	1
-	<u>Recurrent expenditure – drug supplies</u>	Mandatory	1
-	<u>Recurrent expenditure – food supplies</u>	Mandatory	1
-	<u>Recurrent expenditure – interest payments</u>	Mandatory	1
-	<u>Recurrent expenditure – medical and surgical supplies</u>	Mandatory	1
-	<u>Recurrent expenditure – National Mental Health Strategy funded</u>	Mandatory	1
-	<u>Recurrent expenditure – other Commonwealth Government funded</u>	Mandatory	1
-	<u>Recurrent expenditure – other patient revenue funded</u>	Mandatory	1
-	<u>Recurrent expenditure – other recurrent expenditure</u>	Mandatory	1
-	<u>Recurrent expenditure – other revenue funded</u>	Mandatory	1
-	<u>Recurrent expenditure – other State or Territory funded</u>	Mandatory	1
-	<u>Recurrent expenditure – patient transport</u>	Mandatory	1
-	<u>Recurrent expenditure – payments to visiting medical officers</u>	Mandatory	1
-	<u>Recurrent expenditure – recoveries funded</u>	Mandatory	1
-	<u>Recurrent expenditure – repairs and maintenance</u>	Mandatory	1
-	<u>Recurrent expenditure – State or Territory health authority funded</u>	Mandatory	1
-	<u>Recurrent expenditure – superannuation employer contributions</u>	Mandatory	1
-	<u>Region code</u>	Mandatory	1
-	<u>Residual expenditure (mental health service) – academic positions</u>	Mandatory	1

- Residual expenditure (mental health service) – education and training	Mandatory	1
- Residual expenditure (mental health service) – insurance	Mandatory	1
- Residual expenditure (mental health service) – Mental Health Act Regulation or related legislation	Mandatory	1
- Residual expenditure (mental health service) – mental health promotion	Mandatory	1
- Residual expenditure (mental health service) – mental health research	Mandatory	1
- Residual expenditure (mental health service) – other indirect expenditure	Mandatory	1
- Residual expenditure (mental health service) – patient transport services	Mandatory	1
- Residual expenditure (mental health service) – program administration	Mandatory	1
- Residual expenditure (mental health service) – property leasing costs	Mandatory	1
- Residual expenditure (mental health service) – service development	Mandatory	1
- Residual expenditure (mental health service) – superannuation	Mandatory	1
- Residual expenditure (mental health service) – support services	Mandatory	1
- Residual expenditure (mental health service) – workers compensation	Mandatory	1
- Separations	Mandatory	1
- Specialised mental health service program type	Mandatory	1
- Specialised mental health service setting	Conditional	1
- Specialised mental health service target population	Mandatory	1
- Specialised mental health service – hours staffed	Mandatory	1
- Specialised mental health service – supported public housing places	Mandatory	1

Non-admitted patient emergency department care NMDS 2010–2011

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	374220
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	<p>This metadata set is nationally mandated for collection and reporting.</p> <p>The scope of this National Minimum Data Set (NMDS) is non-admitted patients registered for care in emergency departments in selected public hospitals that are classified as either Peer Group A or B in the Australian Institute of Health and Welfare's Australian Hospital Statistics publication from the preceding financial year.</p> <p>The care provided to patients in emergency departments is, in most instances, recognised as being provided to 'non-admitted' patients. Patients being treated in emergency departments may subsequently become 'admitted'. The care provided to non-admitted patients who are treated in the emergency department prior to being admitted is included in this NMDS.</p> <p>Care provided to patients who are being treated in an emergency department site as an admitted patient (e.g. in an observation unit, short-stay unit, 'emergency department ward' or awaiting a bed in an admitted patient ward of the hospital) are excluded from the emergency department care NMDS since the recording of the care provided to these patients is part of the scope of the Admitted patient care NMDS.</p>

Collection and usage attributes

<i>Statistical unit:</i>	Non-admitted patient emergency department service episodes.
<i>Collection methods:</i>	<p>National reporting arrangements</p> <p>State and territory health authorities provide the NMDS data to the Australian Institute of Health and Welfare for national collation, on an annual basis within 3 months of the end of a reporting period.</p> <p>The Institute and the Commonwealth Department of Health and Ageing will agree on a data quality and timeliness protocol. Once cleaned, a copy of the data and a record of the changes made will be forwarded by the Institute to the Commonwealth Department of Health and Ageing. A copy of the cleaned data for each jurisdiction should also be returned to that jurisdiction on request.</p> <p>Periods for which data are collected and nationally collated</p> <p>Financial years, ending 30 June each year. Extraction of data for a financial year should be based on the date of the end of the non-admitted emergency department service episode.</p>
<i>Implementation start date:</i>	01/07/2010

Comments:

Scope links with other metadata sets

Episodes of care for admitted patients are reported through the Admitted patient care NMDS.

Source and reference attributes

Submitting organisation: National Health Information Management Principal Committee

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Area of usual residence	Mandatory	1
-	Compensable status	Mandatory	1
-	Country of birth	Conditional	1
-	Date of birth	Mandatory	1
-	Date of triage	Mandatory	1
-	Date patient presents	Mandatory	1
-	Department of Veterans' Affairs patient	Conditional	1
-	Emergency department arrival mode - transport	Mandatory	1
-	Emergency department date of commencement of service event	Mandatory	1
-	Emergency department departure date	Mandatory	1
-	Emergency department departure time	Mandatory	1
-	Emergency department episode end date	Mandatory	1
-	Emergency department episode end time	Mandatory	1
-	Emergency department service episode end status	Mandatory	1
-	Emergency department time of commencement of service event	Mandatory	1
-	Emergency department waiting time to service delivery	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Indigenous status	Mandatory	1
-	Length of non-admitted patient emergency department service episode	Mandatory	1
-	Person identifier	Mandatory	1
-	Sex	Mandatory	1
-	Time of triage	Mandatory	1
-	Time patient presents	Mandatory	1
-	Triage category	Mandatory	1
-	Type of visit to emergency department	Mandatory	1

Outpatient care NMDS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	336862
<i>Registration status:</i>	Health, Standard 04/07/2007
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	The scope of this National Minimum Data Set (NMDS) is for services provided to non-admitted, non-emergency department, patients registered for care by specialist outpatient clinics of public hospitals that are classified as either principal referral and specialist women's and children's hospitals and large hospitals (Peer Group A or B) as reported in the Australian Institute of Health and Welfare's Australian Hospital Statistics publication from the preceding financial year.

Hospitals use the term 'clinic' to describe various arrangements under which they deliver specialist outpatient services to non-admitted non-emergency department patients. **Outpatient clinic services** should be interpreted as encompassing services provided through specific organisational units staffed to administer and provide a certain range of outpatient care:

- in defined locations;
- at regular or irregular times; and
- where one or more specialist providers deliver care to booked patients.

Generally, in such clinics, a booking system is administered and patient records are maintained to document patient attendances and care provided.

The scope includes all arrangements made to deliver specialist care to non-admitted, non-emergency department patients whose treatment has been funded through the hospital, regardless of the source from which the hospital derives these funds. In particular, Department of Veterans' Affairs, compensable and other patients **funded through the hospital** (including Medicare ineligible patients) are included.

For the purposes of the Outpatient care NMDS, outreach services are counted at the specialist clinic where the patient is booked. Outreach services involve travel by the service provider, or services provided by a service provider via ICT (including but not limited to telephone and telehealth consultations). Such services may also be provided in the home, place of work or other non-hospital site.

Within the scope as defined, and subject to specific counting rules, occasions of service to be counted include outreach clinic services, services delivered in a multidisciplinary mode. A separate count of services delivered in group sessions is also collected.

Excluded from scope are:

- Outreach services which are not funded through the hospital and/or which deliver non-clinical care (activities such as home cleaning, meals on wheels, home maintenance); and

- All private specialist services delivered under private practice arrangements which are not funded through the hospital, regardless of whether or how these services may be funded by third party arrangements.
- All services covered by NMDS for:
 - Admitted Patient Care,
 - Admitted patient mental health care,
 - Alcohol and other drug treatment services,
 - Community mental health care,
 - Non-admitted patient emergency department.

Admitted patient services are excluded from scope. However, outpatient services booked for reasons independent of, or distinct from the admitted patient episode are in scope.

Collection and usage attributes

Statistical unit: Occasions of service.

Group sessions.

Collection methods:

National reporting arrangements:

State and territory Health authorities provide the data to the Department of Health and Ageing and Australian Institute of Health and Welfare on an annual basis by 31 December each calendar year, for the previous financial year.

Periods for which data are collected and nationally collated:

Each financial year ending 30 June.

Implementation start date: 01/07/2007

Source and reference attributes

Submitting organisation: Non-admitted patient NMDS Development Working Party, 2006

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Establishment identifier	Mandatory	1
-	Number of group sessions	Conditional	1
-	Number of occasions of service	Mandatory	1
-	Outpatient clinic type	Mandatory	1

Perinatal NMDS 2010–2011

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	363256
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	<p>The scope of this minimum data set is all births in Australia in hospitals, birth centres and the community. The data set includes information on all births, both live and stillborn, of at least 20 weeks gestation or 400 grams birth weight.</p> <p>These data have two dimensions, which are the baby and the mother. All data relevant to the birth are conveyed in relation to one of these.</p>

Collection and usage attributes

<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>State and territory health authorities provide the data to the Australian Institute of Health and Welfare National Perinatal Statistics Unit for national collation, on an annual basis.</p> <p><i>Periods for which data are collected and nationally collated</i></p> <p>Financial years ending 30 June each year.</p>
<i>Implementation start date:</i>	01/07/2010

Relational attributes

<i>Related metadata references:</i>	Supersedes Perinatal NMDS 2008-2010 Health, Superseded 02/12/2009
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Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Actual place of birth	Mandatory	1
-	Apgar score at 5 minutes	Mandatory	1
-	Area of usual residence	Mandatory	1
-	Birth order	Mandatory	1
-	Birth plurality	Mandatory	1
-	Country of birth	Mandatory	1
-	Date of birth	Mandatory	2
-	Establishment identifier	Mandatory	1
-	Gestational age	Mandatory	1
-	Indigenous status	Mandatory	1
-	Infant weight, neonate, stillborn	Mandatory	1
-	Method of birth	Conditional	1
-	Number of tobacco cigarettes smoked per day after 20 weeks of	Conditional	1

	<u>pregnancy</u>		
-	<u>Onset of labour</u>	Mandatory	1
-	<u>Person identifier</u>	Mandatory	2
-	<u>Pregnancy duration at the first antenatal care visit</u>	Mandatory	1
-	<u>Presentation at birth</u>	Mandatory	1
-	<u>Separation date</u>	Mandatory	2
-	<u>Sex</u>	Mandatory	1
-	<u>State/Territory of birth</u>	Mandatory	1
-	<u>Status of the baby</u>	Mandatory	1
-	<u>Tobacco smoking indicator, after 20 weeks of pregnancy</u>	Mandatory	1
-	<u>Tobacco smoking indicator, first 20 weeks of pregnancy</u>	Mandatory	1

Public hospital establishments NMDS 2010–2011

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	386794
<i>Registration status:</i>	Health, Standard 05/01/2010
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	<p>The scope of this dataset is establishment-level data for public acute and psychiatric hospitals, including hospitals operated for or by the Department of Veterans' Affairs, and alcohol and drug treatment centres.</p> <p>Similar data for private hospitals and free standing day hospital facilities is collected by the Australian Bureau of Statistics in the Private Health Establishments Collection.</p> <p>Hospitals operated by the Australian Defence Force, corrections authorities and Australia's external territories are not currently included. Hospitals specialising in dental, ophthalmic aids and other specialised acute medical or surgical care are included.</p>

Collection and usage attributes

<i>Statistical unit:</i>	Public hospital establishments.
<i>Collection methods:</i>	<p>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).</p> <p><i>National reporting arrangements</i></p> <p>State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis.</p> <p><i>Periods for which data are collected and nationally collated</i></p> <p>Financial years ending 30 June each year.</p>
<i>Implementation start date:</i>	01/07/2010
<i>Comments:</i>	<p><i>Scope links with other NMDSs</i></p> <p>Episodes of care for admitted patients which occur partly or fully in designated psychiatric units of public acute hospitals or in public psychiatric hospitals:</p> <ul style="list-style-type: none">• Admitted patient care NMDS• Admitted patient mental health care NMDS• Admitted patient palliative care NMDS

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Average available beds for overnight-stay patients	Conditional	1
-	Average available beds for same-day patients	Conditional	1
-	Establishment identifier	Mandatory	1

- Establishment type	Mandatory	1
- Full-time equivalent staff – administrative and clerical staff	Mandatory	1
- Full-time equivalent staff – diagnostic and health professionals	Conditional	1
- Full-time equivalent staff – domestic and other staff	Mandatory	1
- Full-time equivalent staff – enrolled nurses	Mandatory	1
- Full-time equivalent staff – other personal care staff	Mandatory	1
- Full-time equivalent staff – registered nurses	Mandatory	1
- Full-time equivalent staff – salaried medical officers	Mandatory	1
- Full-time equivalent staff – student nurses	Mandatory	1
- Full-time equivalent staff – trainee/pupil nurses	Mandatory	1
- Geographical location of establishment	Mandatory	1
- Gross capital expenditure (accrual accounting) – buildings and building services	Mandatory	1
- Gross capital expenditure (accrual accounting) – constructions	Mandatory	1
- Gross capital expenditure (accrual accounting) – equipment	Conditional	1
- Gross capital expenditure (accrual accounting) – information technology	Conditional	1
- Gross capital expenditure (accrual accounting) – intangible assets	Conditional	1
- Gross capital expenditure (accrual accounting) – land	Mandatory	1
- Gross capital expenditure (accrual accounting) – major medical equipment	Mandatory	1
- Gross capital expenditure (accrual accounting) – other equipment	Mandatory	1
- Gross capital expenditure (accrual accounting) – transport	Mandatory	1
- Gross capital expenditure – computer equipment/installations	Mandatory	1
- Gross capital expenditure – intangible assets	Mandatory	1
- Gross capital expenditure – land and buildings	Mandatory	1
- Gross capital expenditure – major medical equipment	Mandatory	1
- Gross capital expenditure – other	Mandatory	1
- Gross capital expenditure – plant and other equipment	Mandatory	1
- Group sessions (public psychiatric, alcohol and drug hospital) – emergency and outpatient	Mandatory	1
- Group sessions (public psychiatric, alcohol and drug hospital) – outreach and community	Mandatory	1
- Group sessions – alcohol and other drug	Mandatory	1
- Group sessions – allied health services	Mandatory	1
- Group sessions – community health services	Mandatory	1
- Group sessions – dental	Mandatory	1
- Group sessions – dialysis	Mandatory	1
- Group sessions – district nursing services	Mandatory	1
- Group sessions – emergency services	Mandatory	1
- Group sessions – endoscopy and related procedures	Mandatory	1
- Group sessions – mental health	Mandatory	1

- <u>Group sessions – other medical/surgical/diagnostic</u>	Mandatory	1
- <u>Group sessions – other outreach services</u>	Mandatory	1
- <u>Group sessions – pathology</u>	Mandatory	1
- <u>Group sessions – pharmacy</u>	Mandatory	1
- <u>Group sessions – radiology and organ imaging</u>	Mandatory	1
- <u>Individual sessions (public psychiatric, alcohol and drug hospital) - emergency and outpatient</u>	Mandatory	1
- <u>Individual sessions (public psychiatric, alcohol and drug hospital) – outreach and community</u>	Mandatory	1
- <u>Individual sessions – alcohol and drug</u>	Mandatory	1
- <u>Individual sessions – allied health services</u>	Mandatory	1
- <u>Individual sessions – community health services</u>	Mandatory	1
- <u>Individual sessions – dental</u>	Mandatory	1
- <u>Individual sessions – dialysis</u>	Mandatory	1
- <u>Individual sessions – district nursing services</u>	Mandatory	1
- <u>Individual sessions – emergency services</u>	Mandatory	1
- <u>Individual sessions – endoscopy and related procedures</u>	Conditional	1
- <u>Individual sessions – mental health</u>	Mandatory	1
- <u>Individual sessions – other medical/surgical/diagnostic</u>	Mandatory	1
- <u>Individual sessions – other outreach services</u>	Mandatory	1
- <u>Individual sessions – pathology</u>	Mandatory	1
- <u>Individual sessions – pharmacy</u>	Mandatory	1
- <u>Individual sessions – radiology and organ imaging</u>	Mandatory	1
- <u>Net capital expenditure (accrual accounting) – buildings and building services</u>	Mandatory	1
- <u>Net capital expenditure (accrual accounting) – constructions</u>	Mandatory	1
- <u>Net capital expenditure (accrual accounting) – equipment</u>	Mandatory	1
- <u>Net capital expenditure (accrual accounting) – information technology</u>	Mandatory	1
- <u>Net capital expenditure (accrual accounting) – intangible assets</u>	Mandatory	1
- <u>Net capital expenditure (accrual accounting) – land</u>	Mandatory	1
- <u>Net capital expenditure (accrual accounting) – major medical equipment</u>	Mandatory	1
- <u>Net capital expenditure (accrual accounting) – other equipment</u>	Mandatory	1
- <u>Net capital expenditure (accrual accounting) – transport</u>	Mandatory	1
- <u>Recurrent expenditure (indirect health care) – public health and monitoring services</u>	Mandatory	1
- <u>Recurrent expenditure (indirect health care) – central administrations</u>	Mandatory	1
- <u>Recurrent expenditure (indirect health care) – central and statewide support services</u>	Mandatory	1
- <u>Recurrent expenditure (indirect health care) – other</u>	Mandatory	1

- Recurrent expenditure (indirect health care) – patient transport services	Mandatory	1
- Recurrent expenditure (salaries and wages) – administrative and clerical staff	Mandatory	1
- Recurrent expenditure (salaries and wages) – diagnostic and health professionals	Mandatory	1
- Recurrent expenditure (salaries and wages) – domestic and other staff	Mandatory	1
- Recurrent expenditure (salaries and wages) – enrolled nurses	Mandatory	1
- Recurrent expenditure (salaries and wages) – other personal care staff	Mandatory	1
- Recurrent expenditure (salaries and wages) – registered nurses	Mandatory	1
- Recurrent expenditure (salaries and wages) – salaried medical officers	Mandatory	1
- Recurrent expenditure (salaries and wages) – student nurses	Mandatory	1
- Recurrent expenditure (salaries and wages) – total	Mandatory	1
- Recurrent expenditure (salaries and wages) – trainee/pupil nurses	Mandatory	1
- Recurrent expenditure – administrative expenses	Mandatory	1
- Recurrent expenditure – depreciation	Mandatory	1
- Recurrent expenditure – domestic services	Mandatory	1
- Recurrent expenditure – drug supplies	Mandatory	1
- Recurrent expenditure – food supplies	Mandatory	1
- Recurrent expenditure – interest payments	Mandatory	1
- Recurrent expenditure – medical and surgical supplies	Mandatory	1
- Recurrent expenditure – other recurrent expenditure	Mandatory	1
- Recurrent expenditure – patient transport	Mandatory	1
- Recurrent expenditure – payments to visiting medical officers	Mandatory	1
- Recurrent expenditure – repairs and maintenance	Mandatory	1
- Recurrent expenditure – superannuation employer contributions	Mandatory	1
- Revenue – other	Mandatory	1
- Revenue – patient	Mandatory	1
- Revenue – recoveries	Mandatory	1
- Specialised service indicators – acquired immune deficiency syndrome unit	Mandatory	1
- Specialised service indicators – acute renal dialysis unit	Mandatory	1
- Specialised service indicators – acute spinal cord injury unit	Mandatory	1
- Specialised service indicators – alcohol and drug unit	Mandatory	1
- Specialised service indicators – bone marrow transplantation unit	Mandatory	1
- Specialised service indicators – burns unit (level III)	Mandatory	1
- Specialised service indicators – cardiac surgery unit	Mandatory	1
- Specialised service indicators – clinical genetics unit	Mandatory	1
- Specialised service indicators – comprehensive epilepsy centre	Mandatory	1
- Specialised service indicators – coronary care unit	Mandatory	1

- <u>Specialised service indicators – diabetes unit</u>	Mandatory	1
- <u>Specialised service indicators – domiciliary care service</u>	Mandatory	1
- <u>Specialised service indicators – geriatric assessment unit</u>	Mandatory	1
- <u>Specialised service indicators – heart, lung transplantation unit</u>	Mandatory	1
- <u>Specialised service indicators – hospice care unit</u>	Mandatory	1
- <u>Specialised service indicators – in-vitro fertilisation unit</u>	Mandatory	1
- <u>Specialised service indicators – infectious diseases unit</u>	Mandatory	1
- <u>Specialised service indicators – intensive care unit (level III)</u>	Mandatory	1
- <u>Specialised service indicators – liver transplantation unit</u>	Mandatory	1
- <u>Specialised service indicators – maintenance renal dialysis centre</u>	Mandatory	1
- <u>Specialised service indicators – major plastic/reconstructive surgery unit</u>	Mandatory	1
- <u>Specialised service indicators – neonatal intensive care unit (level III)</u>	Mandatory	1
- <u>Specialised service indicators – neurosurgical unit</u>	Mandatory	1
- <u>Specialised service indicators – nursing home care unit</u>	Mandatory	1
- <u>Specialised service indicators – obstetric/maternity</u>	Mandatory	1
- <u>Specialised service indicators – oncology unit, cancer treatment</u>	Mandatory	1
- <u>Specialised service indicators – pancreas transplantation unit</u>	Mandatory	1
- <u>Specialised service indicators – psychiatric unit/ward</u>	Mandatory	1
- <u>Specialised service indicators – rehabilitation unit</u>	Mandatory	1
- <u>Specialised service indicators – renal transplantation unit</u>	Mandatory	1
- <u>Specialised service indicators – sleep centre</u>	Mandatory	1
- <u>Specialised service indicators – specialist paediatric</u>	Mandatory	1
- <u>Teaching status</u>	Mandatory	1

Residential mental health care NMDS 2010–2011

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	386809
<i>Registration status:</i>	Health, Standard 05/01/2010
<i>DSS type:</i>	National Minimum Data Set (NMDS)
<i>Scope:</i>	Episodes of residential care for residents in all government-funded residential mental health care services in Australia, except those residential care services that are in receipt of funding under the Aged Care Act and subject to Commonwealth reporting requirements (i.e. report to the System for the payment of Aged Residential Care (SPARC) collection).

Collection and usage attributes

<i>Statistical unit:</i>	Episodes of residential care. Statistical units are entities from or about which statistics are collected, or in respect of which statistics are compiled, tabulated or published.
<i>Collection methods:</i>	Data are collected at each service from resident administrative and care related record systems. Services forward data to the relevant state or territory health authority on a regular basis (e.g. monthly). National reporting arrangements State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collection, on an annual basis. Government-operated services that employ mental health trained staff on-site 24 hours per day are to be included from 1 July 2004. Government-funded, non-government operated services and non 24-hour staffed services can be included from 1 July 2004, optionally. For non 24-hour staffed services to be included they must employ mental health-trained staff on-site at least 50 hours per week with at least 6 hours staffing on any single day. Periods for which data are collected and nationally collated Financial years ending 30 June each year. The reference period starts on 1 July and ends on 30 June each year.
<i>Implementation start date:</i>	01/07/2010
<i>Comments:</i>	Some admitted patient care services may meet the definition of a residential mental health service. However, as they are admitted patient care services, relevant data on their patients are reported to the National Minimum Data Set for Admitted Patient Care.

Glossary items

Episode of residential care end

Episode of residential care start

Resident

Residential mental health care service

Relational attributes

Related metadata references:

Supersedes [Residential mental health care NMDS 2009-2010](#)
Health, Superseded 05/01/2010

Metadata items in this Data Set Specification

Data set specifications

Acute coronary syndrome (clinical) DSS

Identifying and definitional attributes

Metadata item type: Data Set Specification

METeOR identifier: 372930

Registration status: Health, Standard 01/10/2008

DSS type: Data Set Specification (DSS)

Scope: This 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 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:

This 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.

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	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 (units per litre)	Conditional	1
- Creatine kinase MB isoenzyme – upper limit of normal range (micrograms 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

-	<u>Person identifier</u>	Optional	1
-	<u>Premature cardiovascular disease family history (status)</u>	Optional	1
-	<u>Principal diagnosis</u>	Optional	1
-	<u>Reason for readmission – acute coronary syndrome</u>	Optional	1
-	<u>Separation date</u>	Optional	1
-	<u>Sex</u>	Optional	1
-	<u>Time C-reactive protein level measured</u>	Optional	1
-	<u>Time creatine kinase MB isoenzyme measured</u>	Conditional	1
-	<u>Time of diagnostic cardiac catheterisation</u>	Conditional	1
-	<u>Time of implantable cardiac defibrillator procedure</u>	Optional	1
-	<u>Time of intra-aortic balloon pump procedure</u>	Conditional	1
-	<u>Time of non-invasive ventilation administration</u>	Optional	1
-	<u>Time of onset of acute coronary syndrome symptoms</u>	Optional	1
-	<u>Time of pacemaker insertion</u>	Conditional	1
-	<u>Time of triage</u>	Optional	1
-	<u>Time patient presents</u>	Optional	1
-	<u>Time troponin measured</u>	Optional	1
-	<u>Tobacco smoking status</u>	Optional	1
-	<u>Total blood units transfused</u>	Conditional	1
-	<u>Triage category</u>	Conditional	1
-	<u>Triglyceride level (measured)</u>	Optional	1
-	<u>Troponin assay type</u>	Optional	1
-	<u>Troponin assay – upper limit of normal range (micrograms per litre)</u>	Conditional	1
-	<u>Troponin level (measured)</u>	Optional	1
-	<u>Type of visit to emergency department</u>	Optional	1
-	<u>Underlying cause of death</u>	Optional	1
-	<u>Vascular history</u>	Conditional	1
-	<u>Weight in kilograms (measured)</u>	Conditional	1

Breast cancer (Cancer registries) DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	370008
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	<p>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.</p> <p>This data will help inform research, policy, planning and guideline development work in the breast cancer area.</p> <p>Breast cancer may be used as a forerunner for other cancers in terms of establishing common data collections across cancer registries.</p> <p>This data set includes 20 items, with the inclusion of five new standards and the addition of further detail to several existing standards.</p>

Collection and usage attributes

<i>Guide for use:</i>	Report each of the data elements in this data set once, and in no particular order.
<i>Collection methods:</i>	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

<i>Submitting organisation:</i>	National Breast and Ovarian Cancer centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
<i>Steward:</i>	Australasian Association of Cancer Registries (AACR)
<i>Origin:</i>	National Breast and Ovarian Cancer centre (NBOCC) Australasian Association of Cancer Registries (AACR) Australian Institute of Health and Welfare (AIHW)
<i>Reference documents:</i>	Johnson CH, Adamo M (eds.), SEER Program Coding and Staging Manual 2007. National Cancer Institute, NIH Publication number 07-5581, Bethesda, MD 2007.

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	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	Conditional	0
-	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 (ICDO-3 code)	Mandatory	1
-	Regional lymph nodes positive	Mandatory	1
-	Tumour size at diagnosis (solid tumours)	Mandatory	1

Cancer (clinical) DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	393191
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	<p>This Cancer (clinical) data set specification is not mandated for collection but is recommended as best practice if cancer clinical data are to be collected.</p> <p>The Cancer (clinical) data set underpins the evaluation of cancer treatment services and this can occur at a number of levels; the individual clinician, the health care institution, at state or territory level and ultimately at a national level.</p> <p>Clinicians use such data for ongoing patient management and the ability to link patient management to outcomes allows treatments or outcomes to be identified and assessed. Institutions can monitor through-put in their centres for planning and resource allocation purposes to obtain optimum return for cancer expenditure. End-points can be monitored to ensure that objectives are being met.</p> <p>The principal aim of good-quality and consistent data is to provide information that can lead to improved quality and length of life for all patients by providing a systematic foundation for evidence-based medicine, informing quality assurance and improvement decisions and guiding successful planning and evaluation of cancer control activities.</p>

Collection and usage attributes

<i>Collection methods:</i>	This data set is primarily concerned with the clinical use of cancer data. It can also be used by a wider range of health and health-related establishments that create, use, or maintain records on health-care clients.
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Source and reference attributes

<i>Submitting organisation:</i>	National Cancer Control Initiative (NCCI)
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Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Address line (person)	Mandatory	1
-	Cancer initial treatment completion date	Mandatory	1
-	Cancer initial treatment starting date	Mandatory	1
-	Cancer staging – M stage code	Mandatory	1
-	Cancer staging – N stage code	Conditional	1
-	Cancer staging – T stage code	Mandatory	1
-	Cancer staging – TNM stage grouping code	Conditional	1
-	Cancer treatment type	Mandatory	1

-	Cancer treatment – target site (ICD-10-AM)	Mandatory	1
-	Cancer treatment – target site (ICDO-3)	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of death	Conditional	1
-	Date of diagnosis of cancer	Mandatory	1
-	Date of diagnosis of first recurrence	Mandatory	1
-	Date of surgical treatment for cancer	Mandatory	1
-	Establishment number	Mandatory	1
-	Family name	Mandatory	1
-	Given name(s)	Mandatory	1
-	Histopathological grade	Conditional	1
-	Intention of treatment for cancer	Mandatory	1
-	Laterality of primary cancer	Mandatory	1
-	Medicare card number	Mandatory	1
-	Morphology of cancer	Mandatory	1
-	Most valid basis of diagnosis of cancer	Conditional	1
-	Number of regional lymph nodes examined	Conditional	1
-	Oestrogen receptor assay result	Mandatory	0
-	Outcome of initial treatment	Mandatory	1
-	Person identifier	Mandatory	1
-	Primary site of cancer (ICD-10-AM code)	Conditional	1
-	Primary site of cancer (ICDO-3 code)	Mandatory	1
-	Progesterone receptor assay results	Conditional	1
-	Radiotherapy treatment type	Mandatory	1
-	Received radiation dose	Mandatory	1
-	Region of first recurrence	Mandatory	1
-	Regional lymph nodes positive	Conditional	1
-	Sex	Mandatory	1
-	Staging basis of cancer	Mandatory	1
-	Staging scheme source	Mandatory	1
-	Staging scheme source edition number	Mandatory	1
-	Surgical treatment procedure for cancer	Mandatory	1
-	Systemic therapy agent name	Mandatory	1
-	Tumour size at diagnosis (solid tumours)	Conditional	1
-	Tumour thickness at diagnosis (melanoma)	Conditional	1

Cardiovascular disease (clinical) DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	374213
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	<p>The collection of cardiovascular data (CV-Data) in this metadata set is voluntary.</p> <p>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.</p> <p>The data elements specified in this metadata set provide a framework for:</p> <ul style="list-style-type: none">• 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. <p>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.</p> <p>Many of the data elements in this metadata set are also used in the collection of diabetes clinical information.</p> <p>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).</p>

Collection and usage attributes

<i>Collection methods:</i>	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.
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Relational attributes

Related metadata references:

Supersedes [Cardiovascular disease \(clinical\) DSS Health](#),
Superseded 22/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Alcohol consumption frequency (self reported)	Mandatory	1
-	Alcohol consumption in standard drinks per day (self reported)	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
-	Postcode – Australian (person)	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

-	<u>Tobacco smoking status</u>	Mandatory	1
-	<u>Tobacco smoking – consumption/quantity (cigarettes)</u>	Mandatory	1
-	<u>Triglyceride level (measured)</u>	Mandatory	1
-	<u>Vascular history</u>	Mandatory	1
-	<u>Vascular procedures</u>	Mandatory	1
-	<u>Waist circumference (measured)</u>	Mandatory	1
-	<u>Weight in kilograms (measured)</u>	Mandatory	1

Computer Assisted Telephone Interview demographic module DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	374218
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	<p>Key demographic set for use in Computer Assisted Telephone Interviewing (CATI) health surveys. It is intended to be used by anyone conducting population health surveys using the CATI mode, such as State/Territory government health agencies. This data set is to standardise demographic collection in all CATI surveys of health topics, such as CATI asthma and CATI diabetes surveys.</p> <p>The standardisation of the collection of health survey data is a major focus of the National Public Health Partnership (NPHP) work plan. The CATI demographic module DSS is not mandated for collection but recommended as best practice.</p>

Collection and usage attributes

<i>Collection methods:</i>	Population health surveys conducted by CATI
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Source and reference attributes

<i>Submitting organisation:</i>	National Public Health Information Working Group.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Computer Assisted Telephone Interview demographic module DSS Health, Superseded 03/12/2008
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Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Age	Optional	1
-	Age range	Optional	1
-	Country of birth	Optional	1
-	Date of birth	Optional	1
-	Household annual gross income range	Optional	1
-	Household annual gross income range (\$ 10,000 range)	Optional	1
-	Indigenous status	Optional	1
-	Marital status	Optional	1
-	Postcode— Australian (person)	Optional	1
-	Sex	Optional	1
-	Suburb/town/locality name (person)	Optional	1
-	Year of arrival in Australia	Conditional	1

Diabetes (clinical) DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	304865
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	<p>The use of this standard is voluntary.</p> <p>However, if data is to be collected the Diabetes (clinical) Data Set Specification (DSS) aims to ensure national consistency in relation to defining, monitoring and recording information on patients diagnosed with diabetes.</p> <p>The Diabetes (clinical) DSS relates to the clinical status of, the provision of services for, and the quality of care delivered to individuals with diabetes, across all health care settings including:</p> <ul style="list-style-type: none">• General Practitioners;• Divisions of General Practice;• Diabetes Centres• Specialists in private practice; and• Community Health Nurses and Diabetes Educators. <p>The Diabetes (clinical) DSS:</p> <ul style="list-style-type: none">• provides concise, unambiguous definitions for items/conditions related to diabetes quality care, and• aims to ensure standardised methodology of data collection in Australia. <p>The expectation is that collection of this data set facilitates good quality of care, contributes to preventive care and has the potential to enhance self-management by patients with diabetes.</p> <p>The underlying goal is improvement of the length and quality of life of patients with diabetes, and prevention or delay in the development of diabetes related complications.</p>

Collection and usage attributes

<i>Collection methods:</i>	<p>This metadata set is primarily concerned with the clinical use of Diabetes data. It could/should be used by health and health related establishments that create, use or maintain records on health care clients.</p> <p>One methodology is for data to be collected over a 1-month period of all diabetes patients presenting at sites participating in the collection. The information is de-identified to protect the privacy of individuals. The participation is voluntary. An individual benchmarking report is provided. The results provide a snapshot of care of people with diabetes.</p>
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Comments: Statistical units are entities from or about which statistics are collected or in respect of which statistics are compiled, tabulated or published.

Scope links with other Metadata sets

Cardiovascular disease (clinical) DSS.

Source and reference attributes

Submitting organisation: National Diabetes Data Working Group

Relational attributes

Related metadata references: Supersedes [Diabetes \(clinical\) DSS](#) Health, Superseded 21/09/2005

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Blindness (diabetes complication)	Mandatory	1
-	Blood pressure – diastolic (measured)	Mandatory	1
-	Blood pressure – systolic (measured)	Mandatory	1
-	Cardiovascular medication (current)	Mandatory	1
-	Cataract - history	Mandatory	4
-	Cerebral stroke due to vascular disease (history)	Mandatory	1
-	Cholesterol – HDL (measured)	Mandatory	1
-	Cholesterol – total (measured)	Mandatory	1
-	Coronary artery disease – history of intervention or procedure	Mandatory	1
-	Creatinine serum level (measured)	Mandatory	1
-	Date of birth	Mandatory	1
-	Diabetes status	Mandatory	1
-	Diabetes therapy type	Mandatory	1
-	Dyslipidaemia treatment indicator	Mandatory	1
-	Erectile dysfunction	Mandatory	1
-	Fasting status	Mandatory	1
-	Foot deformity	Mandatory	1
-	Foot lesion (active)	Mandatory	1
-	Foot ulcer (history)	Mandatory	1
-	Foot ulcer (current)	Mandatory	1
-	Glycosylated haemoglobin level (measured)	Mandatory	1
-	Glycosylated Haemoglobin – upper limit of normal range (percentage)	Mandatory	1
-	Health professionals attended (diabetes mellitus)	Mandatory	1
-	Height (measured)	Mandatory	1
-	Hypertension - treatment	Mandatory	1
-	Hypoglycaemia - severe	Mandatory	1
-	Indigenous status	Mandatory	1

-	<u>Initial visit indicator – diabetes mellitus</u>	Mandatory	1
-	<u>Lower limb amputation due to vascular disease</u>	Mandatory	1
-	<u>Microalbumin level – albumin/creatinine ratio (measured)</u>	Conditional	1
-	<u>Microalbumin level – micrograms per minute (measured)</u>	Conditional	1
-	<u>Microalbumin level – milligrams per 24 hour (measured)</u>	Conditional	1
-	<u>Microalbumin level – milligrams per litre (measured)</u>	Conditional	1
-	<u>Microalbumin level – upper limit of normal range (albumin/creatinine ratio)</u>	Conditional	1
-	<u>Microalbumin level – upper limit of normal range (micrograms per minute)</u>	Conditional	1
-	<u>Microalbumin level – upper limit of normal range (milligrams per 24 hour)</u>	Conditional	1
-	<u>Microalbumin level – upper limit of normal range (milligrams per litre)</u>	Conditional	1
-	<u>Myocardial infarction (history)</u>	Mandatory	1
-	<u>Ophthalmological assessment – outcome (left retina)</u>	Mandatory	1
-	<u>Ophthalmological assessment – outcome (right retina)</u>	Mandatory	1
-	<u>Ophthalmoscopy performed indicator</u>	Mandatory	1
-	<u>Peripheral neuropathy (status)</u>	Mandatory	1
-	<u>Peripheral vascular disease in feet (status)</u>	Mandatory	1
-	<u>Pregnancy – current status</u>	Mandatory	1
-	<u>Referred to ophthalmologist (diabetes mellitus)</u>	Mandatory	1
-	<u>Renal disease – end-stage (diabetes complication)</u>	Mandatory	1
-	<u>Service contact date</u>	Mandatory	1
-	<u>Sex</u>	Mandatory	1
-	<u>Tobacco smoking status (diabetes mellitus)</u>	Mandatory	1
-	<u>Triglyceride level (measured)</u>	Mandatory	1
-	<u>Visual acuity (left eye)</u>	Mandatory	1
-	<u>Visual acuity (right eye)</u>	Mandatory	1
-	<u>Weight in kilograms (measured)</u>	Mandatory	1
-	<u>Year insulin started</u>	Mandatory	1
-	<u>Year of diagnosis of diabetes mellitus</u>	Mandatory	1

Functioning and Disability DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	320319
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	The Functioning and Disability DSS aims to ensure national consistency in relation to defining and measuring human functioning and disability. This DSS has been developed to be consistent with the International Classification of Functioning, Disability and Health (ICF).

Functioning and disability are dual concepts in a broad framework.

Functioning is the umbrella term for any or all of: body functions, body structures, activities and participation. Functioning is a multidimensional concept denoting the neutral aspects of the interaction between an individual (with a health condition) and that individual's environmental and personal factors.

Disability is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation. Disability is a multi-dimensional and complex concept and is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6).

A health condition may be a disease (acute or chronic), disorder, injury or trauma. Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. Personal factors relate to the individual, such as age, sex and Indigenous status.

The components of functioning and disability are classified and defined in the ICF as **body structures** and **body functions, activities and participation** and **environmental factors**. Each component is composed of various domains; these are sets of related physiological functions, anatomical structures, actions, tasks, areas of life, and external influences. Qualifiers, the numeric measures coded after the relevant domain, are usually essential to the meaningful use of the classification because of the neutral terms of the domains.

Many different 'definitions' of disability are used in Australia, both in administrative data collections and in Acts of Parliament. The consistent identification of disability in national data collections has been recommended in a number of reports, for instance to enable:

- the monitoring of access to generic services by people with disability;
- the collection of more consistent data on disability support and related services, including data on service use by different groups;
- population data and service data to be related, thereby improving the nation's analytical capacity in relation to the need for and supply of services; and

- improved understanding of the relationship between disability, health conditions and other health outcomes.

Defining disability makes it possible to determine the number of people in the population with disability, those who are accessing services, both disability specific and generic, and those with a disability in the general population with unmet need. Better definition of disability will aid better targeting of resources to those in need.

The concept 'Disability' can be operationalised in a wide variety of settings and for various purposes, using a combination of related metadata items as building blocks.

The metadata items selected for a particular application may vary depending on the approach to functioning and disability. For example, in hospital rehabilitation, the focus may be on the impairment and activity dimensions, and in community-based care the focus may be primarily on participation. Some applications may require a broad scope for inclusion (e.g. discrimination legislation). Data collections relating to services will select combinations of the data elements, which best reflect the eligibility criteria for the service.

The Functioning and Disability DSS comprises the following four clusters to describe level of human functioning:

1. Body functioning, qualified by extent of impairment
2. Body structure, qualified by extent, nature and location of impairment
3. Activities and participation, qualified by level of difficulty and need for assistance with undertaking activities and extent of and satisfaction with participation
4. Environmental factors, qualified by extent of influence of the environment

Data collected using this DSS can be related to national data collections which use ICF concepts such as the Commonwealth State Territory Disability Agreement (CSTDA) NMDS collection and the ABS Survey of Ageing, Disability and Carers and, from 2006, the Census.

Collection and usage attributes

Collection methods:

Each of the four clusters that make up the Functioning and Disability DSS should be recorded for a complete description of human functioning. This information can be gathered over time by a range of health and community care providers.

Completion of the DSS will record a person-centred description of the experience of functioning of the individual who is the subject of the data. The experience of functioning is in relation to a health condition, and does not consider decrements in functioning that may be associated with social factors such as ethnic background or economic status. For example, the level of communication is recorded in relation to the health condition, not to the fact that a person does not speak English at home.

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an umbrella term

for 'disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}.

This DSS may be used in data collections in the community services, housing and health sectors.

Comments:

The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002). The ICF is grounded in a human rights philosophy, and its relationship to the UN Standard Rules on Equalization of Opportunities for Persons with Disabilities endorsed by the United Nations in 1994 is acknowledged. The purpose of the Rules is to ensure that people with disabilities, as members of their societies, may exercise the same rights and obligations as others.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Steward:

Advisory Committee on Australian and International Disability Data (ACAIDD)

Origin:

WHO 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

AIHW 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF, including more detailed codes, can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003), at the following websites:

- WHO ICF website <http://www.who.int/classifications/icf/en/>
- Australian Collaborating Centre ICF website <http://www.aihw.gov.au/disability/icf/index.cfm>

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Activities and Participation cluster	Optional	1
-	Body functions cluster	Optional	1
-	Body structures cluster	Optional	1
-	Environmental factors cluster	Optional	1

Health care client identification DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	374201
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	The data elements specified in this metadata set provide a framework for improving the positive identification of persons in health care organisations. This metadata set applies in respect of all potential or actual clients of the Australian health care system. It defines demographic and other identifying data elements suited to capture and use for person identification in health care settings.

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

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

The process of positively identifying people within a health care service delivery context entails matching data supplied by those individuals against data the service provider holds about them. The positive and unique identification of health care clients is a critical event in health service delivery, with direct implications for the safety and quality of health care.

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

Collection and usage attributes

<i>Collection methods:</i>	<p>This metadata set is primarily concerned with the clinical use of Health care client identification data. It should be used by health and health-related establishments that create, use or maintain records on health care clients.</p> <p>Establishments should use this metadata set, where appropriate, for collecting data when registering health care clients or potential health care clients.</p> <p>The collection of data based on this metadata set is voluntary.</p> <p>National reporting arrangements</p> <p>Collectors of this metadata set should refer to relevant privacy legislation, codes of fair information practice and other guidelines so as not to breach personal privacy in their collection,</p>
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use, storage and disclosure of health care client information. There is no comprehensive privacy legislation covering both the public and private sectors across Australia so users need to consider their particular set of circumstances (i.e. location and sector) and whether privacy legislation covers those circumstances.

A Commonwealth legislative scheme applies to the private sector. Users may refer to the Federal Privacy Commissioner's web site for assistance in complying with their privacy obligations. In the public sector, in instances where no legislation, code of fair information practice or other guidelines covers the particular circumstances, users should refer to AS 4400 Personal privacy protection in health care information systems.

Relational attributes

Related metadata references: Supersedes [Health care client identification DSS](#) Health, Superseded 03/12/2008

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Address line (person)	Mandatory	1
-	Address type (person)	Mandatory	1
-	Address – country identifier (person)	Mandatory	1
-	Australian state/territory identifier	Conditional	0
-	Birth order	Mandatory	1
-	Birth plurality	Mandatory	1
-	Building/complex sub-unit number (person)	Mandatory	1
-	Building/complex sub-unit type – abbreviation (person)	Mandatory	1
-	Building/property name (person)	Mandatory	1
-	Centrelink customer reference number	Mandatory	1
-	Country of birth	Mandatory	1
-	Date accuracy indicator	Mandatory	1
-	Date of birth	Mandatory	1
-	Electronic communication address (person)	Mandatory	1
-	Electronic communication medium (person)	Mandatory	1
-	Electronic communication usage code (person)	Mandatory	1
-	Establishment identifier	Mandatory	1
-	Establishment number	Mandatory	1
-	Establishment sector	Mandatory	1
-	Family name	Mandatory	1
-	Floor/level number (person)	Mandatory	1
-	Floor/level type (person)	Mandatory	1
-	Given name sequence number	Mandatory	1
-	Given name(s)	Mandatory	1
-	House/property number (person)	Mandatory	1

-	<u>Indigenous status</u>	Conditional	1
-	<u>Lot/section number (person)</u>	Mandatory	1
-	<u>Medicare card number</u>	Mandatory	1
-	<u>Mother's original family name</u>	Mandatory	1
-	<u>Name context flag</u>	Mandatory	1
-	<u>Name suffix</u>	Mandatory	1
-	<u>Name suffix sequence number</u>	Mandatory	1
-	<u>Name title</u>	Mandatory	1
-	<u>Name title sequence number</u>	Mandatory	1
-	<u>Name type</u>	Mandatory	1
-	<u>Non-Australian state/province (person)</u>	Mandatory	1
-	<u>Person identifier</u>	Mandatory	1
-	<u>Person identifier type – health care (person)</u>	Mandatory	1
-	<u>Postal delivery point identifier (person)</u>	Mandatory	1
-	<u>Postcode – Australian (person)</u>	Mandatory	1
-	<u>Postcode – international (person)</u>	Mandatory	1
-	<u>Region code</u>	Mandatory	1
-	<u>Sex</u>	Mandatory	1
-	<u>State/Territory of birth</u>	Mandatory	1
-	<u>Street name (person)</u>	Mandatory	1
-	<u>Street suffix code (person)</u>	Mandatory	1
-	<u>Street type code (person)</u>	Mandatory	1
-	<u>Suburb/town/locality name (person)</u>	Mandatory	1

Health care provider identification DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	374199
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	<p>The scope of these data elements includes identification of individual and organisation health care providers. The data elements also allow for identification of an individual in a health care organisation. The definition of health care provider is: 'any person or organisation who is involved in or associated with the delivery of healthcare to a client, or caring for client wellbeing'.</p> <p>The data elements have been defined to enable a common, best practice approach to the way data are captured and stored, to ensure that records relating to a provider will be associated with that individual and/or organisation and no other. The definitions are proposed for clinical and administrative data management purposes.</p> <p>The ability to positively identify health care providers and locate their relevant details is an important support to the provision of speedy, safe, high quality, comprehensive and efficient health care. Unambiguous identification of individual health care providers is necessary for:</p> <ul style="list-style-type: none">• Requesting and reporting of orders, tests and results (e.g. pathology, diagnostic imaging)• Other communications and referrals between health care providers regarding ongoing care of patients (e.g. a referral from a GP to a specialist, a hospital discharge plan)• Reporting on health care provision to statutory authorities (e.g. reporting of hospital patient administration systems data to State/Territory government health agencies)• Payments to providers• Registration of providers• Directories or lists of providers and their service locations for consumer information.

Collection and usage attributes

<i>Collection methods:</i>	Collected at point of entry to health care for the purposes of the identification of the provider of that health care.
<i>Comments:</i>	There are many barriers to successfully identifying individuals in health care settings, including variable data quality; differing data capture requirements and mechanisms; and varying data matching methods. This data set specification provides a framework for improving the confidence that the data being associated with any given individual or organisation, is appropriately associated.

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia Inc Health Informatics Committee (IT-014)
<i>Reference documents:</i>	Health care client identification DSS The Australian Standard AS4846 Health Care Provider Identification identifies other data that should be collected. These data are collections of free text information and as such are not capable of standardisation as a national health data standard. Within AS4846 however they form part of the data collection necessary for the complete identification of a health care provider. These data elements are identified in the section Standardised elsewhere section below. If these data elements are collected in conjunction with those of the Data set specification they form a collection equivalent to that of the Australian Standard AS4846.

Relational attributes

<i>Related metadata references:</i>	Supersedes Health care provider identification DSS Health, Superseded 03/12/2008
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Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Address line (person)	Mandatory	1
-	Address line (service provider organisation)	Mandatory	1
-	Address type (person)	Mandatory	1
-	Address type (service provider organisation)	Mandatory	1
-	Address – country identifier (person)	Mandatory	1
-	Australian state/territory identifier	Mandatory	1
-	Australian state/territory identifier (service provider organisation)	Mandatory	1
-	Building/complex sub-unit number (person)	Mandatory	1
-	Building/complex sub-unit number (service provider organisation)	Mandatory	1
-	Building/complex sub-unit type – abbreviation (person)	Mandatory	1
-	Building/complex sub-unit type – abbreviation (service provider organisation)	Mandatory	1
-	Building/property name (person)	Mandatory	1
-	Building/property name (service provider organisation)	Mandatory	1
-	Date accuracy indicator	Mandatory	1
-	Date of birth	Mandatory	1
-	Date of death	Mandatory	1
-	Electronic communication address (person)	Mandatory	1
-	Electronic communication address (service provider organisation)	Mandatory	1
-	Electronic communication medium (person)	Mandatory	1

- Electronic communication medium (service provider organisation)	Mandatory	1
- Electronic communication usage code (person)	Mandatory	1
- Family name	Mandatory	1
- Floor/level number (person)	Mandatory	1
- Floor/level number (service provider organisation)	Mandatory	1
- Floor/level type (person)	Mandatory	1
- Floor/level type (service provider organisation)	Mandatory	1
- Given name sequence number	Mandatory	1
- Given name(s)	Mandatory	1
- House/property number (person)	Mandatory	1
- House/property number (service provider organisation)	Mandatory	1
- Lot/section number (person)	Mandatory	1
- Lot/section number (service provider organisation)	Mandatory	1
- Name context flag	Mandatory	1
- Name suffix	Mandatory	1
- Name suffix sequence number	Mandatory	1
- Name title	Mandatory	1
- Name title sequence number	Mandatory	1
- Name type	Mandatory	1
- Name type (service provider organisation)	Mandatory	1
- Non-Australian state/province (person)	Mandatory	1
- Non-Australian state/province (service provider organisation)	Mandatory	1
- Organisation end date	Mandatory	1
- Organisation name	Mandatory	1
- Organisation start date	Mandatory	1
- Person identifier	Mandatory	1
- Postal delivery point identifier (person)	Mandatory	1
- Postal delivery point identifier (service provider organisation)	Mandatory	1
- Postcode – Australian (person)	Mandatory	1
- Postcode – Australian (service provider organisation)	Mandatory	1
- Postcode – international (person)	Mandatory	1
- Postcode – international (service provider organisation)	Mandatory	1
- Provider occupation category (self-identified) (ANZSCO 1st edition)	Mandatory	1
- Provider occupation end date	Mandatory	1
- Provider occupation start date	Mandatory	1
- Sex	Mandatory	1
- Street name (person)	Mandatory	1
- Street name (service provider organisation)	Mandatory	1
- Street suffix code (person)	Mandatory	1

-	<u>Street suffix code (service provider organisation)</u>	Mandatory	1
-	<u>Street type code (person)</u>	Mandatory	1
-	<u>Street type code (service provider organisation)</u>	Mandatory	1
-	<u>Suburb/town/locality name (person)</u>	Mandatory	1
-	<u>Suburb/town/locality name (service provider organisation)</u>	Mandatory	1

Injury surveillance DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	393268
<i>Registration status:</i>	Health, Standard 14/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	The scope of this minimum data set is patient level data from selected emergency departments of hospitals and other settings.

Collection and usage attributes

<i>Collection methods:</i>	<i>National reporting arrangements</i> State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on an annual basis. <i>Periods for which data are collected and nationally collated</i> Financial years ending 30 June each year.
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Source and reference attributes

<i>Submitting organisation:</i>	National Health Information Group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Injury surveillance DSS Health, Superseded 14/12/2009
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Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	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

Palliative care performance indicators DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	295806
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	<p>This data set specification specifies information for collection about all administrative health regions, and whether they have developed strategic plans which incorporate specified palliative care elements. It also specifies information for collection about all government-funded palliative care agencies (service provider organisations), their approach to some aspects of service delivery, and their efforts in specific areas of quality improvement.</p> <p>This information enables reporting of nationally-agreed palliative care performance indicators. Currently, there are four national performance indicators that have been agreed for reporting by the Palliative Care Intergovernmental Forum. These are:</p> <ol style="list-style-type: none">1. The proportion of administrative health regions that have a written plan for palliative care that incorporates palliative care elements,2. The proportion of palliative care agencies, within their setting of care, that routinely undertake or undergo formal assessment against the Palliative Care Australia standards,3. The proportion of palliative care agencies, within their setting of care, that actively collect feedback from clients and staff (within the workforce) relating to services and service delivery,4. The proportion of palliative care agencies, within their setting of care, that have formal working partnerships with other services provider(s) or organisation(s).

Collection and usage attributes

<i>Collection methods:</i>	The data for this DSS are obtained from two sources: a survey of administrative health regions and a survey of all government-funded palliative care agencies (service provider organisations) that provide care in community and/or admitted patient settings.
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Source and reference attributes

<i>Submitting organisation:</i>	Palliative Care Intergovernmental Forum
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Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Administrative health region name	Mandatory	1
-	Administrative health region palliative care strategic plan indicator	Mandatory	1
-	Coordinator of volunteers indicator	Mandatory	1
-	Feedback collection indicator	Mandatory	1

-	<u>Feedback collection method</u>	Conditional	8
-	<u>Level of palliative care service</u>	Mandatory	1
-	<u>Most common service delivery setting</u>	Mandatory	1
-	<u>Palliative care agency service delivery setting</u>	Mandatory	7
-	<u>Partner organisation type</u>	Conditional	8
-	<u>Standards assessment indicator</u>	Mandatory	1
-	<u>Standards assessment level</u>	Conditional	1
-	<u>Standards assessment method</u>	Conditional	2
-	<u>Working partnership indicator</u>	Mandatory	1

Registered chiropractic labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384097
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	All chiropractors listed with the Australian Health Practitioner Regulation Agency during the reference period. Chiropractors included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered chiropractor.</p> <p>A Registered chiropractor refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a chiropractor at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.</p> <p><i>Periods for which data are collected and collated</i></p> <p>Data are collated annually. The period is determined by the national registration renewal period for chiropractors.</p>

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered chiropractor cluster	Optional	1
-	Second job of registered chiropractor cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered dental and allied dental health professional labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384102
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	All dental and allied dental health professionals listed with the Australian Health Practitioner Regulation Agency during the reference period. Dental and allied dental health professionals included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered dental and allied dental health professional.</p> <p>A Registered dental and allied dental health professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Registration Agency as a dental or allied dental health professional at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.</p>

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for dental and allied dental health professionals.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered dental and allied dental health professional cluster	Optional	1
-	Second job of registered dental and allied dental health professional cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered health labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	380533
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	<p>All health professionals listed with the Australian Health Practitioner Regulation Agency (AHPRA) during the reference period. This encompasses health professions that require registration under the National Registration and Accreditation Scheme and includes, but is not limited to:</p> <ul style="list-style-type: none">• chiropractic• dentistry• dental hygiene• dental prosthetics• dental therapy• medicine• midwifery• nursing (enrolled, registered, practitioner)• optometry• osteopathy• pharmacy• physiotherapy• podiatry• psychology <p>This DSS includes health professionals who are currently registered with AHPRA and health professionals who are no longer registered but remain listed with AHPRA.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered health professional.</p> <p>A Registered health professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS comprises a set of DSS for health professions covered by the Australian Health Practitioner Regulation Agency. It includes:</p> <ul style="list-style-type: none">• Registered chiropractic labour force DSS• Registered dental and allied dental labour force DSS• Registered medical labour force DSS• Registered midwifery labour force DSS

- Registered nursing labour force DSS
- Registered optometry labour force DSS
- Registered osteopathy labour force DSS
- Registered pharmacy labour force DSS
- Registered physiotherapy labour force DSS
- Registered podiatry labour force DSS
- Registered psychology labour force DSS

Note that a health professional may be qualified and registered in more than one profession.

The Registered health labour force DSS provides comprehensive data on Australia's registered health labour force. It assists governments, educators, health care providers and the community to understand the current health labour force and with workforce planning.

Collection methods:

National reporting arrangements

Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.

The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS primarily comprises workforce data.

Periods for which data are collected and collated

Data are collated annually for each profession. The period is determined by the national registration renewal period for health professionals and may differ between health professions.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	<u>Registered chiropractic labour force DSS</u>	Optional	1
-	<u>Registered dental and allied dental health professional labour force DSS</u>	Optional	1
-	<u>Registered medical professional labour force DSS</u>	Optional	1
-	<u>Registered midwifery labour force DSS</u>	Optional	1
-	<u>Registered nursing professional labour force DSS</u>	Optional	1
-	<u>Registered optometry labour force DSS</u>	Optional	1
-	<u>Registered osteopathy labour force DSS</u>	Optional	1
-	<u>Registered pharmacy labour force DSS</u>	Optional	1
-	<u>Registered physiotherapy labour force DSS</u>	Optional	1
-	<u>Registered podiatry labour force DSS</u>	Optional	1
-	<u>Registered psychology labour force DSS</u>	Optional	1

Registered medical professional labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	375422
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	<p>All medical professionals listed with the Australian Health Practitioner Regulation Agency during the reference period, including:</p> <ul style="list-style-type: none">• medical practitioners;• medical specialists; and• medical specialists-in-training. <p>Medical professionals included in this DSS may be currently registered or they may be listed but not currently registered.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered medical professional.</p> <p>A Registered medical professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a medical practitioner, medical specialist or medical specialist-in-training at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises</p>

demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for medical professionals.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered medical professional cluster	Optional	1
-	Second job of registered medical professional cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Field of medicine - medical practitioner	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered midwifery labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384118
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	All midwives listed with the Australian Health Practitioner Regulation Agency during the reference period. Midwives included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered midwife.</p> <p>A Registered midwife refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a midwife at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.</p> <p><i>Periods for which data are collected and collated</i></p> <p>Data are collated annually. The period is determined by the national registration renewal period for midwives.</p> <p><i>Collection of workforce data</i></p> <p>Health professionals are asked to report data for their main</p>

job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered midwife cluster	Optional	1
-	Second job of registered midwife cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered nursing professional labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384109
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	<p>All nursing professionals listed with the Australian Health Practitioner Regulation Agency during the reference period, including:</p> <ul style="list-style-type: none">• enrolled nurses;• registered nurses; and• nurse practitioners. <p>Nursing professionals included in this DSS may be currently registered or they may be listed but not currently registered.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered nursing professional.</p> <p>A Registered nursing professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an enrolled nurse, registered nurse, or nurse practitioner at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises</p>

demographic, registration and work characteristics information.

Periods for which data are collected and collated

Data are collated annually. The period is determined by the national registration renewal period for nursing professionals.

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered nursing professional cluster	Optional	1
-	Second job of registered nursing professional cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered optometry labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384124
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	All optometrists listed with the Australian Health Practitioner Regulation Agency during the reference period. Optometrists included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered optometrist.</p> <p>A Registered optometrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an optometrist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.</p> <p><i>Periods for which data are collected and collated</i></p> <p>Data are collated annually. The period is determined by the national registration renewal period for optometrists.</p>

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered optometrist cluster	Optional	1
-	Second job of registered optometrist cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered osteopathy labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384128
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	All osteopaths listed with the Australian Health Practitioner Regulation Agency during the reference period. Osteopaths included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered osteopath.</p> <p>A Registered osteopath refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an osteopath at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.</p> <p><i>Periods for which data are collected and collated</i></p> <p>Data are collated annually. The period is determined by the national registration renewal period for osteopaths.</p>

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered osteopath cluster	Optional	1
-	Second job of registered osteopath cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered pharmacy labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384152
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	All pharmacists listed with the Australian Health Practitioner Regulation Agency during the reference period. Pharmacists included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered pharmacist.</p> <p>A Registered pharmacist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a pharmacist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.</p> <p><i>Periods for which data are collected and collated</i></p> <p>Data are collated annually. The period is determined by the national registration renewal period for pharmacists.</p>

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered pharmacist cluster	Optional	1
-	Second job of registered pharmacist cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered physiotherapy labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384162
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	All physiotherapists listed with the Australian Health Practitioner Regulation Agency during the reference period. Physiotherapists included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered physiotherapist.</p> <p>A Registered physiotherapist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a physiotherapist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.</p> <p><i>Periods for which data are collected and collated</i></p> <p>Data are collated annually. The period is determined by the national registration renewal period for pharmacists.</p>

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered physiotherapist cluster	Optional	1
-	Second job of registered physiotherapist cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered podiatry labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384166
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	All podiatrists listed with the Australian Health Practitioner Regulation Agency during the reference period. Podiatrists included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered podiatrist.</p> <p>A Registered podiatrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a podiatrist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.</p> <p><i>Periods for which data are collected and collated</i></p> <p>Data are collated annually. The period is determined by the national registration renewal period for podiatrists.</p>

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered podiatrist cluster	Optional	1
-	Second job of registered podiatrist cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Registered psychology labour force DSS

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384170
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	All psychologists listed with the Australian Health Practitioner Regulation Agency during the reference period. Psychologists included in this DSS may be currently registered or they may be listed but not currently registered.

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered psychologist.</p> <p>A Registered psychologist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a psychologist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>This DSS is a component of the Registered health labour force DSS. The Registered health labour force DSS contains profession-specific DSS for health professions listed with the Australian Health Practitioner Regulation Agency.</p> <p>Note that a health professional may be qualified and registered in more than one profession.</p> <p>Within each profession-specific DSS there are data clusters that apply to health professionals employed in the profession. Main job data clusters apply to all health professionals employed in the profession. Second job data clusters relate only to those health professionals employed in more than one job in the profession. All other workforce data elements in the DSS apply to all jobs held in the profession.</p>
<i>Collection methods:</i>	<p><i>National reporting arrangements</i></p> <p>Registered health professionals provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and registration renewal processes. The data includes information required for registration purposes and additional workforce data.</p> <p>The Australian Health Practitioner Regulation Agency provides an extract of these data to the Australian Institute of Health and Welfare (AIHW) for the purposes of national collation and reporting. The data in this DSS comprises demographic, registration and work characteristics information.</p> <p><i>Periods for which data are collected and collated</i></p> <p>Data are collated annually. The period is determined by the national registration renewal period for psychologists.</p>

Collection of workforce data

Health professionals are asked to report data for their main job, second job, and all jobs in the profession. Some health professionals may hold more than two jobs in the profession therefore data reported for main and second jobs may be less than data reported for all jobs in the profession.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Reference documents:

For further information regarding the national registration scheme for health professionals, please see the Australian Health Practitioner Regulation Agency website at <http://www.ahpra.gov.au>

Relational attributes

Implementation in Data Set Specification: [Registered health labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Labour force status cluster	Optional	1
-	Main job of registered psychologist cluster	Optional	1
-	Second job of registered psychologist cluster	Optional	1
-	Work setting hours cluster	Optional	1
-	Australian state of birth	Optional	1
-	Country of birth	Optional	1
-	Hours worked in health profession - clinical	Optional	1
-	Hours worked in health profession - non-clinical	Optional	1
-	Hours worked in health profession - private sector	Optional	1
-	Hours worked in health profession - public sector	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Indigenous status	Optional	1
-	Intended years in health profession	Optional	1
-	Length of employment in health profession	Optional	1
-	Month and year of birth	Mandatory	1
-	Postcode – Australian (person)	Mandatory	1
-	Sex	Mandatory	1
-	Suburb/town/locality name (person)	Mandatory	1
-	Visa type - health professional	Optional	1

Data element clusters

Activities and Participation cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	320111
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a <u>complete</u> description of human functioning it is recommended that this cluster be collected along with the following three clusters over time and by a range of health and community care providers:

1. Body functions cluster
2. Body structures cluster
3. Environmental factors cluster

In the context of health, activity refers to the execution of a task or action by an individual, and participation refers to involvement in a life situation.

The Activities and Participation cluster collects information on a person's level of difficulty with activities, assistance needed to perform activities, extent of participation, and satisfaction with participation in the following life areas:

1. Learning and applying knowledge
2. General tasks and demands
3. Communication
4. Mobility
5. Self-care
6. Domestic life
7. Interpersonal interactions and relationships
8. Major life areas
9. Community, social and civic life

The use of this cluster to collect information on activity limitations and participation restrictions should enhance data quality for medical purposes as well as for a range of purposes related to understanding human functioning. This data cluster should be complementary to information on diseases.

The information collected in the Activities and Participation cluster may also indicate the sorts of interventions that could result in improved functioning. This could be in the form of rehabilitation, health-related interventions, equipment, or support for example.

Collection and usage attributes

Guide for use:

The following four measures are used to describe activities and participation in life areas:

1. **Difficulty** with activities may include pain involved, time taken, effort, number of errors, clumsiness, and modification of the manner in which the activity is performed. Difficulty is the combination of the frequency with which the problem exists, the duration of the problem and the intensity of the problem.
2. **Need for assistance** with activities includes personal assistance and/or supervision.
3. **Extent of participation** indicates the level of participation restriction. This corresponds to an externally observable measure of participation.
4. **Satisfaction with participation** corresponds to the person's own perspective on their participation, and reflects their attitude to their participation in the various life areas. It is essentially a summary measure in which are embedded the concepts of choice, opportunity and importance.

For each life area code recorded there can be one response for each of the measures. The choice of measure will depend on the user and their information requirements.

There are numerous possible methods for collecting activity, activity limitation, participation and participation restriction. A decision could be made to collect information:

- about every domain;
- on domains of particular relevance; or
- on a number of domains which are prioritised according to specified criteria.

See also the *ICF Australian User Guide* for further guidelines.

Collection methods:

The Person—activities/participation life area, code (ICF 2001) AN[NNN] data element is supported by a value domain - Activities and participation code (ICF 2001) AN[NNN] - representing a single list of activity and participation domains that are grouped together.

The World Health Organization suggests the list be used in one of four operational ways.

- a) To designate some domains as activities and others as participation, not allowing any overlap.
- b) Same as (a) above, but allowing partial overlap.
- c) To designate all detailed domains as activities and the broad category headings as participation.
- d) To use all domains as both activities and participation.

The ICF Australian User Guide proposes the use of either option (b) or (d) with the use of additional qualifiers to

delineate between activity and participation.

The Person—activities and participation life area, code (ICF 2001) AN[NNN] data element can be used on its own as a neutral list of tasks, actions and life situations, or together with the four additional data elements in this cluster to record positive or neutral performance as well as activity limitations and participation restrictions. (It is important to note that the Person—activities and participation life area, code (ICF 2001) AN[NNN] data element must always be used when recording any of the other four data elements.)

Comments:

This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF is a reference member of the WHO Family of International Classifications (endorsed by the World Health Assembly in 2001) and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}.

The ICF recognises two constructs that can be used with 'Activities and Participation': performance and capacity. 'Performance' is what the person does in their usual environment. 'Capacity' describes 'an individual's ability to execute a task or an action in a standardised environment, where a standardised environment may be:

- an actual environment commonly used for assessment in test settings; or
- in cases where this is not possible, an assumed environment which can be thought to have a uniform impact' (WHO 2001).

The standardised environment has not been generally operationalised. However, the recognition of these two constructs in the ICF underscores the importance of recording the environment in which activities are being performed.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification: [Functioning and Disability DSS](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	<u>Activity and participation life area</u>	Mandatory	1
-	<u>Assistance with activities</u>	Optional	1
-	<u>Difficulty with activities</u>	Optional	1
-	<u>Extent of participation</u>	Optional	1
-	<u>Satisfaction with participation</u>	Optional	1

Acute coronary syndrome clinical event cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	352671
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	The acute coronary syndrome (ACS) related clinical events are those which can negatively impact on the outcomes of a person with ACS. Information on the occurrence of these events in people with ACS is required due to an emerging appreciation of their relationship with late mortality. The clinical event cluster collects information on the timing and type of clinical events experienced during the current hospitalisation.

Relational attributes

Implementation in Data Set Specification: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Acute coronary syndrome related clinical event type	Conditional	15
-	Date of acute coronary syndrome related clinical event	Conditional	15
-	Time of acute coronary syndrome related clinical event	Conditional	1

Acute coronary syndrome pharmacotherapy data cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	351876
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The pharmacotherapies collected in this data cluster are recommended for the management of acute coronary syndromes (ACS) in the national guidelines. The following pharmacotherapies are collected as part of this data cluster:</p> <ul style="list-style-type: none">• Aspirin• Angiotensin converting enzyme (ACE) inhibitor• Angiotensin II receptor blocker• Antithrombin• Beta-blocker• Clopidogrel• Fibrinolytic• Glycoprotein IIb/IIIa receptor antagonist• Statin <p>The pharmacotherapy cluster collects information on the type of pharmacotherapies prescribed and the timing of each prescription.</p>

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
<i>Reference documents:</i>	National Heart Foundation of Australia & Cardiac Society of Australia and New Zealand. Guidelines for the management of acute coronary syndromes 2006. Med J Aust 2006; 184; S1-S32. © MJA 2006

Relational attributes

Implementation in Data Set Specification: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Date of intravenous fibrinolytic therapy	Conditional	1
-	Fibrinolytic drug used	Conditional	1
-	Pharmacotherapy type prescribed for acute coronary syndrome in hospital	Mandatory	10
-	Pharmacotherapy type taken for acute coronary syndrome post discharge	Mandatory	7

-	<u>Reason for non prescription of pharmacotherapy</u>	Conditional	9
-	<u>Time of intravenous fibrinolytic therapy</u>	Conditional	1
-	<u>Timing of ACE-inhibitor prescription</u>	Conditional	5
-	<u>Timing of angiotensin II receptor blocker prescription</u>	Conditional	5
-	<u>Timing of antithrombin therapy prescription</u>	Conditional	4
-	<u>Timing of aspirin prescription</u>	Conditional	5
-	<u>Timing of beta-blocker prescription</u>	Conditional	5
-	<u>Timing of clopidogrel prescription</u>	Conditional	5
-	<u>Timing of glycoprotein IIb/IIIa inhibitor prescription</u>	Conditional	4
-	<u>Timing of statin prescription</u>	Conditional	5

Body functions cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	320117
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that it be collected along with the following three clusters over time and by a range of health and community care providers:

1. Body Structures cluster
2. Activities and Participation cluster
3. Environmental factors cluster

Body functions are the physiological functions of body systems (including psychological functions). The term 'body' refers to the human organism as a whole; hence it includes the brain and its functions, that is, the mind.

The Body functions cluster collects information on the presence and extent of impairment of the eight body function domains listed below:

1. Mental functions
2. Sensory functions and pain
3. Voice and speech functions
4. Functions of the cardiovascular, haematological, immunological and respiratory systems
5. Functions of the digestive, metabolic and the endocrine system
6. Genitourinary and reproductive functions
7. Neuromusculoskeletal and movement-related functions
8. Functions of the skin and related structures

Impairments of body functions, as defined in the ICF, are problems in body functions such as a loss or significant departure from population standards or averages. The ICD uses impairment as 'signs and symptoms', a 'component of disease' or sometimes 'reason for contact with health services'.

Impairments are recorded in terms of their extent or magnitude, nature and/or location. Determination of impairment is undertaken primarily by those qualified to evaluate physical and mental functioning or structure according to these standards.

Impairments should be detectable or noticeable by others or

the person by direct observation or by inference from indirect observation. Impairments are not the same as the underlying pathology, but are manifestations of that pathology.

Impairments can be temporary or permanent; progressive, regressive or static; intermittent or continuous. The deviation from the population norm may be slight or severe and may fluctuate over time. Impairments may result in other impairments.

Impairments may be part, or an expression of a health condition, but do not necessarily indicate that a disease is present or that the individual should be regarded as sick.

The use of this cluster to collect information on impairments of body functions should enhance data quality for medical purposes as well as for a range of purposes related to human functioning. This data cluster should be complementary to information on diseases.

The information collected in the Body functions cluster may also indicate the sorts of interventions that could result in improved functioning. This could be in the form of rehabilitation, health-related interventions, equipment, or support for example.

Collection and usage attributes

Collection methods:

The Person—body function, code (ICF 2001) AN[NNNN] data element is a neutral list of functions that can be used to record positive or neutral body function, as well as impairment of a specified body function when used in conjunction with Person—extent of impairment of body function, code (ICF 2001)N. For each body function code recorded there should be a code for impairment of body functions.

There are numerous possible methods for collecting body functions and impairments. A decision could be made to collect information:

- about every domain;
- on domains of particular relevance; or
- on a number of domains which are prioritised according to specified criteria.

See also the *ICF Australian User Guide* for further guidelines.

Comments:

This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder,

injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification: [Functioning and Disability DSS](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Body function	Mandatory	1
-	Impairment of body function	Mandatory	1

Body structures cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	320151
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that this cluster be collected along with the following three clusters over time and by a range of health and community care providers:

1. Body functions cluster
2. Activities and participation cluster
3. Environmental factors cluster

Body structures are anatomical parts of the body such as organs, limbs and their components.

The Body structures cluster collects information on the presence and extent of impairment, the nature of the change and the location of the impairment for the eight body structure domains listed below:

1. Structures of the nervous system
2. The eye, ear and related structures
3. Structures involved in voice and speech
4. Structures of the cardiovascular, immunological and respiratory systems
5. Structures related to the digestive, metabolism and endocrine systems
6. Structures related to genitourinary and reproductive systems
7. Structures related to movement
8. Skin and related structures

Impairments of body structures, as defined in the ICF, are problems in body structure such as a loss or significant departure from population standards or averages. The ICD uses impairment as 'signs and symptoms', a 'component of disease' or sometimes 'reason for contact with health services'.

Impairments are recorded in terms of their extent or magnitude, nature and/or location. Determination of impairment is undertaken primarily by those qualified to evaluate physical and mental functioning or structure according to population standards or averages.

Impairments should be detectable or noticeable by others or

the person by direct observation or by inference from indirect observation. Impairments are not the same as the underlying pathology, but are manifestations of that pathology.

Impairments can be temporary or permanent; progressive, regressive or static; intermittent or continuous. The deviation from the population norm may be slight or severe and may fluctuate over time. Impairments may result in other impairments.

Impairments may be part, or an expression of a health condition, but do not necessarily indicate that a disease is present or that the individual should be regarded as sick.

The use of this cluster to collect information on impairments should enhance data quality for medical purposes as well as for a range of purposes related to understanding human functioning. This data cluster should be complementary to information on diseases.

The information collected in the Body structures cluster may also indicate the sorts of interventions that could result in improved functioning. This could be in the form of rehabilitation, health-related interventions, equipment, or support for example.

Collection and usage attributes

Guide for use:

The Person—body structure, code (ICF 2001) AN[NNNN] is a data element supported by the value domain Body structure code (ICF 2001) AN(NNNN) that represents a neutral list of structures from the ICF. This data element can be used to record positive or neutral body structure, as well as impairment of a specified body structure when used in conjunction with Person—extent of impairment of body structure, code (ICF 2001) N.

It is optional to record the location and nature of the impairment using Person—nature of impairment of body structure, code (ICF 2001) X and Person—location of impairment of body structure, code (ICF 2001) X respectively.

There are numerous possible methods for collecting body structures and impairments. A decision could be made to collect information:

- about every domain;
- on domains of particular relevance; or
- on a number of domains which are prioritised according to specified criteria.

Comments:

This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human

functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification: [Functioning and Disability DSS Health](#), Standard 29/11/2006
Community services, Standard 16/10/2006

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Body structure	Mandatory	1
-	Change to body structure	Optional	1
-	Impairment of body structure	Mandatory	1
-	Location of impairment	Optional	1

Coronary artery cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	352651
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>This cluster collects information on the characteristics of and interventions performed for the coronary arteries during the current hospitalisation. The coronary arteries included in this cluster are:</p> <ul style="list-style-type: none">• Left anterior descending coronary artery• Inferior surface artery• Left circumflex coronary artery• Diagonal coronary artery• Left main coronary artery• Posterior descending artery• Right coronary artery

Collection and usage attributes

<i>Collection methods:</i>	<p>When reporting the maximum stenosis in the coronary arteries, reporting of all the following coronary vessels is mandatory:</p> <ul style="list-style-type: none">• Diagonal coronary artery• Left anterior descending coronary artery• Inferior surface artery• Left circumflex coronary artery• Left main coronary artery• Posterior descending artery• Right coronary artery
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Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

Implementation in Data Set Specification: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Coronary artery bypass graft location	Conditional	7
-	Coronary artery stenosis location	Mandatory	7
-	Date of coronary artery bypass graft	Conditional	99

-	<u>Date of primary percutaneous coronary intervention</u>	Conditional	1
-	<u>Date of rescue percutaneous coronary intervention</u>	Conditional	1
-	<u>Date of revascularisation percutaneous coronary intervention</u>	Conditional	1
-	<u>Maximum stenosis coronary artery</u>	Mandatory	1
-	<u>Number of coronary artery lesions attempted</u>	Conditional	99
-	<u>Number of coronary artery lesions successfully dilated</u>	Conditional	99
-	<u>Number of coronary artery stents</u>	Conditional	99
-	<u>Percutaneous coronary intervention procedure type</u>	Conditional	1
-	<u>Time of primary percutaneous coronary intervention</u>	Conditional	1
-	<u>Time of rescue percutaneous coronary intervention</u>	Conditional	1
-	<u>Time of revascularisation percutaneous coronary intervention</u>	Conditional	1

Electrocardiogram cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	351884
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>An electrocardiogram (ECG) measures the electrical activity of the heart over time. The evaluation of an ECG provides important diagnostic information relevant to the risk stratification, diagnosis and management of acute coronary syndromes. The electrocardiogram cluster collects information on the timing of each ECG and specific diagnostic characteristics determined from the ECG:</p> <ul style="list-style-type: none">• ECG change type and location• Bundle-branch block status• Q waves status• ST-segment elevation in lead V4R

Relational attributes

Implementation in Data Set Specification: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Bundle-branch block status	Conditional	1
-	Date of electrocardiogram	Mandatory	99
-	ECG - Q waves indicator	Mandatory	99
-	Electrocardiogram - new Q waves indicator	Conditional	99
-	Electrocardiogram - lead V4R presence indicator	Mandatory	99
-	Electrocardiogram - ST-segment-elevation in lead V4R	Conditional	99
-	Electrocardiogram change location	Conditional	1
-	Electrocardiogram change type	Conditional	99
-	Heart rhythm type	Mandatory	99
-	Time of electrocardiogram	Mandatory	99

Environmental factors cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	320195
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	This data cluster is one of four clusters that make up the Functioning and Disability DSS. To ensure a complete description of human functioning it is recommended that this cluster be collected along with the following three clusters over time and by a range of health and community care providers:

1. Body functions cluster
2. Body structures cluster
3. Activities and participation cluster

Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. These factors can have a positive or negative influence on a person's participation as a member of society, on performance of activities, or on a person's body function or structure.

The Environmental Factors cluster collects information on the extent to which each of the domains in the five chapters listed below influence the body function or structure, activity or participation of a person:

1. Products and technology
2. Natural environment and human-made changes to environment
3. Support and relationships
4. Attitudes
5. Services, systems and policies

Each chapter contains categories at different levels ordered from general to detailed. For detailed information the user should follow the structure of the ICF; the codes should be drawn from the same hierarchical level within any particular chapter.

Codes at the ICF chapter headings may be recorded. If further detail is required the Environmental Factors classification includes 3 and 4 digit codes:

e5 Services, systems and policies
e580 Health services, systems and policies
e5800 Health services

Where multiple environmental factors and the extent of influence are recorded, the following prioritising system may be useful:

- The first recorded environmental factor is the one having the greatest impact on the individual.
- Second and subsequent environmental factors are also of relevance to the individual.

The Environmental factors cluster may be used in health, community services and other disability-related data collections to record the environmental factors that facilitate or inhibit optimum functioning at the body, person or societal level. Identifying whether, and by how much, these environmental factors are influencing an individual's level of functioning, and whether the influence is a facilitator or barrier, may indicate the sorts of interventions that will optimise the individual's functioning. This information may be useful for policy development, service provision, or advocacy purposes. Preventative strategies could also be indicated by this information.

Collection and usage attributes

Guide for use:

For each environmental factor code recorded there should be one response for the influence of the environmental factor.

There are numerous possible methods for collecting environmental factors. Information can be collected on:

- all environmental factors;
- environmental factors of particular relevance;
- a number of environmental factors, prioritised according to specified criteria;
- one environmental factor per person; or
- record environmental factors for each recorded body function, body structure, and activities and participation.

See also the *ICF Australian User Guide* for further guidelines.

Comments:

This cluster is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as:

- Episode of care principal diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}
- Episode of care additional diagnosis, code (ICD-10-AM 5th Ed) ANN{.N[N]}.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare (AIHW) which is the Australian Collaborating Centre for the World Health Organization Family of International Classifications.

Relational attributes

Implementation in Data Set Specification: [Functioning and Disability DSS](#) Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Environmental factor	Mandatory	1
-	Influence of environmental factor	Mandatory	1

Functional stress test cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	351878
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	A functional stress test evaluates arterial blood flow to the heart muscle during increased cardiac work through physical exercise or pharmacological methods. The functional stress test cluster collects information on the timing, characteristics and results of a functional stress test performed during the current hospital presentation.

Relational attributes

Implementation in Data Set Specification: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Date of functional stress test	Conditional	1
-	Functional stress ischaemic and perfusion outcome result	Conditional	1
-	Functional stress test assessment of cardiac perfusion	Conditional	1
-	Functional stress test element	Conditional	1
-	Functional stress test intensity	Conditional	1
-	Functional stress test performed indicator	Mandatory	1

Government health expenditure function revenue data element cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	372219
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	The scope of this data cluster is revenue relating to direct government and government-funded expenditure on health and health-related goods and services or non-health care goods and services to support these activities.

Collection and usage attributes

<i>Guide for use:</i>	Revenues are to be reported in millions to the nearest 100,000 e.g. \$4.1 million.
<i>Collection methods:</i>	This data is collected according to the organisation's source of revenue and type of health or health related function relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Government health expenditure function revenue data cluster Health, Superseded 03/12/2008
<i>Implementation in Data Set Specification:</i>	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009
	<i>Implementation start date:</i> 01/07/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Organisation revenues	Conditional	99
-	Source of public and private revenue	Conditional	1
-	Type of health or health related function	Conditional	1

Government health expenditure organisation expenditure capital consumption data element cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	376401
<i>Registration status:</i>	Health, Standard 01/04/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting of consumption of fixed capital (depreciation). These are all either health and health-related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.

Collection and usage attributes

<i>Guide for use:</i>	Expenses are to be reported in millions to the nearest 100,000 e.g. \$4.1 million.
<i>Collection methods:</i>	This data is collected according to the organisation's main activity types and type of health or health related function relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Relational attributes

<i>Related metadata references:</i>	Supersedes Government health expenditure organisation expenditure capital consumption data element cluster Health, Superseded 01/04/2009
<i>Implementation in Data Set Specification:</i>	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009 <i>Implementation start date:</i> 01/07/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Capital consumption expenses	Conditional	1
-	Health industry relevant organisation type	Conditional	1
-	Type of health or health related function	Conditional	1

Government health expenditure organisation expenditure data element cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	376888
<i>Registration status:</i>	Health, Standard 01/04/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, workers compensation premiums and payouts, purchases of goods and services and consumption of fixed capital (depreciation). These are all either health and health-related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.

Collection and usage attributes

<i>Guide for use:</i>	Expenses are to be reported in millions to the nearest 100,000 e.g. \$4.1 million.
<i>Collection methods:</i>	This data is collected according to the organisation's main activity types and type of health or health related function relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Relational attributes

<i>Related metadata references:</i>	Supersedes Government health expenditure organisation expenditure data cluster Health, Superseded 01/04/2009
<i>Implementation in Data Set Specification:</i>	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009
	<i>Implementation start date:</i> 01/07/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Capital consumption expenses	Mandatory	1
-	Employee expenses	Mandatory	1
-	Health industry relevant organisation type	Mandatory	1
-	Organisation expenses, total Australian currency	Mandatory	1
-	Purchase of goods and services	Mandatory	1
-	Type of health or health related function	Mandatory	1

Government health expenditure organisation expenditure employee related data element cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	376897
<i>Registration status:</i>	Health, Standard 01/04/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting mainly of wages, salaries and supplements, superannuation employer contributions, and workers compensation premiums and payouts. These are all either health and health-related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.

Collection and usage attributes

<i>Guide for use:</i>	Expenses are to be reported in millions to the nearest 100,000 e.g. \$4.1 million.
<i>Collection methods:</i>	This data is collected according to the organisation's main activity types and type of health or health related function relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Relational attributes

<i>Related metadata references:</i>	Supersedes Government health expenditure organisation expenditure employee related data element cluster Health, Superseded 01/04/2009
<i>Implementation in Data Set Specification:</i>	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009 <i>Implementation start date:</i> 01/07/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Employee expenses	Mandatory	1
-	Health industry relevant organisation type	Conditional	1
-	Type of health or health related function	Conditional	1

Government health expenditure organisation expenditure purchase of goods and services data element cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	376891
<i>Registration status:</i>	Health, Standard 01/04/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	The scope of this data cluster is direct government and government-funded expenditure by a health industry relevant organisation consisting mainly of purchases of goods and services. These are all either health and health-related goods and services or non-health care goods and services to support the health industry relevant organisation's activities.

Collection and usage attributes

<i>Guide for use:</i>	Expenses are to be reported in millions to the nearest 100,000 e.g. \$4.1 million.
<i>Collection methods:</i>	This data is collected according to the organisation's main activity types and type of health or health related function relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Relational attributes

<i>Related metadata references:</i>	Supersedes Government health expenditure organisation expenditure purchase of goods and services data element cluster Health, Superseded 01/04/2009
<i>Implementation in Data Set Specification:</i>	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009 <i>Implementation start date:</i> 01/07/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Health industry relevant organisation type	Conditional	1
-	Purchase of goods and services	Mandatory	1
-	Type of health or health related function	Conditional	1

Government health expenditure organisation revenue data element cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	376884
<i>Registration status:</i>	Health, Standard 01/04/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	The scope of this data cluster is revenue relating to direct government and government-funded expenditure by a health industry relevant organisation.

Collection and usage attributes

<i>Guide for use:</i>	Revenues are to be reported in millions to the nearest 100,000 e.g. \$4.1 million.
<i>Collection methods:</i>	This data is collected according to the organisation's source of revenue and main activity types relevant to each State and Territory. This is supplied by the GHE and specified in the reporting guidelines as provided by the AIHW.

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Government health expenditure organisation revenue data element cluster Health, Superseded 01/04/2009
<i>Implementation in Data Set Specification:</i>	Government health expenditure NMDS 2009-2010 Health, Standard 01/04/2009 <i>Implementation start date:</i> 01/07/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Health industry relevant organisation type	Mandatory	1
-	Source of public and private revenue	Mandatory	1
-	Organisation revenues	Conditional	99

Labour force status cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	383452
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	All health professionals renewing their registration with the Australian Health Practitioner Regulation Agency.

Collection and usage attributes

Statistical unit: The statistical unit is the Registered health professional.

Guide for use: The data elements in this cluster, when used together, describe the labour force status of registered health professionals. The cluster assists to describe the size and availability of the health labour force.

The data can be output as sub-groups of the labour force using the following categories:

1. Employed
 1. Employed in Australia in registered profession
 1. Employed in the profession
 2. On extended leave
 2. Employed in Australia outside of registered profession
 1. Looking for work in registered profession
 2. Not looking for work in registered profession
 3. Employed overseas in registered profession
 1. Looking for work in Australia in registered profession
 2. Not looking for work in Australia in registered profession
2. Not employed in Australia
 1. Looking for work in Australia in registered profession
 2. Not looking for work in Australia in registered profession
3. Retired from registered profession in Australia

The employed category excludes those only engaged in unpaid and/or voluntary activities.

Not employed in Australia includes those who are not employed at all and those who are only employed outside Australia.

Collection methods:

Data elements in this cluster comprise five key labour force concepts for the registered profession:

- Country of employment
- Extended leave status
- Jobseeker status
- Labour force status
- Retirement status

It is not necessary to collect these concepts as separate questions. Instead, they are best combined to form the response categories to a set of survey questions.

The following questions are an example of how the separate data elements from this cluster should be used together. They identify the labour force status of a health professional in the registered profession in the last week.

1. Last week, were you:

- Working in the registered profession in Australia? (continue with questionnaire)
- Employed in the registered profession but within a period of leave for 3 months or more? (thank you, nothing further)
- Working in the registered profession overseas? (go to question 2)
- Working, but not in the profession? (go to question 2)
- Not working in paid employment at all? (go to question 2)

2. Last week, did you take active steps to look for work in the registered profession in Australia?

Active steps include: applying for work in the profession, enquiring about a job, answering an advertisement, registering with an employment agency, advertising for work or contacting people in the profession about a job.

- No, I am retired from regular work
- No, not at all
- Yes, I looked for work (either full-time or part-time)

Thank you - no further questions

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification:

[Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009

[Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

[Registered medical professional labour force DSS](#) Health, Standard 10/12/2009

[Registered midwifery labour force DSS](#) Health, Standard
10/12/2009

[Registered nursing professional labour force DSS](#) Health,
Standard 10/12/2009

[Registered optometry labour force DSS](#) Health, Standard
10/12/2009

[Registered osteopathy labour force DSS](#) Health, Standard
10/12/2009

[Registered pharmacy labour force DSS](#) Health, Standard
10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard
10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard
10/12/2009

[Registered psychology labour force DSS](#) Health, Standard
10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Country of employment in registered profession	Optional	1
-	Employment status - health professional	Optional	1
-	Extended leave status in registered profession	Optional	1
-	Jobseeker status in registered profession	Optional	1
-	Retirement status in registered profession	Optional	1

Main job of registered chiropractor cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	383989
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered chiropractors who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered chiropractor.</p> <p>A Registered chiropractor refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a chiropractor at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered chiropractors in their main job. This cluster forms part of the Registered chiropractic labour force DSS, along with <i>Second job of registered chiropractor</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all chiropractors employed in the profession. Data elements in the <i>Second job of registered chiropractor</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered chiropractic labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references:

See also [Second job of registered chiropractor cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specification:

[Registered chiropractic labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - chiropractor	Optional	1

Main job of registered dental and allied dental health professional cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	383991
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered dental and allied dental health professionals who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered dental and allied dental health professional.</p> <p>A Registered dental and allied dental health professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a dental or allied dental health professional at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered dental and allied dental professionals in their main job. This cluster forms part of the Registered dental and allied dental labour force DSS, along with <i>Second job of registered dental and allied dental professionals</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all dental and allied dental professionals employed in the profession. Data elements in the <i>Second job of registered dental and allied dental professionals</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered dental and allied dental labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also [Second job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specification: [Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Area of practice - dental	Conditional	1
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - dental	Optional	1

Main job of registered medical professional cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	375513
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered medical professionals who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered medical professional.</p> <p>A Registered medical professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a medical practitioner, medical specialist or medical specialist-in-training at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered medical professionals in their main job. This cluster forms part of the Registered medical professional labour force DSS, along with <i>Second job of registered medical professional</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all medical professionals employed in the profession. Data elements in the <i>Second job of registered medical professional</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered medical professional labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references:

See also [Second job of registered medical professional cluster Health, Standard 10/12/2009](#)

Implementation in Data Set Specification:

[Registered medical professional labour force DSS Health, Standard 10/12/2009](#)

Conditional obligation:

Applicable to persons who are employed in the registered profession.

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - medical practitioner	Optional	1

Main job of registered midwife cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384011
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered midwives who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered midwife.</p> <p>A Registered midwife refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a midwife at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered midwives in their main job. This cluster forms part of the Registered midwifery labour force DSS, along with <i>Secondjob of registered midwife</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all midwives employed in the profession. Data elements in the <i>Second job of registered midwife</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered midwifery labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references: See also [Second job of registered midwife cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specification: [Registered midwifery labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Area of practice - midwifery	Conditional	1
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - midwife	Optional	1

Main job of registered nursing professional cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	383993
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered nursing professionals who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered nursing professional.</p> <p>A Registered nursing professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a nurse at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered nursing professionals in their main job. This cluster forms part of the Registered nursing labour force DSS, along with <i>Secondjob of registered nursing professional</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all nursing health professionals employed in the profession. Data elements in the <i>Second job of registered nursing professional</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered nursing labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references:

See also [Second job of registered nursing professional cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specification:

[Registered nursing professional labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Area of practice - nursing	Conditional	1
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - nurse	Optional	1

Main job of registered optometrist cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	383998
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered optometrists who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered optometrist.</p> <p>A Registered optometrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an optometrist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered optometrists in their main job. This cluster forms part of the Registered optometry labour force DSS, along with <i>Second job of registered optometrist</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all optometrists employed in the profession. Data elements in the <i>Second job of registered optometrist</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered optometry labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references: See also [Second job of registered optometrist cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specification: [Registered optometry labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - optometrist	Optional	1

Main job of registered osteopath cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384000
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered osteopaths who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered osteopath.</p> <p>A Registered osteopath refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an osteopath at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered osteopaths in their main job. This cluster forms part of the Registered osteopathy labour force DSS, along with <i>Secondjob of registered osteopath</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all osteopaths employed in the profession. Data elements in the <i>Second job of registered osteopath</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered osteopathy labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references: See also [Second job of registered osteopath cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specification: [Registered osteopathy labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - osteopath	Optional	1

Main job of registered pharmacist cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384002
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered pharmacists who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered pharmacist.</p> <p>A Registered pharmacist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a pharmacist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered pharmacists in their main job. This cluster forms part of the Registered pharmacy labour force DSS, along with <i>Secondjob of registered pharmacist</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all pharmacists employed in the profession. Data elements in the <i>Second job of registered pharmacist</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered pharmacy labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references: See also [Second job of registered pharmacist cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specification: [Registered pharmacy labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - pharmacist	Optional	1

Main job of registered physiotherapist cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	383995
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered physiotherapists who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered physiotherapist.</p> <p>A Registered physiotherapist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a physiotherapist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered physiotherapists in their main job. This cluster forms part of the Registered physiotherapy labour force DSS, along with <i>Secondjob of registered physiotherapist</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all physiotherapists employed in the profession. Data elements in the <i>Second job of registered physiotherapist</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered physiotherapy labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references:

See also [Second job of registered physiotherapist cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specification:

[Registered physiotherapy labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - physiotherapist	Optional	1

Main job of registered podiatrist cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384005
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered podiatrists who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered podiatrist.</p> <p>A Registered podiatrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a podiatrist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered podiatrists in their main job. This cluster forms part of the Registered podiatry labour force DSS, along with <i>Secondjob of registered podiatrist</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all podiatrists employed in the profession. Data elements in the <i>Second job of registered podiatrist</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered podiatry labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references: See also [Second job of registered podiatrist cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specification: [Registered podiatry labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - podiatrist	Optional	1

Main job of registered psychologist cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384009
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The main job of registered psychologists who were employed in the profession during the reference week.</p> <p>The main job is defined as the post or position, funded by an organisation, in which the health professional worked the most hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered psychologist.</p> <p>A Registered psychologist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a psychologist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered psychologists in their main job. This cluster forms part of the Registered psychology labour force DSS, along with <i>Second job of registered psychologist</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected from all psychologists employed in the profession. Data elements in the <i>Second job of registered psychologist</i> cluster are collected only from those health professionals employed in more than one job in the profession. All other workforce data elements in the Registered psychology labour force DSS are collected from all health professionals registered in the profession and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their main job.</p> <p>The main job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also [Second job of registered psychologist cluster](#)
Health, Standard 10/12/2009

Implementation in Data Set Specification: [Registered psychology labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Area of practice - psychology	Conditional	1
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - psychologist	Optional	1

Metadata items in this Data Set Specification

Second job of registered chiropractor cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384019
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered chiropractors who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered chiropractor.</p> <p>A Registered chiropractor refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a chiropractor at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered chiropractors in their second job. The cluster forms part of the Registered chiropractic labour force DSS, along with <i>Main job of registered chiropractor</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those chiropractors employed in more than one job in the profession. Data elements in the <i>Main job of registered chiropractor</i> cluster are collected from all chiropractors employed in the profession. All other workforce data elements in the Registered chiropractic labour force DSS are collected from all chiropractors registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation:

Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: [Registered chiropractic labour force DSS](#) Health, Standard
10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - chiropractor	Optional	1

Second job of registered dental and allied dental health professional cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384016
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered dental and allied dental health professionals who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered dental and allied dental health professional.</p> <p>A Registered dental and allied dental health professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a dental and allied dental health professional at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered dental and allied dental health professionals in their second job. The cluster forms part of the Registered dental and allied dental labour force DSS, along with <i>Main job of registered dental and allied dental health professional</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those dental and allied dental health professionals employed in more than one job in the profession. Data elements in the <i>Main job of registered dental and allied dental health professional</i> cluster are collected from all dental and allied dental health professionals employed in the profession. All other workforce data elements in the Registered dental and allied dental labour force DSS are collected from all dental and allied dental health professionals registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Related metadata references: See also [Main job of registered dental and allied dental health professional cluster](#) Health, Standard 10/12/2009

Implementation in Data Set Specification: [Registered dental and allied dental health professional labour force DSS](#) Health, Standard 10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Area of practice - dental	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - dental	Optional	1

Second job of registered medical professional cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	375561
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered medical professionals who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered medical professional.</p> <p>A Registered medical professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a medical practitioner, medical specialist or medical specialist-in-training at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered medical professionals in their second job. The cluster forms part of the Registered medical labour force DSS, along with <i>Main job of registered medical professional</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those medical professionals employed in more than one job in the profession. Data elements in the <i>Main job of registered medical professional</i> cluster are collected from all medical professionals employed in the profession. All other workforce data elements in the Registered medical labour force DSS are collected from all medical professionals registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Implementation in Data Set Specification: [Registered medical professional labour force DSS Health](#), Standard 10/12/2009

Conditional obligation:

Applicable to persons who work in more than one job in the registered profession

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - medical practitioner	Optional	1

Second job of registered midwife cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384021
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered midwives who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered midwife.</p> <p>A Registered midwife refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a midwife at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered midwives in their second job. The cluster forms part of the Registered midwifery labour force DSS, along with <i>Main job of registered midwife</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those midwives employed in more than one job in the profession. Data elements in the <i>Main job of registered midwife</i> cluster are collected from all midwives employed in the profession. All other workforce data elements in the Registered midwifery labour force DSS are collected from all midwives registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Implementation in Data Set Specification: [Registered midwifery labour force DSS](#) Health, Standard
10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Area of practice - midwifery	Conditional	1
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - midwife	Optional	1

Second job of registered nursing professional cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384013
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered nursing professionals who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered nursing professional.</p> <p>A Registered nursing professional refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a nursing professional at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered nursing professionals in their second job. The cluster forms part of the Registered nursing labour force DSS, along with <i>Main job of registered nursing professional</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those nursing professionals employed in more than one job in the profession. Data elements in the <i>Main job of registered nursing professional</i> cluster are collected from all nursing professionals employed in the profession. All other workforce data elements in the Registered nursing labour force DSS are collected from all nursing professionals registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Implementation in Data Set Specification: [Registered nursing professional labour force DSS Health, Standard 10/12/2009](#)

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Area of practice - nursing	Conditional	1
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - nurse	Optional	1

Second job of registered optometrist cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384024
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered optometrists who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered optometrist.</p> <p>A Registered optometrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an optometrist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered optometrists in their second job. The cluster forms part of the Registered optometry labour force DSS, along with <i>Main job of registered optometrist</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those optometrists employed in more than one job in the profession. Data elements in the <i>Main job of registered optometrist</i> cluster are collected from all optometrists employed in the profession. All other workforce data elements in the Registered optometry labour force DSS are collected from all optometrists registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Implementation in Data Set Specification: [Registered optometry labour force DSS](#) Health, Standard
10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - optometrist	Optional	1

Second job of registered osteopath cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384026
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered osteopaths who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered osteopath.</p> <p>A Registered osteopath refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as an osteopath at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered osteopaths in their second job. The cluster forms part of the Registered osteopathy labour force DSS, along with <i>Main job of registered osteopath</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those osteopaths employed in more than one job in the profession. Data elements in the <i>Main job of registered osteopath</i> cluster are collected from all osteopaths employed in the profession. All other workforce data elements in the Registered osteopathy labour force DSS are collected from all osteopaths registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Implementation in Data Set Specification: [Registered osteopathy labour force DSS](#) Health, Standard
10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - osteopath	Optional	1

Second job of registered pharmacist cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384028
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered pharmacists who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered pharmacist.</p> <p>A Registered pharmacist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a pharmacist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered pharmacists in their second job. The cluster forms part of the Registered pharmacy labour force DSS, along with <i>Main job of registered pharmacist</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those pharmacists employed in more than one job in the profession. Data elements in the <i>Main job of registered pharmacist</i> cluster are collected from all pharmacists employed in the profession. All other workforce data elements in the Registered pharmacy labour force DSS are collected from all pharmacists registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Implementation in Data Set Specification: [Registered pharmacy labour force DSS](#) Health, Standard
10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - pharmacist	Optional	1

Second job of registered physiotherapist cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384030
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered physiotherapists who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered physiotherapist.</p> <p>A Registered physiotherapist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a physiotherapist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered physiotherapists in their second job. The cluster forms part of the Registered physiotherapy labour force DSS, along with <i>Main job of registered physiotherapist</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those physiotherapists employed in more than one job in the profession. Data elements in the <i>Main job of registered physiotherapist</i> cluster are collected from all physiotherapists employed in the profession. All other workforce data elements in the Registered physiotherapy labour force DSS are collected from all physiotherapists registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Implementation in Data Set Specification: [Registered physiotherapy labour force DSS](#) Health, Standard
10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - physiotherapist	Optional	1

Second job of registered podiatrist cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384032
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered podiatrists who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered podiatrist.</p> <p>A Registered podiatrist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulation Agency as a podiatrist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered podiatrists in their second job. The cluster forms part of the Registered podiatry labour force DSS, along with <i>Main job of registered podiatrist</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those podiatrists employed in more than one job in the profession. Data elements in the <i>Main job of registered podiatrist</i> cluster are collected from all podiatrists employed in the profession. All other workforce data elements in the Registered podiatry labour force DSS are collected from all podiatrists registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Implementation in Data Set Specification: [Registered podiatry labour force DSS](#) Health, Standard
10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - podiatrist	Optional	1

Second job of registered psychologist cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	384034
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	<p>The second job of registered psychologists who were employed in more than one job in the profession during the reference week.</p> <p>The second job is defined as the post or position, funded by an organisation, in which the health professional worked the second longest hours during the reference week in Australia. The health professional may be an employee or they may be self-employed with the organisation.</p>

Collection and usage attributes

<i>Statistical unit:</i>	<p>The statistical unit for this data set is the Registered psychologist.</p> <p>A Registered psychologist refers to a person who is currently registered, or who has been registered, with the Australian Health Practitioner Regulatory Agency as a psychologist at any time during the reference period.</p>
<i>Guide for use:</i>	<p>Data elements in this cluster assist in describing the type and distribution of services of registered psychologists in their second job. The cluster forms part of the Registered psychology labour force DSS, along with <i>Main job of registered psychologist</i> cluster, <i>Work setting hours</i> cluster, and a range of other data elements.</p> <p>Data elements in this cluster are collected only from those psychologists employed in more than one job in the profession. Data elements in the <i>Main job of registered psychologist</i> cluster are collected from all psychologists employed in the profession. All other workforce data elements in the Registered psychology labour force DSS are collected from all psychologists registered in the profession, and relate to all jobs held in the profession.</p> <p>Registered health professionals on leave at the time of registration are asked to report based on the job that is usually their second job.</p> <p>The second job:</p> <ul style="list-style-type: none">• includes time spent travelling to home visits or calls out;• excludes other time travelling between work locations; and• excludes unpaid professional and/or voluntary activities.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	See also Main job of registered psychologist cluster Health, Standard 10/12/2009
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Implementation in Data Set
Specification:

[Registered psychology labour force DSS](#) Health, Standard
10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Area of practice - psychology	Optional	1
-	Hours worked in health profession - total	Optional	1
-	Postcode – Australian (workplace)	Mandatory	1
-	Principal role - health profession	Optional	1
-	Suburb/town/locality name (workplace)	Mandatory	1
-	Work sector - health professional	Optional	1
-	Work setting - psychologist	Optional	1

Ventricular ejection fraction cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	351881
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	The ventricular ejection fraction is the fraction of blood pumped out of a ventricle with each heart beat. Impaired ventricular ejection fraction can be indicative of damage to the heart muscle, such as that sustained during myocardial infarction. The ventricular ejection fraction cluster collects information on the timing, measurement type and results of a ventricular ejection fraction measurement during the current hospital presentation.

Source and reference attributes

<i>Steward:</i>	The National Heart Foundation of Australia and The Cardiac Society of Australia and New Zealand
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Relational attributes

Implementation in Data Set Specification: [Acute coronary syndrome \(clinical\) DSS](#) Health, Standard 01/10/2008

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Date of ventricular ejection fraction test	Conditional	1
-	Time of ventricular ejection fraction test	Conditional	1
-	Ventricular ejection fraction measurement indicator	Mandatory	1
-	Ventricular ejection fraction test result (percentage)	Conditional	1
-	Ventricular ejection fraction test result (code)	Conditional	1
-	Ventricular ejection fraction test type	Conditional	1

Work setting hours cluster

Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>METeOR identifier:</i>	375565
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>DSS type:</i>	Data Element Cluster
<i>Scope:</i>	Registered health professionals listed with the Australian Health Practitioner Regulation Agency who were employed in the profession during the reference week. They may be an employee or they may be self-employed.

Collection and usage attributes

<i>Statistical unit:</i>	The statistical unit is the Registered health professional.
<i>Guide for use:</i>	<p>The data elements in this cluster, when used together, form a matrix of total hours worked distributed across work sector and setting. The matrix assists to describe the supply and distribution of services by health professionals.</p> <p>The data elements in this cluster include all jobs held in the profession.</p>

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	<p>See also Registered health professional – hours worked in clinical role, total hours NNN Health, Standard 10/12/2009</p> <p>See also Registered health professional – hours worked in non-clinical role, total hours NNN Health, Standard 10/12/2009</p> <p>See also Registered health professional – hours worked in private sector, total hours NNN Health, Standard 10/12/2009</p> <p>See also Registered health professional – hours worked in public sector, total hours NNN Health, Standard 10/12/2009</p>
<i>Implementation in Data Set Specification:</i>	<p>Registered chiropractic labour force DSS Health, Standard 10/12/2009</p> <p>Registered dental and allied dental health professional labour force DSS Health, Standard 10/12/2009</p> <p>Registered medical professional labour force DSS Health, Standard 10/12/2009</p> <p>Registered midwifery labour force DSS Health, Standard 10/12/2009</p> <p>Registered nursing professional labour force DSS Health, Standard 10/12/2009</p> <p>Registered optometry labour force DSS Health, Standard 10/12/2009</p> <p>Registered osteopathy labour force DSS Health, Standard 10/12/2009</p>

[Registered pharmacy labour force DSS](#) Health, Standard
10/12/2009

[Registered physiotherapy labour force DSS](#) Health, Standard
10/12/2009

[Registered podiatry labour force DSS](#) Health, Standard
10/12/2009

[Registered psychology labour force DSS](#) Health, Standard
10/12/2009

Metadata items in this Data Set Specification

<i>Seq No.</i>	<i>Metadata item</i>	<i>Obligation</i>	<i>Max occurs</i>
-	Hours worked in health profession - total	Optional	1
-	Work sector - health professional	Optional	1
-	Work setting - registered health professional	Optional	1

Supporting metadata items

Object classes

Administrative health region

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	288313
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The administrative unit with responsibility for administering health services in a region, area, district or zone, and for developing and implementing strategic and other plans for health service delivery.

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Administrative health region – palliative care strategic plan indicator Health, Standard 05/12/2007
	Administrative health region – region name Health, Standard 05/12/2007

Admitted patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268957
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients). The patient may be admitted if one or more of the following apply:</p> <ul style="list-style-type: none">• the patient's condition requires clinical management and/or facilities not available in their usual residential environment• the patient requires observation in order to be assessed or diagnosed• the patient requires at least daily assessment of their medication needs• the patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (e.g. cardiac catheterisation)• there is a legal requirement for admission (e.g. under child protection legislation)• the patient is aged nine days or less.
<i>Specialisation of:</i>	Hospital patient (Admission status)

Collection and usage attributes

<i>Guide for use:</i>	<p>This metadata item should be used in conjunction with the definition of same-day patient in the glossary item same-day patient.</p> <p>Part 2 of Schedule 3 of the National Health Act (type C) professional attention may be used as a guide for the medical services not normally requiring hospital treatment and therefore not generally related to admitted patients.</p> <p>All babies born in hospital are admitted patients.</p>
<i>Comments:</i>	<p>This definition includes all babies who are nine days old or less. However, all newborn days of stay are further divided into categories of qualified and unqualified for Australian Healthcare Agreements and health insurance benefit purposes. A newborn day is acute (qualified) when a newborn meets at least one of the following criteria:</p> <ul style="list-style-type: none">• is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient;• is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Health Minister for the purpose of the provision of special care;• remains in hospital without its mother;

- is admitted to the hospital without its mother.

Acute (qualified) newborn days are eligible for health insurance benefit purposes and should be counted under the Australian Health Care Agreements. Days when the newborn does not meet these criteria are classified as unqualified (if they are nine days old or less) and should be recorded as such. Unqualified newborn days should not be counted under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.

Relational attributes

Related metadata references:

Supersedes [Admitted patient, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (17.2 KB)

*Data Element Concepts
implementing this Object Class:*

Admitted patient (neonate) – neonatal morbidity Health,
Standard 01/03/2005

Admitted patient care waiting list episode

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	269012
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The period between entry to and removal from a waiting list for admitted patient care.
<i>Specialisation of:</i>	Service/care event (Episode of admitted patient care waiting list status)

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Admitted patient care waiting list episode – scheduled admission date Health, Standard 01/03/2005
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Admitted patient hospital stay

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268995
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The period of treatment and/or care and/or accommodation provided between a formal hospital admission and separation .
<i>Specialisation of:</i>	Service/care event (Admitted patient hospital stay status)

Collection and usage attributes

<i>Comments:</i>	An admitted patient hospital stay is composed of one or more episodes of care, each of which is defined by a single care type (for example acute care, palliative care or rehabilitation care).
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Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Admitted patient hospital stay – number of patient days (of contracted care) Health, Standard 01/03/2005
	Admitted patient hospital stay – operating theatre time Health, Standard 01/03/2005

Adult

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	269001
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An individual aged 18 years or older.
<i>Specialisation of:</i>	Person (Age group)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Adult – body mass index Health, Standard 01/03/2005
	Adult – waist circumference risk indicator Health, Standard 01/03/2005
	Adult – waist-to-hip ratio Health, Standard 01/03/2005
	Adult – weight Health, Superseded 14/07/2005

Available bed

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	373634
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	A suitably located and equipped bed chair, trolley or cot where the necessary financial and human resources are provided for admitted patient care.
<i>Specialisation of:</i>	Establishment (Available bed)

Collection and usage attributes

Comments: This item supports a number of metadata items developed during 2007-08 to replace Establishment – number of available beds for admitted patients, average. The new definitions improve on the counting rules, the definition of availability and provide for the separate reporting of overnight-stay beds, same-day beds, hospital-in-the-home beds and neonatal cots (non-special-care).

During the development phase, it became clear that there are a multitude of bed descriptors, other than 'available', in use. In order to provide clarity in relation to 'available beds' other known terms are defined below:

- Active beds – alternative term for 'available beds'.
- Approved beds – the maximum number of beds that the hospital is authorised to have. This may exceed the number of physical beds.
- Base beds - alternative term for 'available beds'.
- Bed alternatives (QLD) – this term is used to describe furniture, other than beds in overnight wards, such as trolleys, chairs and cots, which provide accommodation for admitted patients – e.g. chairs/trolleys accommodating chemotherapy and dialysis patients.
- Bed Equivalentents (NSW) – a method of equating same day beds to overnight beds – not necessary if counting overnight and same day beds separately.
- Capacity – term which can be used in conjunction with either available or physical beds, but more often the latter – to indicate the maximum number of beds that could be made available, given the appropriate level of funds and nursing and auxiliary staff.
- Designated beds – term used to describe beds set aside for specialist care, e.g. mental health.
- Flex beds – see 'surge/flex beds' below.
- Funded beds – may equate to 'available beds' unless the necessary human resources cannot be provided (e.g. due to a strike or nursing shortage).

- Licensed beds – this is an alternative term for ‘approved beds’, more commonly used for private hospitals where the maximum number of beds is often specified as part of the registration process.
- Medi-hotel bed – this term is used for beds in a non-ward residential service maintained and/or paid for by the hospital, as a substitute for traditional hospital ward accommodation. Residents may be accommodated in a medi-hotel overnight and be admitted as same-day patients or receive non-admitted patient services during the day. They may be accommodated in the medi-hotel before, during or after a multi-day admitted episode. Unlike hospital-in-the-home, however, no clinical services are provided in the medi-hotel and a significant decline in medical condition would always necessitate return from the medi-hotel to the hospital’s Emergency Department or other ward. Thus residents are not reported as admitted while in the medi-hotel (unless they are on leave) and the medi-hotel beds are not counted as available for admitted patients.
- Occupied/Unoccupied beds – categorisation of available beds – a bed is occupied if there is a patient physically in the bed or the bed is being retained for a patient (e.g. the patient is receiving treatment or is on leave). Beds may be available but not occupied, e.g. an 8 bed ward may be fully staffed, but only 7 beds are occupied. Also if a patient has left a bed to receive a different care type and will not be returning within 24 hours, the bed is not occupied.
- Occupancy Rate – calculated by dividing total bed days in a period by the product of the available beds and the days in the period – e.g. if in a non-leap year patients accumulated 33,000 bed days in a hospital with 100 overnight-stay beds, the occupancy rate = $33,000 / (365 * 100) = 90.4\%$. N.B. Occupancy rates calculated for same-day beds could exceed 100%.
- Open beds - alternative term for ‘available beds’.
- Operational beds - alternative term for ‘available beds’.
- Physical beds – the maximum number of beds that could be made available, given the appropriate level of funds and nursing and auxiliary staff.
- Seasonal beds – describes the movement in the number of available beds due to seasonal factors.
- Staffed beds – may equate to ‘available beds’ or may be lower depending on demand.
- Surge/flex beds (NSW) or Flex beds (SA) – the increase in the number of available beds that could be made by making arrangements for additional nursing and auxiliary staff. In other words, the number of surge/flex beds is the difference between the number of physical beds and the number of available beds.
- Swing beds – beds that can alternate between different types of care. Depending on the context, swing beds can be thought of as a sub-category of physical beds or available beds.

- Virtual bed – this term is used to denote a nominal location which the patient is held against in the hospital’s patient administration system. This is because in the patient administration system each admitted patient needs to be held against a bed whether or not they are in a physical bed. For example, if a neonate is sharing a bed with the mother (e.g. in a birth centre) a cot may not be set up. Hospital-in-the-home (HITH) patients may also be held in a virtual bed.

Relational attributes

Data Element Concepts

implementing this Object Class:

Available bed – neonatal admitted care (Non-special-care) Health, Standard 03/12/2008

Available bed – overnight-stay admitted care Health, Standard 03/12/2008

Available bed – residential mental health care Health, Standard 03/12/2008

Available bed – same-day admitted care Health, Standard 03/12/2008

Birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268999
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The complete expulsion or extraction from its mother of a product of conception of at least 20 weeks of gestation or of 400 g or more birthweight , where the product can be liveborn or stillborn.
<i>Context:</i>	Perinatal
<i>Specialisation of:</i>	Person (Birth status)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Birth – Apgar score Health, Superseded 07/12/2005
	Birth – Apgar score Health, Standard 07/12/2005
	Birth – birth order Health, Standard 01/03/2005
	Birth – birth status Health, Standard 01/03/2005
	Birth – birth weight Health, Standard 01/03/2005

Birth event

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268965
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The sequence of actions by which a baby and the afterbirth (placenta) are expelled or extracted from the uterus at childbirth. The process usually starts spontaneously about 280 days after conception with onset of labour, but it may be started by artificial means.
<i>Specialisation of:</i>	Life event (Birth event status)

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	University of Oxford 2002. Concise Colour Medical Dictionary 3rd ed. UK: Oxford University Press

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Birth event – anaesthesia administered Health, Superseded 07/12/2005
	Birth event – anaesthesia administered Health, Standard 07/12/2005
	Birth event – analgesia administered Health, Superseded 07/12/2005
	Birth event – analgesia administered Health, Standard 07/12/2005
	Birth event – baby resuscitation method Health, Standard 01/03/2005
	Birth event – birth method Health, Standard 06/09/2006
	Birth event – birth plurality Health, Standard 01/03/2005
	Birth event – birth presentation Health, Standard 06/09/2006
	Birth event – birth presentation Health, Superseded 06/09/2006
	Birth event – complication Health, Standard 01/03/2005
	Birth event – complication (postpartum) Health, Standard 01/03/2005
	Birth event – delivery method Health, Superseded 06/09/2006
	Birth event – labour augmentation type Health, Standard 01/03/2005
	Birth event – labour induction type Health, Standard 01/03/2005
	Birth event – labour onset type Health, Standard 01/03/2005
	Birth event – setting (intended) Health, Superseded 08/12/2005
	Birth event – setting of birth Health, Standard 01/03/2005
	Birth event – state/territory of birth Health, Standard 01/03/2005

Cancer staging

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	313434
<i>Registration status:</i>	Health, Standard 13/10/2005
<i>Definition:</i>	System of determining the extent or stage of cancer.

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Cancer staging – cancer staging scheme source Health, Standard 04/06/2004
	Cancer staging – cancer staging scheme source edition number Health, Standard 04/06/2004
	Cancer staging – staging basis of cancer Health, Standard 04/06/2004

Cancer treatment

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	288059
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The course of cancer directed treatment or treatments, with defined dates of commencement and cessation, given to the patient by a treatment provider or team of providers. It includes all treatments administered to the patient before disease progression or recurrence and applies to surgical treatment, radiation therapy and systemic agent therapy for cancer.
<i>Context:</i>	This metadata item is required to provide the basis for a standard approach to recording and monitoring patterns of initial treatment for cancer patients.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Commission on Cancer, Standards of the Commission on Cancer Registry Operations and Data Standards (ROADS) Volume II (1998) Commission on Cancer, Facility Oncology Registry Data Standards (2002)

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Cancer treatment – cancer treatment type Health, Standard 04/06/2004
	Cancer treatment – intention of treatment Health, Standard 04/06/2004
	Cancer treatment – non-surgical cancer treatment completion date Health, Standard 04/06/2004
	Cancer treatment – non-surgical cancer treatment start date Health, Standard 04/06/2004
	Cancer treatment – outcome of treatment Health, Standard 04/06/2004
	Cancer treatment – radiation dose received Health, Standard 13/06/2004
	Cancer treatment – radiotherapy treatment type Health, Standard 13/06/2004
	Cancer treatment – surgical procedure date Health, Standard 04/06/2004
	Cancer treatment – surgical procedure for cancer Health, Standard 04/06/2004
	Cancer treatment – systemic therapy agent name (primary cancer) Health, Standard 04/06/2004
	Cancer treatment – target site for cancer treatment Health, Standard 13/06/2004

Child

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268987
<i>Registration status:</i>	Health, Standard 25/02/2005 Community services, Standard 01/12/2004
<i>Definition:</i>	An individual under the age of 18 years.
<i>Specialisation of:</i>	Person (Age group)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Child – body mass index Health, Standard 01/03/2005
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Client

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>Synonymous names:</i>	Client
<i>METeOR identifier:</i>	268969
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	A person, group or organisation eligible to receive services either directly or indirectly from an agency.
<i>Context:</i>	<p>Agencies may provide assistance to individual persons, groups of persons (e.g. support groups) or to other organisations. All of these may be considered clients of an agency. Specific data collections may circumscribe the Type of clients that are included in the collection. For example, at the current stage of development of the Home and Community Care (HACC) Minimum Data Set (MDS), HACC funded agencies are only required to report on clients who are individual persons. Future developments may extend the coverage of the HACC MDS collection to include organisational or group clients.</p> <p>The definition of a 'client' may also be circumscribed by the definition of 'assistance'. What is included as 'assistance' may depend on what activities are considered significant enough to warrant separate recording and reporting of the nature and/or amount of the assistance provided to a person. For example, an agency worker answering a telephone call from an anonymous member of the public seeking some basic information (e.g. a phone number for someone) would not usually consider that this interaction constituted assistance of sufficient significance to warrant recording that person as a 'client'.</p> <p>Furthermore, what constitutes 'assistance' may be influenced by the type of assistance the agency was established to provide. In the above example, the agency in question was funded specifically to provide telephone advice, and referral information, to members of the public or specific sub-groups of the public. The agency may have a policy that all persons telephoning the agency for information are classified as clients, albeit anonymous clients.</p> <p>The level of support or the amount of support given to a person by an agency can also be used to define them as a client or not. For example in the Supported Accommodation Assistance Program (SAAP) National data collection, clients are defined by either taking up an amount of time of an agency; being accommodated by an agency; or by entering an ongoing support relationship with an agency.</p>
<i>Specialisation of:</i>	Person (Client status)

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

Related metadata references:

Supersedes [Client, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf](#) (15.7 KB)

*Data Element Concepts
implementing this Object Class:*

Client – injecting drug use status Health, Standard 01/03/2005

Client – method of drug use (principal drug of concern) Health, Standard 01/03/2005

Community nursing service episode

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268998
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A period of time during which a person receives care from a community nursing service.
<i>Specialisation of:</i>	Episode of care (Community nursing service episode status)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Community nursing service episode – first contact date Health, Standard 01/03/2005
	Community nursing service episode – goal of care Health, Standard 01/03/2005
	Community nursing service episode – last contact date Health, Standard 01/03/2005
	Community nursing service episode – nursing intervention Health, Standard 01/03/2005

Contracted hospital care

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268981
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Contracted hospital care is provided to a patient under an agreement between a purchaser of hospital care (contracting hospital or external purchaser) and a provider of an admitted or non-admitted service (contracted hospital).
<i>Specialisation of:</i>	Service/care event (Contracted hospital care status)

Collection and usage attributes

Guide for use: Related contracted hospital care metadata items should only be completed where services are provided which represent some, but not all of the contracted hospital's total services. It is not necessary to complete contracted hospital care items where all of the hospital services are contracted by a health authority, e.g. privately owned and/or operated public hospitals.

Contracted hospital care must involve all of the following:

- a purchaser, which can be a public or private hospital, or a health authority (department or region) or another external purchaser
- a contracted hospital, which can be a public or private hospital or day procedure centre
- the purchaser paying the contracted hospital for the contracted service; thus, services provided to a patient in a separate facility during their episode of care, where the patient is directly responsible for payment of this additional service, are not considered contracted services for reporting purposes
- the patient being physically present in the contracted hospital for the provision of the contracted service.

Thus, pathology or other investigations performed at another location on specimens gathered at the contracting hospital would not be considered contracted services for reporting purposes.

Allocation of diagnosis and procedure codes should not be affected by the contract status of an episode: the Australian Coding Standards should be applied when coding all episodes. In particular, procedures which would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

Procedures performed by a health care service (i.e. not a recognised hospital) should be coded if appropriate but are not considered to be contracted hospital procedures.

Any Diagnosis Related Group (DRG) derived for episodes involving contracted hospital care, should reflect the total treatment provided (all patient days and procedures), even

where part of the treatment was provided under contract by another hospital.

Relational attributes

Related metadata references:

Supersedes [Contracted hospital care, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.9 KB)

*Data Element Concepts
implementing this Object Class:*

Contracted hospital care – contracted care commencement date Health, Standard 01/03/2005

Contracted hospital care – contracted care completed date Health, Standard 01/03/2005

Contracted hospital care – organisation identifier Health, Standard 01/03/2005

Date

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	294409
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The day of the month and year as specified by a number.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Reference documents:</i>	Oxford English dictionary.

Relational attributes

<i>Data Element Concepts</i>	Date—accuracy indicator Health, Standard 04/05/2005
<i>implementing this Object Class:</i>	Community services, Standard 30/09/2005

Division of general practice

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268989
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A geographically based network of general practitioners.
<i>Specialisation of:</i>	Health service provider (Division of general practice status)

Collection and usage attributes

<i>Guide for use:</i>	In geographical terms, each Division of General Practice can be described by the postcodes that fall within its jurisdiction.
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Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular data working group
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Division of general practice – organisation identifier Health, Standard 01/03/2005
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Elective care waiting list episode

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268974
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The period between entry to and removal from an elective care waiting list.
<i>Specialisation of:</i>	Episode of admitted care waiting list (Elective care status)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Elective care waiting list episode – category reassignment date Health, Standard 01/03/2005
	Elective care waiting list episode – elective care type Health, Standard 01/03/2005
	Elective care waiting list episode – listing date for care Health, Standard 01/03/2005

Elective surgery waiting list episode

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	269007
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The period between entry to and removal from an elective surgery waiting list.
<i>Specialisation of:</i>	Elective care waiting list episode (Elective surgery status)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Elective surgery waiting list episode – anticipated accommodation status Health, Standard 01/03/2005
	Elective surgery waiting list episode – clinical urgency Health, Standard 01/03/2005
	Elective surgery waiting list episode – extended wait patient indicator Health, Standard 01/03/2005
	Elective surgery waiting list episode – indicator procedure Health, Standard 01/03/2005
	Elective surgery waiting list episode – overdue patient status Health, Standard 01/03/2005
	Elective surgery waiting list episode – patient listing status Health, Standard 01/03/2005
	Elective surgery waiting list episode – reason for removal from a waiting list Health, Standard 01/03/2005
	Elective surgery waiting list episode – surgical specialty (of scheduled doctor) Health, Standard 01/03/2005
	Elective surgery waiting list episode – waiting list removal date Health, Standard 01/03/2005
	Elective surgery waiting list episode – waiting time Health, Standard 01/03/2005

Electrocardiogram

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	359999
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A means of studying the activity of the heart from electrical signals.
<i>Specialisation of:</i>	Service/care event (Electrocardiogram status)

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Electrocardiogram – bundle-branch block status Health, Standard 01/10/2008
	Electrocardiogram – change location Health, Standard 01/10/2008
	Electrocardiogram – change type Health, Standard 01/10/2008
	Electrocardiogram – electrocardiogram date Health, Standard 01/10/2008
	Electrocardiogram – electrocardiogram ST-segment-elevation in lead V4R indicator Health, Standard 01/10/2008
	Electrocardiogram – electrocardiogram time Health, Standard 01/10/2008
	Electrocardiogram – heart rhythm type Health, Standard 01/10/2008
	Electrocardiogram – lead V4R presence indicator Health, Standard 01/10/2008
	Electrocardiogram – new Q waves indicator Health, Standard 01/10/2008

Emergency department stay

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	322591
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	The period between when a patient presents at an emergency department and when that person departs.
<i>Context:</i>	Emergency department care.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Government Department of Health and Ageing
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Emergency department stay – physical departure date Health, Standard 24/03/2006
	Emergency department stay – physical departure time Health, Standard 24/03/2006

Episode of admitted patient care

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268956
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The period of admitted patient care between a formal or statistical admission and a formal or statistical separation , characterised by only one care type.
<i>Context:</i>	Admitted patient care.
<i>Specialisation of:</i>	Episode of care (Episode of admitted patient care status)

Collection and usage attributes

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

<i>Origin:</i>	Health Data Standards Committee.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Episode of admitted patient care, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005 02/10/2003.pdf (13.0 KB)
<i>Data Element Concepts implementing this Object Class:</i>	Episode of admitted patient care (newborn) – date of change to qualification status Health, Standard 01/03/2005
	Episode of admitted patient care (newborn) – number of qualified days Health, Standard 01/03/2005
	Episode of admitted patient care (procedure) – procedure commencement date Health, Standard 01/03/2005
	Episode of admitted patient care – admission date Health, Standard 01/03/2005
	Episode of admitted patient care – admission mode Health, Standard 01/03/2005
	Episode of admitted patient care – admission time Health, Standard 01/03/2005
	Episode of admitted patient care – admission urgency status Health, Standard 01/03/2005
	Episode of admitted patient care – condition onset flag Health, Standard 05/02/2008
	Episode of admitted patient care – diagnosis onset type Health, Superseded 05/02/2008
	Episode of admitted patient care – diagnosis related group Health, Standard 01/03/2005
	Episode of admitted patient care – elected accommodation status Health, Superseded 28/11/2006

Episode of admitted patient care – intended length of hospital stay Health, Standard 01/03/2005

Episode of admitted patient care – length of stay (excluding leave days) Health, Standard 01/03/2005

Episode of admitted patient care – length of stay (including leave days) Health, Standard 01/03/2005

Episode of admitted patient care – length of stay (special/neonatal intensive care) Health, Standard 01/03/2005

Episode of admitted patient care – major diagnostic category Health, Standard 01/03/2005

Episode of admitted patient care – number of days of hospital-in-the-home care Health, Standard 01/03/2005

Episode of admitted patient care – number of leave days Health, Standard 01/03/2005

Episode of admitted patient care – number of leave periods Health, Standard 01/03/2005

Episode of admitted patient care – patient election status Health, Standard 28/11/2006

Episode of admitted patient care – procedure Health, Standard 01/03/2005

Episode of admitted patient care – referral destination Health, Standard 01/03/2005

Episode of admitted patient care – referral source Health, Standard 01/03/2005

Episode of admitted patient care – separation date Health, Standard 01/03/2005

Episode of admitted patient care – separation mode Health, Standard 01/03/2005

Episode of admitted patient care – separation time Health, Standard 01/03/2005

Episode of care

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268978
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A period of health care with a defined start and end.
<i>Specialisation of:</i>	Service/care (Episode of care)

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Episode of admitted patient care – inter-hospital contracted patient status Health, Standard 01/03/2005
	Episode of care (procedure) – contracted procedure flag Health, Standard 01/03/2005
	Episode of care – additional diagnosis Health, Superseded 05/02/2008
	Episode of care – additional diagnosis Health, Standard 05/02/2008
	Episode of care – behaviour-related risk factor intervention Health, Standard 01/03/2005
	Episode of care – behaviour-related risk factor intervention purpose Health, Standard 01/03/2005
	Episode of care – expected principal source of funding Health, Superseded 29/11/2006
	Episode of care – first service delivery date (community setting) Health, Standard 01/03/2005
	Episode of care – funding eligibility indicator Health, Standard 01/03/2005
	Episode of care – mental health legal status Health, Standard 01/03/2005
	Episode of care – number of psychiatric care days Health, Standard 01/03/2005
	Episode of care – nursing diagnosis Health, Standard 01/03/2005
	Episode of care – principal diagnosis Health, Standard 01/03/2005
	Episode of care – principal source of funding Health, Standard 29/11/2006
	Episode of care – specialist private sector rehabilitation care indicator Health, Standard 01/03/2005

Episode of residential care

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268968
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The period of care between the start of residential care (either through the formal start of the residential stay or the start of new reference period) and the end of the residential care (either through the formal end of residential care, commencement of leave intended to be greater than seven days or the end of the reference period i.e. 30 June).
<i>Specialisation of:</i>	Episode of care (Episode of residential care status)

Collection and usage attributes

<i>Comments:</i>	For residents provided with care intended to be on an overnight basis. This may occasionally include episodes of residential care that unexpectedly ended on the same day as they started (for example, the resident died or left against advice) or began at the end of the reference period (i.e. starting care on 30 June).
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Episode of residential care – episode end date Health, Standard 01/03/2005
	Episode of residential care – episode end mode Health, Standard 01/03/2005
	Episode of residential care – episode start date Health, Standard 01/03/2005
	Episode of residential care – episode start mode Health, Standard 01/03/2005
	Episode of residential care – number of episodes of residential care Health, Standard 08/12/2004
	Episode of residential care – number of leave days Health, Standard 01/03/2005
	Episode of residential care – referral destination (mental health care) Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268961
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers in which there is no change in the main treatment type or the principal drug of concern, and there has not been a non-planned absence of contact for greater than three months.
<i>Context:</i>	Alcohol and drug treatment services. This concept is required to provide the basis for a standard approach to recording and monitoring patterns of service utilisation by clients.
<i>Specialisation of:</i>	Episode of care (Episode of treatment for alcohol and other drugs status)

Collection and usage attributes

<i>Guide for use:</i>	<p>A treatment episode must have a defined date of commencement of treatment episode for alcohol and other drugs and a date of cessation of treatment episode for alcohol and other drugs.</p> <p>A treatment episode can have only one main treatment type for alcohol and other drugs and only one principal drug of concern. If the main treatment or principal drug changes then the treatment episode is closed and a new treatment episode is opened.</p> <p>A treatment episode may also be considered closed (ceased) if there is a change in the treatment delivery setting or the service delivery outlet. Where the change reflects a substantial alteration in the nature of the treatment episode, for instance where an agency operates in more than one treatment setting (or outlet) they may consider that a change from one setting (or outlet), to another necessitates closure of one episode and commencement of a new one.</p>
<i>Collection methods:</i>	Is taken as the period starting from the date of commencement of treatment and ending at the date of cessation of treatment episode.

Source and reference attributes

<i>Submitting organisation:</i>	Intergovernmental Committee on Drugs National Minimum Data Set - Working Group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Treatment episode for alcohol and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)
<i>Data Element Concepts implementing this Object Class:</i>	Episode of treatment for alcohol and other drugs – cessation reason Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs – client type
Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs – drug of
concern Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs – drug of
concern (principal) Health, Superseded 13/10/2005

Episode of treatment for alcohol and other drugs – number of
service contacts Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs – referral source
Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs – service
delivery setting Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs – treatment
cessation date Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs – treatment
commencement date Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs – treatment type
Health, Standard 01/03/2005

Episode of treatment for alcohol and other drugs – treatment type
(other) Health, Superseded 13/10/2005

Establishment

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268953
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Institutions, organisations or the community from which health services are provided. The term establishment covers conventional health establishments and also organisations which may provide services in the community.
<i>Specialisation of:</i>	Health service provider (Establishment status)

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Establishment (residential aged care service) – number of occasions of service Health, Standard 01/03/2005
	Establishment – accrued mental health care days Health, Standard 08/12/2004
	Establishment – Australian state/territory identifier Health, Standard 01/03/2005
	Community services, Standard 01/03/2005
	Establishment – establishment type Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (administrative and clerical staff) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (carer consultants) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (consumer consultants) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (diagnostic and health professionals) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (domestic and other staff) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (enrolled nurses) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (occupational therapists) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (other diagnostic and health professionals) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (other medical officers) Health, Standard 08/12/2004

Establishment – full-time equivalent staff (paid) (other personal care staff) Health, Standard 01/03/2005

Establishment – full-time equivalent staff (paid) (psychiatry registrars and trainees) Health, Standard 08/12/2004

Establishment – full-time equivalent staff (paid) (psychologists) Health, Standard 08/12/2004

Establishment – full-time equivalent staff (paid) (registered nurses) Health, Standard 01/03/2005

Establishment – full-time equivalent staff (paid) (salaried medical officers) Health, Standard 01/03/2005

Establishment – full-time equivalent staff (paid) (social workers) Health, Standard 08/12/2004

Establishment – full-time equivalent staff (paid) (student nurses) Health, Standard 01/03/2005

Establishment – full-time equivalent staff (paid) (trainee/pupil nurses) Health, Standard 01/03/2005

Establishment – geographic location Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

Establishment – gross capital expenditure (computer equipment/installations) Health, Standard 01/03/2005

Establishment – gross capital expenditure (intangible assets) Health, Standard 01/03/2005

Establishment – gross capital expenditure (land and buildings) Health, Standard 01/03/2005

Establishment – gross capital expenditure (major medical equipment) Health, Standard 01/03/2005

Establishment – gross capital expenditure (other capital expenditure) Health, Standard 01/03/2005

Establishment – gross capital expenditure (plant and other equipment) Health, Standard 01/03/2005

Establishment – net capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005

Establishment – net capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005

Establishment – net capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005

Establishment – net capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005

Establishment – net capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005

Establishment – net capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005

Establishment – net capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Establishment – net capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005

Establishment – net capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

Establishment – number of available beds for admitted patients/residents Health, Superseded 03/12/2008

Establishment – number of day centre attendances Health, Standard 01/03/2005

Establishment – number of group session occasions of service for non-admitted patients Health, Standard 01/03/2005

Establishment – number of group sessions Health, Superseded 04/07/2007

Establishment – number of group sessions Health, Standard 04/07/2007

Establishment – number of individual session occasions of service for non-admitted patients Health, Standard 01/03/2005

Establishment – number of non-admitted patient service events Health, Standard 01/03/2005

Establishment – number of occasions of service Health, Standard 04/05/2005

Establishment – number of patient days Health, Standard 01/03/2005

Establishment – number of separations Health, Standard 01/03/2005

Establishment – organisation identifier Health, Standard 01/03/2005

Establishment – organisation identifier (state/territory) Health, Standard 01/03/2005

Establishment – outpatient clinic type Health, Standard 04/07/2007

Establishment – outpatient clinic type Health, Superseded 04/07/2007

Establishment – patients/clients in residence at year end Health, Standard 01/03/2005

Establishment – quality accreditation/certification standard indicator Health, Standard 01/03/2005

Establishment – recurrent expenditure Health, Standard 08/12/2004

Establishment – recurrent expenditure (administrative expenses) Health, Standard 01/03/2005

Establishment – recurrent expenditure (Department of Veterans' Affairs funded) Health, Standard 02/12/2009

Establishment – recurrent expenditure (Department of Veterans' Affairs funded) Health, Superseded 02/12/2009

Establishment – recurrent expenditure (depreciation) Health, Standard 01/03/2005

Establishment – recurrent expenditure (domestic services) Health, Standard 01/03/2005

Establishment – recurrent expenditure (drug supplies) Health, Standard 01/03/2005

Establishment – recurrent expenditure (food supplies) Health, Standard 01/03/2005

Establishment – recurrent expenditure (indirect health care) Health, Standard 01/03/2005

Establishment – recurrent expenditure (interest payments) Health, Standard 01/03/2005

Establishment – recurrent expenditure (medical and surgical supplies) Health, Standard 01/03/2005

Establishment – recurrent expenditure (National Mental Health Strategy payments) Health, Standard 08/12/2004

Establishment – recurrent expenditure (non-salary operating costs) Health, Standard 01/03/2005

Establishment – recurrent expenditure (other Commonwealth Government funded expenditure) Health, Standard 08/12/2004

Establishment – recurrent expenditure (other patient revenue funded expenditure) Health, Standard 08/12/2004

Establishment – recurrent expenditure (other recurrent expenditure) Health, Standard 01/03/2005

Establishment – recurrent expenditure (other revenue funded expenditure) Health, Standard 08/12/2004

Establishment – recurrent expenditure (other state or territory funded expenditure) Health, Standard 08/12/2004

Establishment – recurrent expenditure (patient transport cost) Health, Standard 01/03/2005

Establishment – recurrent expenditure (recoveries funded expenditure) Health, Standard 08/12/2004

Establishment – recurrent expenditure (repairs and maintenance) Health, Standard 01/03/2005

Establishment – recurrent expenditure (salaries and wages) Health, Standard 01/03/2005

Establishment – recurrent expenditure (state or territory health authority funded) Health, Standard 08/12/2004

Establishment – recurrent expenditure (superannuation employer contributions) Health, Standard 01/03/2005

Establishment – recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005

Establishment – region identifier Health, Standard 01/03/2005

Establishment – revenue (other revenue) Health, Superseded 05/12/2007

Establishment – revenue (other revenue) Health, Standard 05/12/2007

Establishment – revenue (patient) Health, Superseded 05/12/2007

Establishment – revenue (patient) Health, Standard 05/12/2007

Establishment – revenue (recoveries) Health, Superseded 05/12/2007

Establishment – revenue (recoveries) Health, Standard 05/12/2007

Establishment – sector Health, Standard 01/03/2005

Establishment – specialised service indicator Health, Standard 01/03/2005

Establishment – teaching status (university affiliation) Health, Standard 01/03/2005

Female

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	269000
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A human being of the sex which conceives and brings forth young.
<i>Specialisation of:</i>	Person (Sex)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
<i>Origin:</i>	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd.

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Female (mother) – postpartum perineal status Health, Standard 01/03/2005
	Female (pregnant) – estimated gestational age Health, Standard 01/03/2005
	Female (pregnant) – maternal medical condition Health, Standard 01/03/2005
	Female (pregnant) – number of cigarettes smoked (after 20 weeks of pregnancy) Health, Standard 03/12/2008
	Female (pregnant) – number of cigarettes smoked (first 20 weeks of pregnancy) Health, Standard 03/12/2008
	Female (pregnant) – tobacco smoking indicator (after twenty weeks of pregnancy) Health, Standard 03/12/2008
	Female (pregnant) – tobacco smoking indicator (first twenty weeks of pregnancy) Health, Standard 03/12/2008
	Female – pregnancy indicator Health, Standard 21/09/2005
	Female – caesarean section indicator Health, Standard 29/11/2006
	Female – current pregnancy status Health, Superseded 21/09/2005
	Female – number of caesarean sections Health, Standard 29/11/2006
	Female – number of previous pregnancies Health, Standard 01/03/2005
	Female – parity Health, Standard 29/11/2006

Functional stress test

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	358931
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A test performed to evaluate arterial blood flow to the myocardium (heart muscle) during physical exercise, compared to blood flow while at rest.
<i>Specialisation of:</i>	Service event (Functional stress test status)

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Functional stress test – assessment of cardiac perfusion Health, Standard 01/10/2008
	Functional stress test – functional stress test element Health, Standard 01/10/2008
	Functional stress test – ischaemic and perfusion outcome result Health, Standard 01/10/2008
	Functional stress test – stress test intensity Health, Standard 01/10/2008
	Functional stress test – test date Health, Standard 01/10/2008

Health industry relevant organisation

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	352194
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	An organisation that provides health care goods and services to prevent or cure disease, care for illness, impairment, disability or handicap, or non-health care good and services to support these activities.

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Health industry relevant organisation – main activity type Health, Standard 05/12/2007
	Health industry relevant organisation – source of revenue Health, Standard 05/12/2007

Health professional

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268985
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person whose primary employment role is to diagnose and treat physical and mental illnesses and conditions or recommend, administer, dispense and develop medications and treatment to promote or restore good health.
<i>Specialisation of:</i>	Individual service provider (Health professional status)

Collection and usage attributes

<i>Guide for use:</i>	Health professionals include medical practitioners, nursing professionals, dental practitioners, pharmacists, physiotherapists and podiatrists.
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Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
<i>Origin:</i>	ABS (Australian Bureau of Statistics) 1997. Australian Standard Classification of Occupations, 2nd ed. Cat. no. 1220.0. Canberra: ABS

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Health professional – area of clinical practice (principal) Health, Standard 01/03/2005
	Health professional – establishment type (employment) Health, Standard 01/03/2005
	Health professional – hours worked Health, Standard 01/03/2005
	Health professional – labour force status Health, Standard 01/03/2005
	Health professional – occupation Health, Standard 01/03/2005
	Health professional – principal role Health, Standard 01/03/2005

Health service event

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268979
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An interaction between one or more health care providers with one or more persons for assessment, care, consultation and/or treatment.
<i>Specialisation of:</i>	Service/care event (Health service event status)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Health service event – fasting indicator Health, Standard 01/03/2005
	Health service event – presentation date Health, Standard 01/03/2005
	Health service event – presentation time Health, Standard 01/03/2005
	Health service event – referral to ophthalmologist status Health, Superseded 21/09/2005
	Health service event – referral to rehabilitation service date Health, Standard 01/03/2005
	Health service event – service commencement date Health, Superseded 07/12/2005
	Health service event – service commencement time Health, Superseded 07/12/2005

Hospital

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268971
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A health care facility established under Commonwealth, state or territory legislation as a hospital or a free-standing day procedure unit, and authorised to provide treatment and/or care to patients.
<i>Context:</i>	Admitted patient care, admitted patient palliative care, admitted patient mental health care and public hospital establishments.
<i>Specialisation of:</i>	Establishment (Hospital status)

Collection and usage attributes

<i>Comments:</i>	<p>A hospital thus defined may be located at one physical site or may be a multicampus hospital. A multicampus hospital treats movements of patients between sites as ward transfers.</p> <p>For the purposes of these definitions, the term hospital includes satellite units managed and staffed by the hospital.</p> <p>This definition includes, but is not limited to, hospitals as recognised under Australian Health Care Agreements.</p> <p>Residential aged care services as approved under the National Health Act 1953 (Cwlth.) or equivalent state legislation are excluded from this definition.</p> <p>This definition includes entities with multipurpose facilities (e.g. those which contain both recognised and non-recognised components).</p>
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Hospital, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)
<i>Data Element Concepts implementing this Object Class:</i>	Hospital – contract role Health, Standard 01/03/2005
	Hospital – contract type Health, Standard 01/03/2005

Hospital census

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	269010
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A point in time count by a hospital of all its admitted patients and/or patients currently on a waiting list.
<i>Context:</i>	Admitted patient care.
<i>Specialisation of:</i>	Service/care event (Hospital census status)

Relational attributes

<i>Related metadata references:</i>	Supersedes Hospital census, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.8 KB)
<i>Data Element Concepts implementing this Object Class:</i>	Hospital census (of elective surgery waitlist patients) – census date Health, Standard 01/03/2005

Hospital service

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	269008
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A service provided within a hospital, characterised by only one care type.
<i>Specialisation of:</i>	Service/care event (Hospital service status)

Collection and usage attributes

<i>Guide for use:</i>	Includes hospital services provided to an admitted patient, to a hospital boarder , and to an organ donor who has been declared brain dead.
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Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Hospital service – care type Health, Standard 01/03/2005
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Household

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268977
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Superseded 27/04/2007 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	A group of two or more related or unrelated people who usually reside in the same dwelling, and who make common provision for food or other essentials for living. Or a single person living in a dwelling who makes provision for his or her own food and other essentials for living, without combining with any other person.
<i>Context:</i>	Together with family, household is considered one of the basic groups of social aggregation. Information on household numbers and composition aids in identifying groups within the population such as Indigenous households or the number of people living alone.
<i>Specialisation of:</i>	Group of persons (Household status)

Collection and usage attributes

<i>Guide for use:</i>	For housing data collections, the number of tenancy agreements is a practical proxy for calculating the number of households receiving housing assistance. The persons in the group may pool their incomes and have a common budget to a greater or lesser extent: they may be related or unrelated persons, or a combination of both. Only usual residents of the household are included as members of the household. Visitors to a household are, by definition, excluded from the household.
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Source and reference attributes

<i>Origin:</i>	CSHA Public rental housing data manual 2001-02
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Relational attributes

<i>Related metadata references:</i>	Supersedes Household, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (13.7 KB) Supersedes Household, version 2, DEC, NHADD, NHDAMG, Superseded 01/03/2005.pdf (13.6 KB)
<i>Data Element Concepts implementing this Object Class:</i>	Household – gross income Health, Standard 15/12/2005 Housing assistance, Retired 10/02/2006

Individual service provider

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	269021
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	A person who provides a service and/or care.
<i>Specialisation of:</i>	Service/care provider (Organisation status)

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Individual service provider – occupation (self-identified) Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Individual service provider – occupation end date Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Individual service provider – occupation start date Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Injury event

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268967
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An occurrence of injury, poisoning or other adverse effect inflicted on the person as the direct or indirect result of an environmental event, circumstance or condition.
<i>Specialisation of:</i>	Life event (Injury event status)

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Injury event – activity type Health, Standard 01/03/2005
	Injury event – external cause Health, Standard 01/03/2005
	Injury event – human intent of injury Health, Standard 24/11/2005
	Injury event – nature of main injury Health, Standard 01/03/2005
	Injury event – place of occurrence Health, Standard 01/03/2005

Jurisdiction

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	352330
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The territory or area over which authority is exercised.

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Jurisdiction – Australian state/territory identifier Health, Standard 05/12/2007
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Laboratory standard

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	310463
<i>Registration status:</i>	Health, Standard 27/10/2005
<i>Definition:</i>	The acknowledged measure of comparison of a laboratory test result for the specified laboratory. The measure of comparison can vary between laboratories.

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Laboratory standard – upper limit of normal range for creatine kinase isoenzyme Health, Standard 01/10/2008
	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme Health, Standard 04/06/2004
	Laboratory standard – upper limit of normal range for microalbumin Health, Standard 01/03/2005
	Laboratory standard – upper limit of normal range of glycosylated haemoglobin Health, Standard 01/03/2005
	Laboratory standard – upper limit of normal range of troponin assay Health, Standard 04/06/2004

Medical practitioner

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	269005
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person whose primary employment role is to diagnose physical and mental illnesses, disorders and injuries and prescribe medications and treatment to promote or restore good health.
<i>Specialisation of:</i>	Health professional (Profession)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
<i>Origin:</i>	ABS (Australian Bureau of Statistics) 1997. Australian Standard Classification of Occupations, 2nd ed. Cat. no. 1220.0. Canberra: ABS

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Medical practitioner – hours on-call Health, Standard 01/03/2005
	Medical practitioner – hours worked Health, Standard 01/03/2005

Mental health service contact

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	286670
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The provision of a clinically significant service by a specialised mental health service provider(s) for patients/clients, other than those patients/clients admitted to psychiatric hospitals or designated psychiatric units in acute care hospitals, and those resident in 24 hour staffed specialised residential mental health services, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.
<i>Specialisation of:</i>	Service/care event (Service contact status)

Collection and usage attributes

<i>Guide for use:</i>	<p>A service contact must involve at least two persons, one of whom must be a specialised mental health service provider.</p> <p>Mobile and outreach services and consultation and liaison services are included as service contacts.</p> <p>Service contacts are not restricted to in person communication but can include telephone, video link or other forms of direct communication.</p> <p>Service contacts can either be with a patient/client, or with a third party such as a carer or family member, other professional or mental health worker or other service provider. Services involving only a service provider and a third party(ies) are included as service contacts, where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.</p> <p>There may be multiple service contacts on any one day for a patient/client or a third party(ies) and each service contact should be recorded separately.</p> <p>A service contact should be recorded for each patient/client for which the service is provided, whether by phone or other electronic means or in person, regardless of the number of patients/clients or third parties participating or the number of service providers providing the service. Service provision is only regarded as a service contact if it is relevant to the clinical condition of the patient/client. This means that it does not include services of an administrative nature (e.g. telephone contact to schedule an appointment) except where the nature of the service would normally warrant a dated entry in the clinical record of the patient/client in question.</p> <p>There may however be instances where notes are made in the patient/client clinical record that have not been prompted by a service provision for a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as service contacts.</p> <p>In instances where documenting the patient/client's service contact details is separated in time from the service provision, this is not counted as a separate service contact.</p>
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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 a service contact.

Source and reference attributes

Submitting organisation: Australian Institute of Health and Welfare

Relational attributes

Data Element Concepts implementing this Object Class: Mental health service contact – mental health service contact duration
Health, Standard 08/12/2004

Mental health service contact – patient/client participation indicator
Health, Standard 08/12/2004

Mental health service contact – service contact date
Health, Standard 08/12/2004

Mental health service contact – session type
Health, Standard 08/12/2004

Non-admitted patient emergency department service episode

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268976
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The treatment or care between when a patient presents at an emergency department and when the non-admitted patient emergency department treatment or care ends.
<i>Context:</i>	Emergency department care.
<i>Specialisation of:</i>	Episode of care (Non-admitted patient emergency department service episode status)

Collection and usage attributes

<i>Guide for use:</i>	<p>Includes patients who do not wait for treatment once registered or triaged, and those who are dead on arrival at the emergency department.</p> <p>Both a non-admitted patient emergency department service episode and an admitted patient episode of care should be recorded for patients who subsequently undergo a formal admission. The end of the non-admitted patient emergency department service episode should indicate the commencement of the admitted episode of care, if applicable.</p> <p>A non-admitted patient emergency department service episode ends when either the patient is admitted 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.</p>
<i>Comments:</i>	This metadata item has been defined to support the national minimum data set for Non-admitted patient emergency department care.

Source and reference attributes

<i>Submitting organisation:</i>	National reference group for non-admitted patient data development, 2001-02
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Relational attributes

<i>Related metadata references:</i>	Supersedes Non-admitted patient emergency department service episode, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
<i>Data Element Concepts implementing this Object Class:</i>	Non admitted patient emergency department service episode - presenting problem Health, Standard 05/12/2007 Non-admitted patient emergency department service episode - principal diagnosis Health, Standard 05/12/2007 Non-admitted patient emergency department service episode – episode end date Health, Standard 24/03/2006

Non-admitted patient emergency department service episode – episode end status Health, Standard 24/03/2006

Non-admitted patient emergency department service episode – episode end time Health, Standard 24/03/2006

Non-admitted patient emergency department service episode – patient departure status Health, Superseded 24/03/2006

Non-admitted patient emergency department service episode – service commencement date Health, Standard 07/12/2005

Non-admitted patient emergency department service episode – service commencement time Health, Standard 07/12/2005

Non-admitted patient emergency department service episode – service episode length Health, Standard 01/03/2005

Non-admitted patient emergency department service episode – transport mode Health, Standard 01/03/2005

Non-admitted patient emergency department service episode – triage category Health, Standard 01/03/2005

Non-admitted patient emergency department service episode – triage date Health, Standard 07/12/2005

Non-admitted patient emergency department service episode – triage time Health, Standard 07/12/2005

Non-admitted patient emergency department service episode – type of visit to emergency department Health, Standard 01/03/2005

Non-admitted patient emergency department service episode – waiting time Health, Standard 01/03/2005

Non-admitted patient emergency department service episode – waiting time (to hospital admission) Health, Standard 01/03/2005

Non-admitted patient service event

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268972
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An interaction between one or more health care professionals with one or more non-admitted patients, for assessment, consultation and/or treatment intended to be unbroken in time. A service event means that a dated entry is made in the patient/client's medical record.
<i>Context:</i>	Hospital non-admitted patient care: This definition applies to non-admitted hospital patients and is not intended to apply to community based services.
<i>Specialisation of:</i>	Service/care event (Non-admitted patient service event status)

Collection and usage attributes

<i>Guide for use:</i>	<p>The period of interaction can be broken but still regarded as one service event if it was intended to be unbroken in time. This covers those circumstances in which treatment during a service event is temporarily interrupted for unexpected reasons, for example, a clinician is called to assess another patient who requires more urgent care.</p> <p>Service events can occur in an outpatient, emergency, radiology, pathology and/or pharmacy department or, by a hospital-based outreach service, in a location that is not part of the hospital campus.</p> <p>Service events may or may not be pre-arranged (except for telephone calls).</p> <p>Imaging, pathology and/or pharmacy services that are associated with a service event in an outpatient clinic, emergency department or outreach service are not regarded as service events themselves.</p> <p>Imaging, pathology or pharmacy services provided independent of a service event in an outpatient clinic, emergency department or outreach service are regarded as individual service events.</p> <p>Service events delivered via a telephone call are included if</p> <ul style="list-style-type: none">• they are a substitute for a face-to-face service event, and• they are pre-arranged, and• a record of the service event is included in the patient's medical record. <p>Service events include when the patient is participating via a video link (telemedicine). A service event can be counted at each site participating via the video link.</p> <p>If a carer/relative accompanies a patient during a service event, this is not considered to be a service event for the carer/relative, provided that the carer/relative is not a patient in their own right for the service contact.</p>
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Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

A service event is regarded as having occurred when a consultation occurs between their carer/relative and a service provider at an appointment when the patient is not present, provided that the carer/relative is not a patient in their own right for the service contact. Where both are patients, it is considered that service events have been provided for the person(s) in whose medical record the service event is noted.

A service event is regarded as having occurred for each patient who attends a group session such as an antenatal class. Outpatient department services provided to admitted patients are not regarded as service events.

Work-related services provided in clinics for staff are not service events.

Source and reference attributes

Origin: National Health Data Committee

Relational attributes

Related metadata references: Supersedes [Non-admitted patient service event, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (18.0 KB)

Data Element Concepts implementing this Object Class: Non-admitted patient service event – multi-disciplinary team status Health, Standard 01/03/2005

Non-admitted patient service event – new/repeat service event status Health, Standard 01/03/2005

Non-admitted patient service event – patient present status Health, Standard 01/03/2005

Non-admitted patient service event – service event type (clinical) Health, Standard 01/03/2005

Non-admitted patient service event – service mode Health, Standard 01/03/2005

Occupied bed

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	375696
<i>Registration status:</i>	Health, Standard 24/03/2009
<i>Definition:</i>	An occupied bed is an available bed where there is a patient physically in the bed or the bed is being retained for a patient (e.g. the patient is receiving treatment or is on leave).

Collection and usage attributes

<i>Comments:</i>	<p>Beds may be available but not occupied, e.g. an 8 bed ward may be fully staffed, but only 7 beds are occupied. Also if a patient has left a bed to receive a different care type and will not be returning within 24 hours, the bed is not occupied.</p> <p>The Occupancy Rate is calculated by dividing total bed days in a period by the product of the available beds and the days in the period – e.g. if in a non-leap year patients accumulated 33,000 bed days in a hospital with 100 overnight-stay beds, the occupancy rate = $33,000 / (365 * 100) = 90.4\%$. N.B. Occupancy rates calculated for same-day beds could exceed 100%.</p>
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Occupied bed – hospital in the home care Health, Standard 24/03/2009
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Organisation

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	354505
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The smallest type of accounting unit within a management unit within a State or Territory of Australia which controls its productive activities and for which a specified range of detailed data is available, at least on an annual basis, thus enabling measures such as value added to be calculated.

Source and reference attributes

<i>Reference documents:</i>	Australian Bureau of Statistics 2002. Standard Economic Sector Classifications of Australia (SESCA). ABS cat. no. 1218.0. Canberra: ABS.
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Organisation – capital consumption expenses Health, Standard 01/04/2009
	Organisation – depreciation expenses Health, Superseded 01/04/2009
	Organisation – employee related expenses Health, Standard 05/12/2007
	Organisation – expenses Health, Standard 05/12/2007
	Organisation – purchase of goods and services Health, Standard 05/12/2007
	Organisation – revenue Health, Standard 05/12/2007
	Organisation – type of health or health related function Health, Standard 05/12/2007

Patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268959
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person for whom a health service accepts responsibility for treatment and or care.
<i>Specialisation of:</i>	Person (Patient status)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Patient, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.2 KB)
<i>Data Element Concepts implementing this Object Class:</i>	Patient – compensable status Health, Standard 01/03/2005
	Patient – diagnosis date Health, Standard 01/03/2005
	Patient – hospital insurance status Health, Standard 01/03/2005
	Patient – initial visit since diagnosis indicator (diabetes mellitus) Health, Standard 21/09/2005
	Patient – initial visit since diagnosis status (diabetes mellitus) Health, Superseded 21/09/2005
	Patient – insulin start date Health, Standard 01/03/2005
	Patient – number of psychiatric outpatient clinic/day program attendances Health, Standard 01/03/2005
	Patient – previous specialised treatment Health, Standard 01/03/2005

Person

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268955
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	A human being, whether man, woman or child.
<i>Specialisation of:</i>	Person/group of persons (Group status)

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Macquarie University 2003. <i>The Macquarie Dictionary 3rd ed.</i> Sydney: The Macquarie Library Pty. Ltd

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Person (address) – address line Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Person (address) – address type Health, Standard 01/03/2005 Community services, Standard 30/09/2005
	Person (address) – Australian postcode Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
	Person (address) – building/complex sub-unit identifier Health, Standard 01/03/2005 Community services, Standard 30/09/2005
	Person (address) – building/complex sub-unit type Health, Standard 01/03/2005 Community services, Standard 30/09/2005
	Person (address) – building/property name Health, Standard 01/03/2005 Community services, Standard 30/09/2005
	Person (address) – country identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Person (address) – electronic communication address Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Person (address) – electronic communication medium Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Person (address) – electronic communication usage code Health, Standard 04/05/2005 Community services, Standard 30/09/2005
	Person (address) – floor/level identifier Health, Standard 01/03/2005 Community services, Standard 30/09/2005
	Person (address) – floor/level type Health, Standard 01/03/2005 Community services, Standard 30/09/2005

Person (address) – health address line Health, Superseded 04/05/2005

Person (address) – house/property identifier Health, Standard 01/03/2005
Community services, Standard 30/09/2005

Person (address) – international postcode Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Person (address) – lot/section identifier Health, Standard 01/03/2005
Community services, Standard 30/09/2005

Person (address) – non-Australian state/province Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Person (address) – postal delivery point identifier Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person (address) – postal delivery service type identifier Health, Standard 01/03/2005

Person (address) – street name Health, Standard 01/03/2005
Community services, Standard 30/09/2005

Person (address) – street suffix Health, Standard 01/03/2005
Community services, Standard 30/09/2005

Person (address) – street type Health, Standard 01/03/2005
Community services, Standard 30/09/2005

Person (address) – suburb/town/locality name Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person (identifier) – identifier type Health, Standard 01/03/2005

Person (male) – erectile dysfunction Health, Standard 01/03/2005

Person (name) – family name Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 28/07/2005

Person (name) – given name Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 01/08/2005

Person (name) – given name sequence number Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Person (name) – name conditional use flag Health, Standard 04/05/2005
Community services, Standard 25/08/2005

Person (name) – name context flag Health, Superseded 04/05/2005
Community services, Superseded 25/08/2005

Person (name) – name suffix Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person (name) – name suffix sequence number Health, Standard 04/05/2005
Community services, Standard 30/09/2005

Person (name) – name title Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person (name) – name title sequence number Health, Standard 04/05/2005
 Community services, Standard 30/09/2005
 Person (name) – name type Health, Standard 01/03/2005
 Community services, Standard 30/09/2005
 Person (requiring care) – carer availability status Health, Superseded 04/07/2007
 Community services, Superseded 02/05/2006
 Person (telephone) – telephone number type Health, Standard 01/03/2005
 Community services, Standard 01/03/2005
 Person – electrocardiogram Q waves indicator Health, Standard 01/10/2008
 Person – accommodation type Health, Standard 01/03/2005
 Person – activity and participation life area Health, Standard 29/11/2006
 Community services, Standard 16/10/2006
 Person – acute coronary syndrome concurrent clinical condition Health, Superseded 01/10/2008
 Person – acute coronary syndrome procedure type Health, Standard 04/06/2004
 Person – acute coronary syndrome related medical history Health, Standard 01/10/2008
 Person – acute coronary syndrome risk stratum Health, Superseded 01/10/2008
 Person – acute coronary syndrome risk stratum Health, Standard 01/10/2008
 Person – acute coronary syndrome symptoms onset date Health, Standard 01/10/2008
 Person – acute coronary syndrome symptoms onset time Health, Standard 01/10/2008
 Person – age Health, Standard 04/05/2005
 Community services, Standard 04/05/2005
 Housing assistance, Standard 17/06/2005
 Person – age range Health, Standard 04/05/2005
 Community services, Standard 30/11/2007
 Person – alcohol consumption amount Health, Standard 01/03/2005
 Person – alcohol consumption frequency Health, Standard 01/03/2005
 Person – angina status Health, Standard 01/10/2008
 Person – angiotensin converting enzyme inhibitors therapy status Health, Standard 04/06/2004
 Person – area of usual residence Health, Standard 01/03/2005
 Community services, Standard 21/05/2010
 Person – aspirin therapy status Health, Standard 04/06/2004
 Person – Australian state/territory identifier Health, Standard 01/03/2005
 Community services, Standard 01/03/2005
 Housing assistance, Standard 10/02/2006

Person—beta-blocker therapy status Health, Standard 04/06/2004
 Person—bleeding episode status Health, Superseded 01/10/2008
 Person—bleeding episode status Health, Standard 01/10/2008
 Person—blindness Health, Standard 01/03/2005
 Person—blood pressure (diastolic) Health, Standard 01/03/2005
 Person—blood pressure (systolic) Health, Standard 01/03/2005
 Person—bodily location of main injury Health, Standard 01/03/2005
 Person—body function Health, Standard 29/11/2006
 Community services, Standard 16/10/2006
 Person—body mass index (classification) Health, Standard 01/03/2005
 Person—body structure Health, Standard 29/11/2006
 Community services, Standard 16/10/2006
 Person—C-reactive protein level (measured) Health, Standard 01/10/2008
 Person—C-reactive protein level measured date Health, Standard 01/10/2008
 Person—C-reactive protein level measured time Health, Standard 01/10/2008
 Person—cardiovascular disease condition targeted by drug therapy Health, Standard 01/03/2005
 Person—cardiovascular medication taken Health, Standard 01/03/2005
 Person—cataract status Health, Standard 01/03/2005
 Person—cerebral stroke due to vascular disease Health, Standard 01/03/2005
 Person—chest pain pattern Health, Standard 04/06/2004
 Person—cholesterol level Health, Standard 01/03/2005
 Person—clinical evidence status (acute coronary syndrome related medical history) Health, Standard 01/10/2008
 Person—clinical evidence status (chronic lung disease) Health, Superseded 01/10/2008
 Person—clinical evidence status (heart failure) Health, Superseded 01/10/2008
 Person—clinical evidence status (peripheral arterial disease) Health, Superseded 01/10/2008
 Person—clinical evidence status (sleep apnoea syndrome) Health, Superseded 01/10/2008
 Person—clinical evidence status (stroke) Health, Superseded 01/10/2008
 Person—clinical procedure timing Health, Standard 04/06/2004
 Person—clopidogrel therapy status Health, Standard 04/06/2004
 Person—congenital malformation Health, Standard 01/03/2005
 Person—coronary artery bypass graft date Health, Standard 01/10/2008
 Person—coronary artery bypass graft location Health, Standard 01/10/2008
 Person—coronary artery disease intervention Health, Standard 01/03/2005

Person—coronary artery stenosis location Health, Standard 01/10/2008

Person—count of angina episodes Health, Standard 01/10/2008

Person—count of coronary artery lesions attempted Health, Standard 01/10/2008

Person—count of coronary artery lesions successfully dilated Health, Standard 01/10/2008

Person—count of coronary artery stents Health, Standard 01/10/2008

Person—country of birth Health, Standard 01/03/2005

Community services, Standard 01/03/2005

Housing assistance, Standard 27/07/2005

Person—creatine kinase isoenzyme level Health, Standard 01/10/2008

Person—creatine kinase myocardial band isoenzyme measured date Health, Standard 04/06/2004

Person—creatine kinase myocardial band isoenzyme measured time Health, Standard 04/06/2004

Person—creatine kinase-myocardial band isoenzyme level Health, Standard 04/06/2004

Person—creatinine serum level Health, Standard 01/03/2005

Person—creatinine serum level measured date Health, Standard 01/10/2008

Person—date of birth Health, Standard 01/03/2005

Community services, Standard 01/03/2005

Housing assistance, Standard 27/07/2005

Person—date of death Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Person—dependency in activities of daily living Health, Standard 01/03/2005

Community services, Recorded 16/11/2009

Person—diabetes mellitus status Health, Standard 01/03/2005

Person—diabetes therapy type Health, Standard 01/03/2005

Person—diagnostic cardiac catheterisation date Health, Standard 01/10/2008

Person—diagnostic cardiac catheterisation time Health, Standard 01/10/2008

Person—dyslipidaemia treatment status (anti-lipid medication) Health, Superseded 22/09/2005

Person—dyslipidaemia treatment with anti-lipid medication indicator Health, Standard 21/09/2005

Person—electrocardiogram change location Health, Superseded 01/10/2008

Person—electrocardiogram change type Health, Superseded 01/10/2008

Person—eligibility status Health, Standard 04/01/2006

Community services, Standard 04/01/2006

Person—end-stage renal disease status Health, Standard 01/03/2005

Person—environmental factor Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Person—extent of environmental factor influence Health, Standard 29/11/2006
 Community services, Standard 16/10/2006
 Person—extent of impairment of body function Health, Standard 29/11/2006
 Community services, Standard 16/10/2006
 Person—extent of impairment of body structure Health, Standard 29/11/2006
 Community services, Standard 16/10/2006
 Person—extent of participation in a life area Health, Standard 29/11/2006
 Community services, Standard 16/10/2006
 Person—fibrinolytic drug administered Health, Standard 01/10/2008
 Person—fibrinolytic drug administered Health, Superseded 01/10/2008
 Person—fibrinolytic therapy status Health, Standard 04/06/2004
 Person—first angioplasty balloon inflation or stenting date Health, Superseded 01/10/2008
 Person—first angioplasty balloon inflation or stenting time Health, Superseded 01/10/2008
 Person—foot deformity indicator Health, Standard 01/03/2005
 Person—foot lesion indicator Health, Standard 01/03/2005
 Person—foot ulcer history status Health, Standard 01/03/2005
 Person—foot ulcer indicator Health, Standard 21/09/2005
 Person—foot ulcer status (current) Health, Superseded 21/09/2005
 Person—formal community support access indicator Health, Standard 01/03/2005
 Person—functional stress test element Health, Superseded 01/10/2008
 Person—functional stress test ischaemic result Health, Superseded 01/10/2008
 Person—functional stress test performed indicator Health, Standard 01/10/2008
 Person—glycoprotein IIb/IIIa receptor antagonist status Health, Standard 04/06/2004
 Person—glycosylated haemoglobin level Health, Standard 01/03/2005
 Person—government funding identifier Health, Standard 01/03/2005
 Community services, Standard 31/08/2007
 Person—health professionals attended for diabetes mellitus Health, Standard 01/03/2005
 Person—heart rate Health, Standard 04/06/2004
 Person—heart rhythm type Health, Superseded 01/10/2008
 Person—height Health, Standard 01/03/2005
 Person—high-density lipoprotein cholesterol level Health, Standard 01/03/2005
 Person—hip circumference Health, Standard 01/03/2005
 Person—hypertension treatment status (antihypertensive medication) Health, Superseded 21/09/2005

Person – hypertension treatment with antihypertensive medication indicator Health, Standard 21/09/2005

Person – implantable cardiac defibrillator procedure date Health, Standard 01/10/2008

Person – implantable cardiac defibrillator procedure time Health, Standard 01/10/2008

Person – Indigenous status Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 01/03/2005

Person – informal carer existence indicator Health, Standard 04/07/2007
Community services, Standard 02/05/2006

Person – interpreter service required Health, Standard 08/02/2006
Community services, Standard 10/04/2006

Person – interpreter service required status (health) Health, Superseded 08/02/2006

Person – intra-aortic balloon pump procedure date Health, Standard 01/10/2008

Person – intra-aortic balloon pump procedure time Health, Standard 01/10/2008

Person – intravenous fibrinolytic therapy date Health, Standard 01/10/2008

Person – intravenous fibrinolytic therapy date Health, Superseded 01/10/2008

Person – intravenous fibrinolytic therapy time Health, Standard 04/06/2004

Person – Killip classification Health, Standard 04/06/2004

Person – labour force status Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 01/08/2005

Person – level of difficulty with activities in a life area Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person – level of satisfaction with participation in a life area Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person – lipid-lowering therapy status Health, Standard 04/06/2004

Person – living arrangement Health, Standard 19/04/2005
Community services, Standard 01/03/2005

Person – location of impairment of body structure Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person – low-density lipoprotein cholesterol level Health, Standard 01/03/2005

Person – lower limb amputation due to vascular disease Health, Standard 01/03/2005

Person – main language other than English spoken at home Health, Standard 01/03/2005

Community services, Standard 01/03/2005
 Housing assistance, Standard 10/02/2006
 Person – marital status Health, Standard 01/03/2005
 Community services, Standard 01/03/2005
 Housing assistance, Standard 10/02/2006
 Person – maximum stenosis coronary artery Health, Standard 01/10/2008
 Person – microalbumin level Health, Standard 01/03/2005
 Person – most recent stroke date Health, Standard 01/10/2008
 Person – mother’s original family name Health, Standard 01/03/2005
 Community services, Standard 01/03/2005
 Person – myocardial infarction Health, Standard 01/03/2005
 Person – nature of impairment of body structure Health, Standard 29/11/2006
 Community services, Standard 16/10/2006
 Person – need for assistance with activities in a life area Health, Standard 29/11/2006
 Community services, Standard 16/10/2006
 Person – non-invasive ventilation administration date Health, Standard 01/10/2008
 Person – non-invasive ventilation administration time Health, Standard 01/10/2008
 Person – number of cigarettes smoked Health, Standard 01/03/2005
 Person – number of service contact dates Health, Standard 01/03/2005
 Person – occupation (main) Health, Superseded 04/07/2007
 Community services, Superseded 27/03/2007
 Housing assistance, Superseded 10/08/2007
 Person – occupation (main) Health, Standard 04/07/2007
 Community services, Standard 27/03/2007
 Housing assistance, Standard 10/08/2007
 Person – ophthalmological assessment outcome Health, Standard 01/03/2005
 Person – ophthalmoscopy performed indicator Health, Standard 21/09/2005
 Person – ophthalmoscopy performed status Health, Superseded 21/09/2005
 Person – pacemaker insertion date Health, Standard 01/10/2008
 Person – pacemaker insertion time Health, Standard 01/10/2008
 Person – percutaneous coronary intervention procedure type Health, Standard 01/10/2008
 Person – period of residence in Australia Health, Standard 01/03/2005
 Person – peripheral neuropathy indicator Health, Standard 01/03/2005
 Person – peripheral vascular disease indicator (foot) Health, Standard 01/03/2005
 Person – person identifier Health, Standard 04/05/2005
 Community services, Standard 25/08/2005

Person – person identifier (within establishment/agency) Health, Superseded 04/05/2005
Community services, Superseded 25/08/2005

Person – physical activity sufficiency status Health, Standard 01/03/2005

Person – postal delivery service type Health, Standard 01/03/2005

Person – preferred language Health, Standard 01/03/2005
Community services, Standard 10/04/2006

Person – premature cardiovascular disease family history status Health, Standard 01/03/2005

Person – primary percutaneous coronary intervention date Health, Standard 01/10/2008

Person – primary percutaneous coronary intervention time Health, Standard 01/10/2008

Person – proficiency in spoken English Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006

Person – proteinuria status Health, Standard 01/03/2005

Person – reason for non prescription of pharmacotherapy Health, Standard 01/10/2008

Person – reason for readmission following acute coronary syndrome episode Health, Standard 04/06/2004

Person – reason for readmission following acute coronary syndrome episode Health, Standard 01/10/2008

Person – referral to ophthalmologist indicator Health, Standard 21/09/2005

Person – regular tobacco smoking indicator Health, Standard 21/09/2005

Person – renal disease therapy Health, Standard 01/03/2005

Person – rescue percutaneous coronary intervention date Health, Standard 01/10/2008

Person – rescue percutaneous coronary intervention time Health, Standard 01/10/2008

Person – revascularisation percutaneous coronary intervention date Health, Standard 01/10/2008

Person – revascularisation percutaneous coronary intervention time Health, Standard 01/10/2008

Person – severe hypoglycaemia history Health, Superseded 21/09/2005

Person – severe hypoglycaemia indicator Health, Standard 21/09/2005

Person – sex Health, Standard 01/03/2005
Community services, Standard 01/03/2005
Housing assistance, Standard 10/02/2006

Person – state/territory of birth Health, Standard 10/12/2009

Person – technical nursing care requirement Health, Standard 13/10/2005

Person – telephone number Health, Standard 01/03/2005
Community services, Standard 01/03/2005

Person – time since quitting tobacco smoking Health, Standard 01/03/2005

Person – timing of ACE-inhibitor prescription Health, Standard 01/10/2008

Person – timing of angiotensin II receptor blocker prescription Health, Standard 01/10/2008

Person – timing of antithrombin therapy prescription Health, Standard 01/10/2008

Person – timing of aspirin prescription Health, Standard 01/10/2008

Person – timing of beta-blocker prescription Health, Standard 01/10/2008

Person – timing of clopidogrel prescription Health, Standard 01/10/2008

Person – timing of glycoprotein IIb/IIIa inhibitor prescription Health, Standard 01/10/2008

Person – timing of statin prescription Health, Standard 01/10/2008

Person – tobacco product smoked Health, Standard 01/03/2005

Person – tobacco smoking daily use status Health, Standard 01/03/2005

Person – tobacco smoking duration Health, Standard 01/03/2005

Person – tobacco smoking frequency Health, Standard 01/03/2005

Person – tobacco smoking quit age Health, Standard 01/03/2005

Person – tobacco smoking start age Health, Standard 01/03/2005

Person – tobacco smoking status Health, Standard 01/03/2005

Person – tobacco smoking status (last three months) Health, Superseded 21/09/2005

Person – triglyceride level Health, Standard 01/03/2005

Person – troponin assay type Health, Standard 04/06/2004

Person – troponin level Health, Standard 04/06/2004

Person – troponin level measured date Health, Standard 04/06/2004

Person – troponin level measured time Health, Standard 04/06/2004

Person – underlying cause of acute coronary syndrome Health, Standard 01/10/2008

Person – underlying cause of death Health, Standard 01/10/2008

Person – units of blood transfused Health, Standard 01/10/2008

Person – vascular condition status Health, Standard 01/03/2005

Person – vascular procedure Health, Standard 01/03/2005

Person – ventricular ejection fraction test performed indicator Health, Standard 01/10/2008

Person – visual acuity Health, Standard 01/03/2005

Person – waist circumference Health, Standard 01/03/2005

Person – weight Health, Standard 01/03/2005

Person – year of first arrival in Australia Health, Standard 04/05/2005

Community services, Standard 01/03/2005

Person with acute coronary syndrome

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	284638
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	A person receiving treatment for acute myocardial ischaemia resulting from coronary artery disease.
<i>Specialisation of:</i>	Person (Health condition)

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Person with acute coronary syndrome – acute coronary syndrome related clinical event date Health, Standard 01/10/2008
	Person with acute coronary syndrome – acute coronary syndrome related clinical event time Health, Standard 01/10/2008
	Person with acute coronary syndrome – bleeding location Health, Standard 01/10/2008
	Person with acute coronary syndrome – lifestyle counselling type Health, Standard 01/10/2008
	Person with acute coronary syndrome – pharmacotherapy type prescribed in hospital Health, Standard 01/10/2008
	Person with acute coronary syndrome – pharmacotherapy type taken post discharge from hospital Health, Standard 01/10/2008
	Person with acute coronary syndrome – type of acute coronary syndrome related clinical event Health, Standard 01/10/2008

Person with cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268990
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person who has been diagnosed with a cancer.
<i>Specialisation of:</i>	Person (Health condition)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Person with cancer – degree of spread of a cancer Health, Standard 01/03/2005
	Person with cancer – distant metastasis status Health, Standard 13/06/2004
	Person with cancer – extent of primary cancer Health, Standard 04/06/2004
	Person with cancer – histopathological grade Health, Standard 04/06/2004
	Person with cancer – human epidermal growth factor receptor-2 test result Health, Standard 06/03/2009
	Person with cancer – human epidermal growth factor receptor-2 test type Health, Standard 06/03/2009
	Person with cancer – laterality of primary cancer Health, Standard 01/03/2005
	Person with cancer – lymphovascular invasion Health, Standard 06/03/2009
	Person with cancer – melanoma thickness Health, Standard 01/03/2005
	Person with cancer – morphology of cancer Health, Standard 01/03/2005
	Person with cancer – most valid basis of diagnosis of a cancer Health, Standard 01/03/2005
	Person with cancer – neoadjuvant therapy indicator Health, Standard 06/03/2009
	Person with cancer – number of positive regional lymph nodes Health, Standard 04/06/2004
	Person with cancer – number of positive sentinel lymph nodes Health, Standard 06/03/2009
	Person with cancer – number of regional lymph nodes examined Health, Standard 04/06/2004
	Person with cancer – number of sentinel lymph nodes examined Health, Standard 06/03/2009

Person with cancer – oestrogen receptor assay result Health, Standard
04/06/2004

Person with cancer – primary site of cancer Health, Standard
01/03/2005

Person with cancer – primary tumour status Health, Standard
13/06/2004

Person with cancer – progesterone receptor assay results Health,
Standard 13/06/2004

Person with cancer – region of first recurrence of cancer Health,
Standard 04/06/2004

Person with cancer – regional lymph node metastasis status Health,
Standard 13/06/2004

Person with cancer – solid tumour size Health, Standard 01/03/2005

Pregnancy

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268966
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The period during which a woman carries a developing fetus, normally in the uterus. Pregnancy lasts for approximately 266 days, from conception until the baby is born, or 280 days from the first day of the last menstrual period. During pregnancy menstruation is absent, there may be a great increase in appetite, and the breasts increase in size; the woman may also experience morning sickness. These and other changes brought about by a hormone (progesterone) produced at first day the ovary and later by the placenta. Definite evidence of pregnancy is provided by various pregnancy tests, by the detection of the heartbeat of the fetus, and by ultrasound.
<i>Specialisation of:</i>	Life event (Pregnancy event status)

Source and reference attributes

<i>Submitting organisation:</i>	Australia Institute of Health and Welfare
<i>Origin:</i>	University of Oxford 2002. Concise Colour Medical Dictionary 3rd ed. UK: Oxford University Press

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Pregnancy (current) – complication Health, Standard 01/03/2005
	Pregnancy (last previous) – pregnancy completion date Health, Standard 01/03/2005
	Pregnancy (last previous) – pregnancy outcome Health, Standard 01/03/2005
	Pregnancy – estimated duration Health, Standard 02/12/2009
	Pregnancy – first day of the last menstrual period Health, Standard 01/03/2005

Product of conception

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	324090
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	A conceptus, embryo, fetus or placenta.

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Product of conception – gestational age Health, Standard 02/12/2009
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Registered health professional

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>Synonymous names:</i>	Health professional
<i>METeOR identifier:</i>	372858
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	A person who is listed as a health professional during the reference period with the Australian Health Practitioner Regulatory Agency under the <i>Health Practitioner Regulation National Law Bill</i> .

Collection and usage attributes

<i>Guide for use:</i>	Registered health professionals include <ul style="list-style-type: none">• chiropractors• dental hygienists• dental prosthetists• dental therapists• dentists• medical practitioners• midwives• nurses - enrolled• nurses - registered• nurse practitioners• optometrists• osteopaths• pharmacists• physiotherapists• podiatrists• psychologists.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Health professional Health, Standard 01/03/2005
<i>Data Element Concepts implementing this Object Class:</i>	Registered health professional – country of employment in registered profession Health, Standard 10/12/2009
	Registered health professional – extended leave status in registered profession Health, Standard 10/12/2009
	Registered health professional – hours worked in clinical role Health, Standard 10/12/2009
	Registered health professional – hours worked in health profession Health, Standard 10/12/2009

Registered health professional – hours worked in non-clinical role Health, Standard 10/12/2009

Registered health professional – hours worked in private sector Health, Standard 10/12/2009

Registered health professional – hours worked in public sector Health, Standard 10/12/2009

Registered health professional – intended years in profession Health, Standard 10/12/2009

Registered health professional – jobseeker status in registered profession Health, Standard 10/12/2009

Registered health professional – labour force status Health, Standard 10/12/2009

Registered health professional – length of employment in profession in Australia Health, Standard 10/12/2009

Registered health professional – principal area of practice Health, Standard 10/12/2009

Registered health professional – principal field of medicine Health, Standard 10/12/2009

Registered health professional – principal role Health, Standard 10/12/2009

Registered health professional – retirement status in registered profession Health, Standard 10/12/2009

Registered health professional – visa type Health, Standard 10/12/2009

Registered health professional – work sector in registered health profession Health, Standard 10/12/2009

Registered health professional – work setting Health, Standard 10/12/2009

Residential stay

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268960
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The period of care beginning with a formal start of residential care and ending with a formal end of the residential care and accommodation. It may involve more than one reference period, that is, more than one episode of residential care.
<i>Context:</i>	Specialised mental health services (Residential mental health care).
<i>Specialisation of:</i>	Service/care (Residential stay status)

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Residential stay – episode start date Health, Standard 01/03/2005
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Service contact

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268983
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>A contact between a patient/client and an ambulatory care health unit (including outpatient and community health units) which results in a dated entry being made in the patient/client record.</p>
<i>Context:</i>	<p>Identifies service delivery at the patient level for mental health services (including consultation/liaison, mobile and outreach services).</p> <p>A service contact can include either face-to-face, telephone or video link service delivery modes. Service contacts would either be with a client, carer or family member or another professional or mental health worker involved in providing care and do not include contacts of an administrative nature (e.g. telephone contact to schedule an appointment) except where a matter would need to be noted on a patient's record.</p> <p>Service contacts may be differentiated from administrative and other types of contacts by the need to record data in the client record. However, there may be instances where notes are made in the client record that have not been prompted by a service contact with a patient/client (e.g. noting receipt of test results that require no further action). These instances would not be regarded as a service contact.</p>
<i>Specialisation of:</i>	Service/care event (Service contact status)

Collection and usage attributes

<i>Comments:</i>	The proposed definition is not able to measure case complexity or level of resource usage with each service contact alone. This limitation also applies to the concept of occasions of service (in admitted patient care) and hospital separations. The National Health Data Committee also acknowledges that information about group sessions or activities that do not result in a dated entry being made in each individual participant's patient/client record is not currently covered by this metadata item.
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Source and reference attributes

<i>Steward:</i>	Australian Bureau of Statistics (ABS)
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Relational attributes

<i>Related metadata references:</i>	Supersedes Service contact, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.6 KB)
<i>Data Element Concepts implementing this Object Class:</i>	Service contact – group session status Health, Standard 04/05/2005
	Service contact – service contact date Health, Standard 01/03/2005

Service delivery outlet

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268970
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A site from which an organisation, or sub-unit of an organisation, delivers a health/community service.
<i>Context:</i>	Alcohol and other drug treatment services: Required to identify the agency sites that conduct treatment episodes, as distinguished from administration centres. Identification of sites from which health care or community services are delivered facilitates assessment of the accessibility of services to the population.
<i>Specialisation of:</i>	Service provider organisation (Service delivery outlet status)

Collection and usage attributes

<i>Comments:</i>	<p>An organisation may have one or more service delivery outlets. An organisation with a devolved structure for service delivery may or may not devolve all functions to the service delivery outlet level. It is common for administrative functions, including personnel management, to be retained at a higher or central level of an organisation. The service delivery outlet is the lowest level of an organisation at which, or from which, services are delivered. The site from which a service is delivered relates to the physical location of the service and is to be clearly differentiated from the service delivery setting which refers to the type of physical setting in which a service is actually provided to a client (e.g. client's home, non-residential treatment facility etc).</p> <p>For example, where a service provider regularly delivers a service at a variety of clients' homes (e.g. home visits every Monday, Wednesday and Friday) or a mobile service delivers a service to a variety of different locations, then the service delivery outlet should be recorded as the location of the clinic in which the service provider is based. However, where a mobile unit regularly (e.g. every Monday) delivers a service from the same geographical location then this location will be recorded as the service delivery outlet.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Intergovernmental Committee on Drugs NMDS-WG
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Relational attributes

<i>Related metadata references:</i>	Supersedes Service delivery outlet, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)
<i>Data Element Concepts implementing this Object Class:</i>	Service delivery outlet – geographic location Health, Standard 01/03/2005

Service provider organisation

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	269022
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	An organisation that provides services and/or care.
<i>Specialisation of:</i>	Service/care provider (Organisation status)

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Service provider organisation (address) – address line Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – address type Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – Australian postcode Health, Standard 04/05/2005 Community services, Standard 31/08/2005 Service provider organisation (address) – building/complex sub-unit identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – building/complex sub-unit type Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – building/property name Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – electronic communication address Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – electronic communication medium Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – floor/level identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – floor/level type Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – house/property identifier Health, Standard 04/05/2005
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Community services, Standard 25/09/2005

Service provider organisation (address) – international postcode Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Service provider organisation (address) – lot/section identifier Health, Standard 04/05/2005

Community services, Standard 25/09/2005

Service provider organisation (address) – non-Australian state/province Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Service provider organisation (address) – postal delivery point identifier Health, Standard 04/05/2005

Community services, Standard 31/08/2005

Service provider organisation (address) – street name Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Service provider organisation (address) – street suffix Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Service provider organisation (address) – street type Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Service provider organisation (address) – suburb/town/locality name Health, Standard 04/05/2005

Community services, Standard 31/08/2005

Service provider organisation (name) – name type Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Service provider organisation (name) – organisation name Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Service provider organisation – Australian state/territory identifier Health, Standard 04/05/2005

Community services, Standard 07/12/2005

Service provider organisation – coordinator of volunteers indicator Health, Standard 05/12/2007

Service provider organisation – feedback collection indicator Health, Standard 05/12/2007

Service provider organisation – feedback collection method Health, Standard 05/12/2007

Service provider organisation – level of service delivery Health, Standard 05/12/2007

Service provider organisation – most common service delivery setting Health, Standard 05/12/2007

Service provider organisation – organisation end date Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Service provider organisation – organisation start date Health,

Standard 04/05/2005
Community services, Standard 30/09/2005
Service provider organisation – partner organisation type Health,
Standard 05/12/2007
Service provider organisation – service delivery setting Health,
Standard 05/12/2007
Community services, Standard 29/04/2006
Service provider organisation – standards assessment indicator
Health, Standard 05/12/2007
Service provider organisation – standards assessment level Health,
Standard 05/12/2007
Service provider organisation – standards assessment method Health,
Standard 05/12/2007
Service provider organisation – working partnership indicator Health,
Standard 05/12/2007

Specialised mental health service

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	268984
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Specialised mental health services are those with a primary function to provide treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability. These activities are delivered from a service or facility that is readily identifiable as both specialised and serving a mental health care function.
<i>Context:</i>	Hospitals and community mental health establishments and residential mental health establishments.
<i>Specialisation of:</i>	Health service provider (Specialised mental health service status)

Collection and usage attributes

<i>Guide for use:</i>	<p>The concept of a specialised mental health service is not dependent on the inclusion of the service within the state or territory mental health budget.</p> <p>A service is not defined as a specialised mental health service solely because its clients include people affected by a mental disorder or psychiatric disability.</p> <p>The definition excludes specialist drug and alcohol services and services for people with intellectual disabilities, except where they are established to assist people affected by a mental disorder who also have drug and alcohol related disorders or intellectual disability.</p> <p>These services can be a sub-unit of a hospital even where the hospital is not a specialised mental health establishment itself (e.g. designated psychiatric units and wards, outpatient clinics etc.).</p>
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Specialised mental health service – admitted patient care program type Health, Standard 08/12/2004
	Specialised mental health service – co-location with acute care hospital Health, Standard 08/12/2004
	Specialised mental health service – number of hours staffed Health, Standard 08/12/2004
	Specialised mental health service – number of supported public housing places Health, Standard 08/12/2004
	Specialised mental health service – number of supported public housing places Health, Standard 02/12/2009
	Specialised mental health service – residual expenditure (academic positions) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (education and training) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (insurance) Health, Standard 08/12/2004

Specialised mental health service – residual expenditure (Mental Health Act Regulation or related legislation) Health, Standard 02/12/2009

Specialised mental health service – residual expenditure (mental health promotion) Health, Standard 08/12/2004

Specialised mental health service – residual expenditure (mental health research) Health, Standard 08/12/2004

Specialised mental health service – residual expenditure (other indirect expenditure) Health, Standard 08/12/2004

Specialised mental health service – residual expenditure (patient transport services) Health, Standard 08/12/2004

Specialised mental health service – residual expenditure (program administration) Health, Standard 08/12/2004

Specialised mental health service – residual expenditure (property leasing costs) Health, Standard 08/12/2004

Specialised mental health service – residual expenditure (service development) Health, Standard 02/12/2009

Specialised mental health service – residual expenditure (superannuation) Health, Standard 08/12/2004

Specialised mental health service – residual expenditure (support services) Health, Standard 08/12/2004

Specialised mental health service – residual expenditure (workers compensation) Health, Standard 08/12/2004

Specialised mental health service – service setting Health, Standard 01/03/2005

Specialised mental health service – specialised mental health service target population group Health, Standard 08/12/2004

Specialised mental health service organisation

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	286449
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	A separately constituted specialised mental health service that is responsible for the clinical governance, administration and financial management of service units providing specialised mental health care.
<i>Context:</i>	Specialised mental health services.

Collection and usage attributes

Guide for use: A specialised mental health service organisation may consist of one or more service units based in different locations and providing services in admitted patient, residential and ambulatory settings. For example, a specialised mental health service organisation may consist of several hospitals or two or more community centres.

Where the specialised mental health service organisation consists of multiple service units, those units can be considered to be components of the same organisation where they:

- operate under a common clinical governance arrangement;
- aim to work together as interlocking services that provide integrated, coordinated care to consumers across all mental health service settings; and
- share clinical records or, in the case where is more than one physical clinical record for each patient, staff may access (if required) the information contained in all of the physical records held by the organisation for that patient.

For most states and territories, the Specialised mental health service organisation object class is equivalent to the Area/District Mental Health Service. These are usually organised to provide the full range of admitted patient, residential and ambulatory services to a given catchment population. However, the object class may also be used to refer to health care organisations which provide only one type of mental health service (e.g. acute admitted patient care) or which serve a specialised or state-wide function.

Source and reference attributes

Origin: Department of Health and Ageing 2003. Mental Health National Outcomes and Casemix Collection. Technical specification of State and Territory reporting requirements for the outcomes and casemix components of 'Agreed Data', Version 1.50. Canberra: Department of Health and Ageing

Relational attributes

Data Element Concepts implementing this Object Class: Specialised mental health service organisation – accommodation services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation – advocacy services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation – carer participation arrangements status (carer consultants employed) Health, Standard 08/12/2004

Specialised mental health service organisation – carer participation arrangements status (carer satisfaction surveys) Health, Standard 08/12/2004

Specialised mental health service organisation – carer participation arrangements status (formal complaints mechanism) Health, Standard 08/12/2004

Specialised mental health service organisation – carer participation arrangements status (formal participation policy) Health, Standard 08/12/2004

Specialised mental health service organisation – carer participation arrangements status (regular discussion groups) Health, Standard 08/12/2004

Specialised mental health service organisation – community awareness/health promotion services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation – consumer committee representation arrangements Health, Standard 08/12/2004

Specialised mental health service organisation – consumer participation arrangements (consumer consultants employed) Health, Standard 08/12/2004

Specialised mental health service organisation – consumer participation arrangements (consumer satisfaction surveys) Health, Standard 08/12/2004

Specialised mental health service organisation – consumer participation arrangements (formal internal complaints mechanism) Health, Standard 08/12/2004

Specialised mental health service organisation – consumer participation arrangements (formal participation policy) Health, Standard 08/12/2004

Specialised mental health service organisation – consumer participation arrangements (regular discussion groups) Health, Standard 08/12/2004

Specialised mental health service organisation – counselling services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation – independent living skills support services grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation – other and unspecified mental health services grants to non-government organisations Health, Standard 07/12/2005

Specialised mental health service organisation – other and unspecified services grants to non-government organisations Health, Superseded 07/12/2005

Specialised mental health service organisation – pre-vocational

training services grants for non-government organisations Health,
Standard 08/12/2004

Specialised mental health service organisation – psychosocial support
services grants for non-government organisations Health, Standard
08/12/2004

Specialised mental health service organisation – recreation services
grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation – recurrent expenditure
(residual mental health) Health, Standard 08/12/2004

Specialised mental health service organisation – respite services
grants to non-government organisations Health, Standard 08/12/2004

Specialised mental health service organisation – self-help support
groups services grants for non-government organisations Health,
Standard 08/12/2004

Specialised mental health service unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	287787
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	A specialised mental health service unit.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Specialised mental health service unit – implementation of National standards for mental health services status Health, Standard 08/12/2004
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State or Territory Government

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	301333
<i>Registration status:</i>	Health, Standard 07/12/2005 Community services, Standard 30/11/2007
<i>Definition:</i>	A separately constituted legal entity established by political processes which have legislative, judicial or executive authority over a specific state or territory and is responsible for the governance, administration and financial management of that state or territory.

Source and reference attributes

<i>Reference documents:</i>	Australian Bureau of Statistics 2002. Standard Economic Sector Classifications of Australia (SESCA). ABS Cat No. 1218.0. Canberra: ABS.
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	State or Territory Government – mental health services grants to non-government organisations by non-health departments Health, Standard 07/12/2005
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Ventricular ejection fraction test

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	358951
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Test used to measure the amount of blood pumped out of a ventricle per heart beat.
<i>Specialisation of:</i>	Service event (Ventricular ejection fraction test status)

Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Ventricular ejection fraction test – test date Health, Standard 01/10/2008
	Ventricular ejection fraction test – test type Health, Standard 01/10/2008
	Ventricular ejection fraction – test result Health, Standard 01/10/2008
	Ventricular ejection fraction – test time Health, Standard 01/10/2008

Workplace

Identifying and definitional attributes

<i>Metadata item type:</i>	Object Class
<i>METeOR identifier:</i>	386191
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The place in which paid work is undertaken.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Object Class:</i>	Workplace (address) – Australian postcode Health, Standard 10/12/2009
	Workplace (address) – suburb/town/locality name Health, Standard 10/12/2009

Properties

Accommodation services grants to non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	286596
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of accommodation services.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – accommodation services grants to non-government organisations Health, Standard 08/12/2004
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Accommodation type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269143
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the class of accommodation.
<i>Property group:</i>	Accommodation/living characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – accommodation type Health, Standard 01/03/2005
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Accrued mental health care days

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	286766
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Mental health care days are days of admitted patient care provided to admitted patients in psychiatric hospitals, designated psychiatric units and days of residential care provided to residents in residential mental health services. Accrued mental health care days can also be referred to as occupied bed days in specialised mental health services.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – accrued mental health care days Health, Standard 08/12/2004
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Accuracy indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	294414
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The level of detail to which recorded information is correct.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Date—accuracy indicator Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Activity and participation life area

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	324432
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	Life areas in which individuals may participate or undertake activities.
<i>Property group:</i>	Physical characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – activity and participation life area Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Activity type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269042
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the class of activity.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Injury event—activity type Health, Standard 01/03/2005
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Acute coronary syndrome procedure type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284640
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The type of procedure performed for the treatment of acute coronary syndrome.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – acute coronary syndrome procedure type Health, Standard 04/06/2004
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Acute coronary syndrome related clinical event date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	349641
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date a clinical event was experienced that can affect the health outcome from acute coronary syndromes.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with acute coronary syndrome – acute coronary syndrome related clinical event date Health, Standard 01/10/2008
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Acute coronary syndrome related clinical event time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	349803
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time a clinical event was experienced that can affect the health outcomes from acute coronary syndrome.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with acute coronary syndrome – acute coronary syndrome related clinical event time Health, Standard 01/10/2008
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Acute coronary syndrome related medical history

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359152
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A history of medical conditions which are pertinent to the risk stratification and treatment of acute coronary syndrome.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Related metadata references:</i>	Supersedes Acute coronary syndrome concurrent clinical condition Health, Superseded 01/10/2008
<i>Data Element Concepts implementing this Property:</i>	Person – acute coronary syndrome related medical history Health, Standard 01/10/2008

Acute coronary syndrome risk stratum

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284646
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Risk stratum of clinical features consistent with an acute coronary syndrome.
<i>Property group:</i>	Service/care urgency

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—acute coronary syndrome risk stratum Health, Superseded 01/10/2008
	Person—acute coronary syndrome risk stratum Health, Standard 01/10/2008

Acute coronary syndrome symptoms onset date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	321193
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date on which symptoms for acute coronary syndrome first occurred and prompted medical attention, either at the hospital or from a general practitioner.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – acute coronary syndrome symptoms onset date Health, Standard 01/10/2008
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Acute coronary syndrome symptoms onset time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	321203
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when symptoms for acute coronary syndrome first occurred and prompted medical attention, either at the hospital or from a general practitioner.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – acute coronary syndrome symptoms onset time Health, Standard 01/10/2008
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Additional diagnosis

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269371
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A condition or complaint either coexisting with the principal diagnosis or arising during a service event or episode.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care – additional diagnosis Health, Superseded 05/02/2008
	Episode of care – additional diagnosis Health, Standard 05/02/2008

Address line

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	292741
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A composite of one or more standard address components that describes a low level of geographical/physical description of a location.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Health address line Health, Superseded 04/05/2005
<i>Data Element Concepts implementing this Property:</i>	Person (address) – address line Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – address line Health, Standard 04/05/2005 Community services, Standard 30/09/2005

Address type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269037
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A descriptor of the class of a geographical/physical location.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – address type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – address type Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Admission date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269247
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which an episode of admitted patient care commences.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – admission date Health, Standard 01/03/2005
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Admission mode

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269028
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The method by which an episode of admitted patient care commences.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – admission mode Health, Standard 01/03/2005
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Admission time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269046
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time at which an episode of admitted patient care commences
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – admission time Health, Standard 01/03/2005
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Admission urgency status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269032
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the urgency status assigned to an admission .
<i>Property group:</i>	Service/care urgency

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – admission urgency status Health, Standard 01/03/2005
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Admitted patient care program type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288881
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The type of admitted patient care program.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service – admitted patient care program type Health, Standard 08/12/2004
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Advocacy services grants to non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	286876
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of advocacy services.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – advocacy services grants to non-government organisations Health, Standard 08/12/2004
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Age

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269152
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 04/05/2005 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	The length of life or existence.
<i>Property group:</i>	Physical characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—age Health, Standard 04/05/2005 Community services, Standard 04/05/2005 Housing assistance, Standard 17/06/2005
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Age range

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	290491
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/11/2007
<i>Definition:</i>	A chronological grouping of age.
<i>Property group:</i>	Physical characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – age range Health, Standard 04/05/2005 Community services, Standard 30/11/2007
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Alcohol consumption amount

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Alcohol consumption - concept; Ethanol consumption
<i>METeOR identifier:</i>	269217
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the amount of alcohol consumed.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular Data Working Group
<i>Origin:</i>	Australian Alcohol Guidelines: Health Risks and Benefits, NH&MRC, October 2001

Relational attributes

<i>Related metadata references:</i>	Supersedes Alcohol consumption - concept, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.7 KB)
<i>Data Element Concepts implementing this Property:</i>	Person – alcohol consumption amount Health, Standard 01/03/2005

Alcohol consumption frequency

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269363
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of how frequently alcohol is consumed.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – alcohol consumption frequency Health, Standard 01/03/2005
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Anaesthesia administered

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269079
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Drug or other medical intervention administered to cause inability to feel pain.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event – anaesthesia administered Health, Superseded 07/12/2005
	Birth event – anaesthesia administered Health, Standard 07/12/2005

Analgesia administered

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269080
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An agent given to alleviate pain without causing loss of consciousness.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event – analgesia administered Health, Superseded 07/12/2005
	Birth event – analgesia administered Health, Standard 07/12/2005

Angina episodes count

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	338283
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A count of episodes of pain in the centre of chest which may have spread to either of both shoulders, the back, neck or jaws or down the arm.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – count of angina episodes Health, Standard 01/10/2008
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Angina status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	338327
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The categorisation of the type of pain caused by reduced blood oxygen supply to an area of heart muscle.
<i>Property group:</i>	Crisis event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person— angina status Health, Standard 01/10/2008
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Angiotensin converting enzyme inhibitors therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	ACE inhibitors therapy status
<i>METeOR identifier:</i>	284728
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	An indicator of the use of angiotensin converting enzyme (ACE) inhibitors therapy.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – angiotensin converting enzyme inhibitors therapy status Health, Standard 04/06/2004
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Anticipated accommodation status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	319942
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of whether a person has nominated to be treated as either a public or private patient. The anticipated accommodation status is not binding on the patient and may vary from the elected accommodation status.
<i>Property group:</i>	Funding characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective surgery waiting list episode – anticipated accommodation status Health, Standard 01/03/2005
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Apgar score

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269035
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The score used to evaluate the fitness of a newborn infant, based on heart rate, respiration, muscle tone, cough reflex, and colour.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth – Apgar score Health, Superseded 07/12/2005
	Birth – Apgar score Health, Standard 07/12/2005

Area of practice

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	377929
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The area of practice in which the most hours were spent in the week prior to registration.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – principal area of practice Health, Standard 10/12/2009
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Area of usual residence

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269104
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 21/05/2010
<i>Definition:</i>	The geographical region in which a person or group of people usually reside.
<i>Property group:</i>	Location characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – area of usual residence Health, Standard 01/03/2005 Community services, Standard 21/05/2010
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Aspirin therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284754
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	An indicator of the use of aspirin therapy.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – aspirin therapy status Health, Standard 04/06/2004
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Assessment of cardiac perfusion method

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344426
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The method of functional assessment of cardiac perfusion undertaken in a stress test.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Functional stress test – assessment of cardiac perfusion Health, Standard 01/10/2008
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Australian postcode

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269316
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place.
<i>Context:</i>	Postcode is an important part of a postal address and facilitates written communication. It is one of a number of geographic identifiers that can be used to determine a geographic location.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – Australian postcode Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006 Service provider organisation (address) – Australian postcode Health, Standard 04/05/2005 Community services, Standard 31/08/2005 Workplace (address) – Australian postcode Health, Standard 10/12/2009
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Australian state/territory identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269056
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	An identifier of the Australian state or territory.
<i>Context:</i>	This is a geographic indicator which is used for analysis of the distribution of clients or patients, agencies or establishments and services.
<i>Property group:</i>	Location characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – Australian state/territory identifier Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Jurisdiction – Australian state/territory identifier Health, Standard 05/12/2007 Person – Australian state/territory identifier Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006 Service provider organisation – Australian state/territory identifier Health, Standard 04/05/2005 Community services, Standard 07/12/2005
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Baby resuscitation method

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269026
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The action taken for a baby to revive from apparent death or unconsciousness.
<i>Property group:</i>	Birth event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event – baby resuscitation method Health, Standard 01/03/2005
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Behaviour-related risk factor intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269285
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The action taken to address a behaviour-related risk factor.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care – behaviour-related risk factor intervention Health, Standard 01/03/2005
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Behaviour-related risk factor intervention purpose

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269286
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A lifestyle choice related risk factor associated with an intervention.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care – behaviour-related risk factor intervention purpose Health, Standard 01/03/2005
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Beta-blocker therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284791
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	An indicator of the use of beta-blocker therapy.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – beta-blocker therapy status Health, Standard 04/06/2004
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Birth method

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	337674
<i>Registration status:</i>	Health, Standard 06/09/2006
<i>Definition:</i>	The method of complete expulsion or extraction from its mother of a product of conception.
<i>Property group:</i>	Birth event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Delivery method Health, Superseded 06/09/2006
<i>Data Element Concepts implementing this Property:</i>	Birth event – birth method Health, Standard 06/09/2006

Birth order

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269038
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The sequence number in the multiple birth.
<i>Context:</i>	National Minimum Data Set (NMDS) Perinatal: Required to analyse pregnancy outcome according to birth order and identify the individual baby resulting from a multiple birth pregnancy. Multiple births have higher risks of perinatal mortality and morbidity. Multiple birth pregnancies are often associated with obstetric complications, labour and delivery complications, higher rates of neonatal morbidity, low birthweight , and a higher perinatal death rate. Data Set Specification (DSS) - Health care client identification: While this piece of information is normally recorded for multiple births against the mother's record, if the health care client volunteers the information, it should be recorded.
<i>Property group:</i>	Birth event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	AS5017 Health Care Client Identification

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth—birth order Health, Standard 01/03/2005
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Birth plurality

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269039
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of multiple birth, showing the total number of births resulting from a single pregnancy.
<i>Context:</i>	National Minimum Data Set (NMDS) Perinatal: Multiple pregnancy increases the risk of complications during pregnancy, labour and delivery and is associated with higher risk of perinatal morbidity and mortality. Data Set Specification (DSS) Health Care Client Identification: While this piece of information is normally recorded for multiple births against the mother's record, if the health care client volunteers the information, it should be recorded.
<i>Property group:</i>	Birth event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event – birth plurality Health, Standard 01/03/2005
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Birth presentation

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269062
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Presenting part of the fetus (at lower segment of uterus).
<i>Property group:</i>	Birth event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event – birth presentation Health, Standard 06/09/2006
	Birth event – birth presentation Health, Superseded 06/09/2006

Birth status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269064
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Status of the baby at birth as an outcome of pregnancy.
<i>Property group:</i>	Birth event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth – birth status Health, Standard 01/03/2005
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Birth weight

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269347
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The weight of a newborn as recorded at birth.
<i>Property group:</i>	Physical characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth – birth weight Health, Standard 01/03/2005
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Bleeding episode status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	360954
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An episode of bleeding.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Related metadata references:</i>	Supersedes Bleeding episode status Health, Superseded 01/10/2008
<i>Data Element Concepts implementing this Property:</i>	Person – bleeding episode status Health, Standard 01/10/2008

Bleeding location

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344781
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The source of bleeding or escape of blood from a vessel.
<i>Property group:</i>	Crisis event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with acute coronary syndrome – bleeding location Health, Standard 01/10/2008
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Blindness

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269103
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Blindness is less than 6/60 vision in the better eye with glasses. Vision 6/60 is the ability to see only at 6 metres what the normal eye can see at 60 metres. An indicator of the presence or development of a visual impairment or inability to see.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – blindness Health, Standard 01/03/2005
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Blood pressure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269105
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The pressure exerted by blood against the inner walls of the blood vessels
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—blood pressure (diastolic) Health, Standard 01/03/2005
	Person—blood pressure (systolic) Health, Standard 01/03/2005

Bodily location of main injury

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Site
<i>METeOR identifier:</i>	269098
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The position on the body of the primary injury of concern.
<i>Property group:</i>	Crisis event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – bodily location of main injury Health, Standard 01/03/2005
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Body function

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	320237
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The physiological or psychological function of body system.
<i>Property group:</i>	Physical characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—body function Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Body mass index

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269114
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A measure of body fat that gives an indication of nutritional status. Body mass index is the weight in kilograms divided by the square of the height in meters.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Origin:</i>	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Adult – body mass index Health, Standard 01/03/2005
	Child – body mass index Health, Standard 01/03/2005
	Person – body mass index (classification) Health, Standard 01/03/2005

Body structure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	320249
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	An anatomical part of the body such as organs, limbs or their components.
<i>Property group:</i>	Physical characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – body structure Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Building/complex sub-unit identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269388
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The specification of the number or identifier of a building/complex, marina, etc. to clearly distinguish it from another.
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – building/complex sub-unit identifier Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – building/complex sub-unit identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Building/complex sub-unit type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269380
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The specification of the type of a separately identifiable portion within a building/complex, marina, etc. to clearly distinguish it from another.
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
<i>Origin:</i>	Australia Post Address Presentation Standard.

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – building/complex sub-unit type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – building/complex sub-unit type Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Building/property name

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269387
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The full name used to identify the physical building or property as part of its location.
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – building/property name Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – building/property name Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Bundle-branch block status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	343860
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The status of an abnormal conduction through one of the conductive branches which normally supply the right and left ventricles of the heart.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Electrocardiogram – bundle-branch block status Health, Standard 01/10/2008
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C-reactive protein level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	CRP
<i>METeOR identifier:</i>	338236
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The measured level of the inflammatory marker C-reactive protein.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—C-reactive protein level (measured) Health, Standard 01/10/2008
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C-reactive protein level measured date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	338273
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date the level of the inflammatory marker C-reactive protein (CRP) is measured.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—C-reactive protein level measured date Health, Standard 01/10/2008
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C-reactive protein level measured time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	343849
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time the level of the inflammatory marker C-reactive protein measured.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—C-reactive protein level measured time Health, Standard 01/10/2008
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Caesarean section indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	302129
<i>Registration status:</i>	Health, Standard 29/11/2006
<i>Definition:</i>	Pregnancy resulting in a live birth or a stillbirth.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Female – caesarean section indicator Health, Standard 29/11/2006
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Cancer staging scheme source

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	296984
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The reference which describes in detail the methods of staging and the definitions for the classification system used in determining the extent of cancer.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Reference documents:</i>	UICC TNM Classification of Malignant Tumours (5th Edition) (1997)

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer staging—cancer staging scheme source Health, Standard 04/06/2004
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Cancer staging scheme source edition number

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	297000
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The edition number of the reference used for the purposes of staging a cancer.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer staging – cancer staging scheme source edition number Health, Standard 04/06/2004
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Cancer treatment type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288143
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The type of cancer treatment provided.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – cancer treatment type Health, Standard 04/06/2004
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Capital consumption expenses

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	376395
<i>Registration status:</i>	Health, Standard 01/04/2009
<i>Definition:</i>	Expenses of an organisation consisting of consumption of fixed capital (depreciation).
<i>Property group:</i>	Financial characteristics

Relational attributes

<i>Related metadata references:</i>	Supersedes Depreciation expenses Health, Superseded 01/04/2009
<i>Data Element Concepts implementing this Property:</i>	Organisation – capital consumption expenses Health, Standard 01/04/2009

Cardiac catheterisation date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359783
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when a catheter is inserted into a chamber or vessel of the heart for diagnostic purposes.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person— diagnostic cardiac catheterisation date Health, Standard 01/10/2008
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Cardiac catheterisation time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359770
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when a catheter is inserted into a chamber or vessel of the heart for diagnostic purposes.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person— diagnostic cardiac catheterisation time Health, Standard 01/10/2008
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Cardiovascular disease condition targeted by drug therapy

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269329
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the cardiovascular disease condition for which a drug therapy is being used.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – cardiovascular disease condition targeted by drug therapy Health, Standard 01/03/2005
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Cardiovascular medication taken

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269391
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Medication taken for a cardiovascular condition.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – cardiovascular medication taken Health, Standard 01/03/2005
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Care type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269177
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the overall nature of a service provided.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Hospital service – care type Health, Standard 01/03/2005
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Carer participation arrangements

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288821
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Mechanisms in place to promote the participation of mental health carers in the planning, delivery and evaluation of a service.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – carer participation arrangements status (carer consultants employed) Health, Standard 08/12/2004
	Specialised mental health service organisation – carer participation arrangements status (carer satisfaction surveys) Health, Standard 08/12/2004
	Specialised mental health service organisation – carer participation arrangements status (formal complaints mechanism) Health, Standard 08/12/2004
	Specialised mental health service organisation – carer participation arrangements status (formal participation policy) Health, Standard 08/12/2004
	Specialised mental health service organisation – carer participation arrangements status (regular discussion groups) Health, Standard 08/12/2004

Cataract status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269230
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of previous experience with cataracts.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – cataract status Health, Standard 01/03/2005
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Category reassignment date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269115
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a clinical urgency category or patient listing status category is reassigned.
<i>Property group:</i>	Service/care urgency

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective care waiting list episode – category reassignment date Health, Standard 01/03/2005
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Census date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269364
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a population is officially enumerated and characterised.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Hospital census (of elective surgery waitlist patients) – census date Health, Standard 01/03/2005
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Cerebral stroke due to vascular disease

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269298
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of previous experience of a cerebral stroke due to vascular disease and the recency of the stroke.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – cerebral stroke due to vascular disease Health, Standard 01/03/2005
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Cessation reason

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269077
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The reason for ending an event or process.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of treatment for alcohol and other drugs – cessation reason Health, Standard 01/03/2005
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Chest pain pattern

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284815
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Identification of the frequency and severity of chest pain of myocardial ischaemic origin.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – chest pain pattern Health, Standard 04/06/2004
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Cholesterol level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269323
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The amount of cholesterol in the blood, usually indicated by a number within a range going from low to high, these numbers being correlated with the risk of coronary heart disease.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd.

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—cholesterol level Health, Standard 01/03/2005
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Client type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269128
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether treatment is focused on the client's conditions and problems or on those of another person.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of treatment for alcohol and other drugs – client type Health, Standard 01/03/2005
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Clinical evidence status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285279
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Indicator of the status of evidence of a pre-existing clinical condition.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Acute Coronary Syndrome Data Working Group
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – clinical evidence status (acute coronary syndrome related medical history) Health, Standard 01/10/2008
	Person – clinical evidence status (chronic lung disease) Health, Superseded 01/10/2008
	Person – clinical evidence status (heart failure) Health, Superseded 01/10/2008
	Person – clinical evidence status (peripheral arterial disease) Health, Superseded 01/10/2008
	Person – clinical evidence status (sleep apnoea syndrome) Health, Superseded 01/10/2008
	Person – clinical evidence status (stroke) Health, Superseded 01/10/2008

Clinical procedure timing

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284841
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Identifies when a clinical procedure was performed.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – clinical procedure timing Health, Standard 04/06/2004
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Clinical urgency

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269075
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A clinical assessment of the urgency with which care, treatment or assistance is required.
<i>Property group:</i>	Service/care urgency

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective surgery waiting list episode – clinical urgency Health, Standard 01/03/2005
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Clopidogrel therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284865
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	An indicator of the use of clopidogrel therapy.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – clopidogrel therapy status Health, Standard 04/06/2004
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Co-location with acute care hospital

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	286929
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The co-location of a service with an acute care hospital.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service – co-location with acute care hospital Health, Standard 08/12/2004
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Community awareness/health promotion services grants to non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287005
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of community awareness/health promotion services.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – community awareness/health promotion services grants to non-government organisations Health, Standard 08/12/2004
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Compensable status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269123
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of an entitlement for compensation.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Patient—compensable status Health, Standard 01/03/2005
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Complication

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269096
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A disease or disorder concurrent with another disease, disorder or condition.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event – complication Health, Standard 01/03/2005
	Birth event – complication (postpartum) Health, Standard 01/03/2005
	Pregnancy (current) – complication Health, Standard 01/03/2005

Condition onset flag

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	354805
<i>Registration status:</i>	Health, Standard 05/02/2008
<i>Definition:</i>	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the episode of care.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Diagnosis onset type Health, Superseded 05/02/2008
<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – condition onset flag Health, Standard 05/02/2008

Congenital malformation

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269324
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An anomaly that is present at birth.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – congenital malformation Health, Standard 01/03/2005
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Consumer committee representation arrangements

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288847
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	An indicator of the extent of formal committee mechanisms in place to promote the participation of mental health consumers.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare.
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – consumer committee representation arrangements Health, Standard 08/12/2004
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Consumer participation arrangements

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288859
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	An indicator of whether mechanisms are in place to promote the participation of mental health consumers.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – consumer participation arrangements (consumer consultants employed) Health, Standard 08/12/2004
	Specialised mental health service organisation – consumer participation arrangements (consumer satisfaction surveys) Health, Standard 08/12/2004
	Specialised mental health service organisation – consumer participation arrangements (formal internal complaints mechanism) Health, Standard 08/12/2004
	Specialised mental health service organisation – consumer participation arrangements (formal participation policy) Health, Standard 08/12/2004
	Specialised mental health service organisation – consumer participation arrangements (regular discussion groups) Health, Standard 08/12/2004

Contract role

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269131
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The assigned responsibility under a contractual arrangement.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Hospital – contract role Health, Standard 01/03/2005
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Contract type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269174
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the class of a contractual agreement.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Hospital – contract type Health, Standard 01/03/2005
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Contracted care commencement date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269263
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date the period of contracted care commenced.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Contracted hospital care—contracted care commencement date Health, Standard 01/03/2005
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Contracted care completed date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269102
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date the period of contracted care is completed.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Contracted hospital care – contracted care completed date Health, Standard 01/03/2005
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Contracted procedure flag

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269345
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Indicator that a procedure was performed as a contracted service.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care (procedure) – contracted procedure flag Health, Standard 01/03/2005
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Coordinator of volunteers indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	352858
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	An indicator of whether a person is designated to coordinate the volunteer labour force.
<i>Property group:</i>	Organisational characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – coordinator of volunteers indicator Health, Standard 05/12/2007
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Coronary artery bypass graft date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344420
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when a coronary artery bypass graft (CABG) is performed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—coronary artery bypass graft date Health, Standard 01/10/2008
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Coronary artery bypass graft location

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	347157
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The artery where a coronary artery bypass graft has been performed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – coronary artery bypass graft location Health, Standard 01/10/2008
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Coronary artery disease intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269207
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of whether treatment has been received for a coronary artery condition.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – coronary artery disease intervention Health, Standard 01/03/2005
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Coronary artery stenosis location

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	361082
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The coronary artery in which abnormal narrowing is located.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—coronary artery stenosis location Health, Standard 01/10/2008
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Counselling services grants to non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287013
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of counselling services.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – counselling services grants to non-government organisations Health, Standard 08/12/2004
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Count of coronary artery lesions attempted

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344400
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A count of coronary artery lesions into which an attempt was made to pass a guidewire.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person— count of coronary artery lesions attempted Health, Standard 01/10/2008
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Count of coronary artery lesions successfully dilated

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344407
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A count of successful dilatation of lesions (blockages) to restore adequate blood flow through the coronary artery.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person— count of coronary artery lesions successfully dilated Health, Standard 01/10/2008
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Count of coronary artery stents

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344413
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	A count of tubes made of metal or plastic inserted during an angioplasty procedure into a coronary artery to keep the lumen open and prevent closure.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – count of coronary artery stents Health, Standard 01/10/2008
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Country identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288063
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The country component of an address.
<i>Property group:</i>	Identifier characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – country identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Country of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269206
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	The country in which an individual was born.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – country of birth Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 27/07/2005
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Country of employment in registered profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Country of employment
<i>METeOR identifier:</i>	383396
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The country in which a person is working in the registered profession.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – country of employment in registered profession Health, Standard 10/12/2009
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Creatine kinase isoenzyme level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	319418
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The level of creatine kinase enzymes found in the blood which (if elevated) indicate damage to either the muscle or brain.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – creatine kinase isoenzyme level Health, Standard 01/10/2008
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Creatine kinase myocardial band isoenzyme measured date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284969
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The date creatine kinase myocardial band (CK-MB) isoenzyme was measured.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – creatine kinase myocardial band isoenzyme measured date Health, Standard 04/06/2004
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Creatine kinase myocardial band isoenzyme measured time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285175
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The time at which the creatine kinase myocardial band (CK-MB) isoenzyme was measured.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – creatine kinase myocardial band isoenzyme measured time Health, Standard 04/06/2004
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Creatine kinase-myocardial band isoenzyme level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284893
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The level of creatine kinase-myocardial band (CK-MB) isoenzyme.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – creatine kinase-myocardial band isoenzyme level Health, Standard 04/06/2004
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Creatinine serum level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269319
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The amount of creatinine in the blood.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – creatinine serum level Health, Standard 01/03/2005
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Creatinine serum level measured date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	343839
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when the level of creatinine serum was measured.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—creatinine serum level measured date Health, Standard 01/10/2008
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Date of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269318
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	The date on which an individual was born.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – date of birth Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 27/07/2005
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Date of change to qualification status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269082
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a newborn qualification status changes.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care (newborn) – date of change to qualification status Health, Standard 01/03/2005
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Date of death

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287292
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	Date on which an individual died.
<i>Context:</i>	
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – date of death Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Degree of spread of a cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269182
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The progression/extent of a cancer measured at a particular point in time.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer — degree of spread of a cancer Health, Standard 01/03/2005
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Dependency in activities of daily living

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269342
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Recorded 16/11/2009
<i>Definition:</i>	An indicator of the extent to which help is required for tasks of everyday life.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – dependency in activities of daily living Health, Standard 01/03/2005 Community services, Recorded 16/11/2009
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Diabetes mellitus status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269209
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a risk of developing diabetes mellitus or a diagnosis of diabetes mellitus.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person — diabetes mellitus status Health, Standard 01/03/2005
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Diabetes therapy type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269378
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The class of treatment received for diabetes.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – diabetes therapy type Health, Standard 01/03/2005
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Diagnosis date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269392
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date a disease or condition is diagnosed.
<i>Context:</i>	Health services and clinical setting: Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities and conditions.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Patient – diagnosis date Health, Standard 01/03/2005
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Diagnosis related group

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269188
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A resource utilisation classification based on diagnosed conditions, usage of hospital resources, and demographic characteristics of the patient.
<i>Context:</i>	The development of Australian refined diagnosis related groups has created a descriptive framework for studying hospitalisation. Diagnosis related groups provide a summary of the varied reasons for hospitalisation and the complexity of cases a hospital treats. Moreover, as a framework for describing the products of a hospital (that is, patients receiving services), they allow meaningful comparisons of hospitals' efficiency and effectiveness under alternative systems of health care provision.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – diagnosis related group Health, Standard 01/03/2005
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Distant metastasis status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	293228
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The absence or presence of distant metastasis.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Sobin LH (Editors) (1997) International Union Against Cancer (UICC) TNM classification of malignant tumours, 5th edition. Wiley-Liss, New York

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – distant metastasis status Health, Standard 13/06/2004
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Drug of concern

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269127
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the psychoactive substance that is of concern.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of treatment for alcohol and other drugs – drug of concern Health, Standard 01/03/2005
	Episode of treatment for alcohol and other drugs – drug of concern (principal) Health, Superseded 13/10/2005

Dyslipidaemia treatment with anti-lipid medication indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	304483
<i>Registration status:</i>	Health, Standard 22/09/2005
<i>Definition:</i>	An indicator of the receipt of treatment for abnormal lipid levels using anti-lipid medication.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Dyslipidaemia treatment status Health, Superseded 22/09/2005
<i>Data Element Concepts implementing this Property:</i>	Person – dyslipidaemia treatment with anti-lipid medication indicator Health, Standard 21/09/2005

Elective care type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Waiting list category
<i>METeOR identifier:</i>	269040
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the class of elective hospital care.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective care waiting list episode—elective care type Health, Standard 01/03/2005
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Electrocardiogram change location

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	356839
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The area in which the change is located on an electrocardiogram (ECG).
<i>Property group:</i>	Service provision event

Relational attributes

<i>Related metadata references:</i>	Supersedes Electrocardiogram change location Health, Superseded 01/10/2008
<i>Data Element Concepts implementing this Property:</i>	Electrocardiogram – change location Health, Standard 01/10/2008

Electrocardiogram change type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285301
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The type of change to the heart rhythm as seen on an electrocardiogram (ECG).
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Electrocardiogram – change type Health, Standard 01/10/2008
	Person – electrocardiogram change type Health, Superseded 01/10/2008

Electrocardiogram date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	343816
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Date when an electrocardiogram (ECG) is recorded to measure the electrical activity of the heart.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Electrocardiogram – electrocardiogram date Health, Standard 01/10/2008
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Electrocardiogram lead V4R indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	349651
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An indicator of whether lead V4R is present on the electrocardiogram (ECG).
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Electrocardiogram—lead V4R presence indicator Health, Standard 01/10/2008
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Electrocardiogram Q waves

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	343892
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The initial downward deflection of the QRS complex in an electrocardiogram.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Electrocardiogram—new Q waves indicator Health, Standard 01/10/2008
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Electrocardiogram Q waves indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	347706
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An indicator of whether Q waves that are greater than or equal to 0.03 seconds in width and greater than or equal to 1mm (0.1mV) in depth are present in at least 2 contiguous leads of the electrocardiogram (ECG).
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – electrocardiogram Q waves indicator Health, Standard 01/10/2008
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Electrocardiogram ST-segment-elevation in lead V4R indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	343883
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Presence of ST-segment-elevation of greater than or equal to 1mm (0.1mV) in lead V4R
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Electrocardiogram – electrocardiogram ST-segment-elevation in lead V4R indicator Health, Standard 01/10/2008
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Electrocardiogram time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	343825
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Time when an electrocardiogram (ECG) is recorded, to measure the electrical activity of the heart.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Electrocardiogram – electrocardiogram time Health, Standard 01/10/2008
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Electronic communication address

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287451
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The characters used for the purpose of communication by electronic means.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – electronic communication address Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – electronic communication address Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Electronic communication medium

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287501
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The type of mechanism used for electronic communication.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – electronic communication medium Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – electronic communication medium Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Electronic communication usage code

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287523
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The manner of use of an electronic communication address.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – electronic communication usage code Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Eligibility status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	304551
<i>Registration status:</i>	Health, Standard 05/01/2006 Community services, Standard 04/01/2006
<i>Definition:</i>	An indicator of eligibility for services.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—eligibility status Health, Standard 04/01/2006 Community services, Standard 04/01/2006
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Employee related expenses

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	360140
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The expenditure incurred for wages, salaries and supplements, superannuation employer contributions, workers compensation premiums and payouts.
<i>Property group:</i>	Financial characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Organisation – employee related expenses Health, Standard 05/12/2007
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End-stage renal disease status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269307
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the development of end-stage renal disease.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – end-stage renal disease status Health, Standard 01/03/2005
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Environmental factor

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	320223
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	Environmental factors make up the physical, social and attitudinal environment in which individuals live and conduct their lives.
<i>Property group:</i>	Environmental characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – environmental factor Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Episode end date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269252
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 16/05/2006
<i>Definition:</i>	The date on which an episode is completed.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of residential care – episode end date Health, Standard 01/03/2005 Non-admitted patient emergency department service episode – episode end date Health, Standard 24/03/2006
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Episode end mode

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269144
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The method by which an episode ends.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of residential care—episode end mode Health, Standard 01/03/2005
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Episode end status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	322637
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	The status of the patient at the end of the episode of care or service episode.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Government Department of Health and Ageing
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Relational attributes

<i>Related metadata references:</i>	Supersedes Patient departure status Health, Superseded 24/03/2006
<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient emergency department service episode—episode end status Health, Standard 24/03/2006

Episode end time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	322612
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	The time at which an episode is completed.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Government Department of Health and Ageing.
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient emergency department service episode – episode end time Health, Standard 24/03/2006
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Episode start date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269253
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 16/05/2006
<i>Definition:</i>	The date on which an episode commenced.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of residential care – episode start date Health, Standard 01/03/2005 Residential stay – episode start date Health, Standard 01/03/2005
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Episode start mode

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269106
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The method by which an episode begins.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of residential care—episode start mode Health, Standard 01/03/2005
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Erectile dysfunction

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Impotence
<i>METeOR identifier:</i>	269149
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The inability to achieve or maintain an erection of sufficient rigidity to perform sexual intercourse successfully.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (male) – erectile dysfunction Health, Standard 01/03/2005
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Establishment type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269027
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the class of establishment.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – establishment type Health, Standard 01/03/2005 Health professional – establishment type (employment) Health, Standard 01/03/2005
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Estimated duration

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	379592
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	The period of time during which something continues.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Pregnancy – estimated duration Health, Standard 02/12/2009
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Expenses

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	356286
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Expenses consisting mainly of wages, salaries and supplements, purchases of goods and services and consumption of fixed capital (depreciation).
<i>Property group:</i>	Financial characteristics

Collection and usage attributes

<i>Collection methods:</i>	Data are collected and nationally collated for the reporting period – the financial year ending in 30 June each year.
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Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
<i>Reference documents:</i>	Australian Bureau of Statistics 2006. Australian System of Government Finance Statistics: Concepts, sources and methods, 2005. Cat. no. 5514.0.55.001 Canberra: ABS. Australian Accounting Standards Board 1049, September 2006, < www.asb.com.au >.

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Organisation – expenses Health, Standard 05/12/2007
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Extended leave status in registered profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	383409
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	Whether a person is on extended leave from their position of employment in the registered profession.
<i>Context:</i>	Employed persons.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – extended leave status in registered profession Health, Standard 10/12/2009
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Extended wait patient indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269074
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a patient who has experienced a prolonged wait for care.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective surgery waiting list episode – extended wait patient indicator Health, Standard 01/03/2005
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Extent of environmental factor influence

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	320232
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The degree to which specified environmental factors influence functioning and disability.
<i>Property group:</i>	Environmental characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – extent of environmental factor influence Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Extent of impairment of body function

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	320240
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The degree of impairment in a specified body function.
<i>Property group:</i>	Physical characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person— extent of impairment of body function Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Extent of impairment of body structure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	320252
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The degree of impairment in a specified body structure.
<i>Property group:</i>	Physical characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – extent of impairment of body structure Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Extent of participation in a life area

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	324449
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The degree of participation in a life area.
<i>Property group:</i>	Lifestyle characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person— extent of participation in a life area Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Extent of primary cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	296911
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Degree of spread of the primary cancer.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – extent of primary cancer Health, Standard 04/06/2004
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External cause

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269034
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The circumstances in which an injury, poisoning or other adverse effect has occurred.
<i>Property group:</i>	Crisis event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Reference documents:</i>	International Classification of Diseases - Tenth Revision - Australian Modification National Centre for Classification in Health, Sydney

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Injury event—external cause Health, Standard 01/03/2005
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Family name

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269355
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	A designation for a family.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (name) – family name Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 28/07/2005
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Fasting indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269148
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of abstinence from all food and drink except water.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Reference documents:</i>	Dorland I & Newman W.A 2003. Dorland's illustrated medical dictionary, 30th ed. Philadelphia: Saunders.

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Health service event – fasting indicator Health, Standard 01/03/2005
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Feedback collection indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	290389
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	An indicator of whether feedback relating to services and service delivery is actively and routinely collected.
<i>Property group:</i>	Performance indicators

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – feedback collection indicator Health, Standard 05/12/2007
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Feedback collection method

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	356484
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The method employed to actively and routinely collect feedback.
<i>Property group:</i>	Performance indicators

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation—feedback collection method Health, Standard 05/12/2007
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Fibrinolytic drug administered

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	356876
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of fibrinolytic drug therapy administered.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Related metadata references:</i>	Supersedes Fibrinolytic drug administered Health, Superseded 01/10/2008
<i>Data Element Concepts implementing this Property:</i>	Person – fibrinolytic drug administered Health, Standard 01/10/2008

Fibrinolytic therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285081
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	An indicator of the use of fibrinolytic therapy.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—fibrinolytic therapy status Health, Standard 04/06/2004
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First contact date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269337
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which first contact between a service provider and a patient/client occurred.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Community nursing service episode – first contact date Health, Standard 01/03/2005
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First day of the last menstrual period

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269086
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date of the first day of the last menstrual period (LMP).
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Pregnancy – first day of the last menstrual period Health, Standard 01/03/2005
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First service delivery date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269359
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Date on which service is delivered for the first time.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care – first service delivery date (community setting) Health, Standard 01/03/2005
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Floor/level identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269053
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	Descriptor used to identify the floor or level of a multi-storey building/complex.
<i>Context:</i>	Australian addresses
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – floor/level identifier Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – floor/level identifier Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Floor/level type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269379
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	Descriptor used to classify the type of floor or level of a multi-storey building/complex.
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – floor/level type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – floor/level type Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Foot deformity indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Foot malformation
<i>METeOR identifier:</i>	269160
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the presence of a distortion of the normal shape or size of either foot.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Reference documents:</i>	United States National Library of Medicine 2004. Medical Subject Headings (MESH) Browser. National Library of Medicine, Maryland. Viewed 21 June 2004,

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – foot deformity indicator Health, Standard 01/03/2005
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Foot lesion indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269162
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the presence of a foot lesion other than an ulcer on either foot.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – foot lesion indicator Health, Standard 01/03/2005
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Foot ulcer indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269163
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the presence of a lesion on the surface of the skin of either foot, produced by the sloughing of inflammatory necrotic tissue.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Reference documents:</i>	Dorland I & Newman W.A 2003. Dorland's illustrated medical dictionary, 30th ed. Philadelphia: Saunders United States National Library of Medicine 2004. Medical Subject Headings (MESH) Browser. National Library of Medicine, Maryland. Viewed 21 June 2004,

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—foot ulcer indicator Health, Standard 21/09/2005
	Person—foot ulcer status (current) Health, Superseded 21/09/2005

Formal community support access indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269170
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the receipt of community-based assistance from paid workers or volunteers organised by formal services (including paid staff in funded group houses).
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – formal community support access indicator Health, Standard 01/03/2005
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Full-time equivalent staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269172
<i>Registration status:</i>	Health, Standard 13/05/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	Hours actually worked divided by the number of normal hours worked by a full-time staff member.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – full-time equivalent staff (paid) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (administrative and clerical staff) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (carer consultants) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (consumer consultants) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (diagnostic and health professionals) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (domestic and other staff) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (enrolled nurses) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (occupational therapists) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (other diagnostic and health professionals) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (other medical officers) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (other personal care staff) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (psychiatry registrars and trainees) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (psychologists) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (registered nurses) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (salaried medical officers) Health, Standard 01/03/2005

Establishment – full-time equivalent staff (paid) (social workers)
Health, Standard 08/12/2004

Establishment – full-time equivalent staff (paid) (student nurses)
Health, Standard 01/03/2005

Establishment – full-time equivalent staff (paid) (trainee/pupil
nurses) Health, Standard 01/03/2005

Functional stress test date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	347049
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when a functional stress test is performed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Functional stress test – test date Health, Standard 01/10/2008
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Functional stress test element

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	356901
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The element used to monitor the changes in heart function that occur during a functional stress test.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Related metadata references:</i>	Supersedes Functional stress test element Health, Superseded 01/10/2008
<i>Data Element Concepts implementing this Property:</i>	Functional stress test – functional stress test element Health, Standard 01/10/2008

Functional stress test performed indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	347692
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An indicator of whether a functional stress test was performed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—functional stress test performed indicator Health, Standard 01/10/2008
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Funding eligibility indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269120
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Whether eligible services are actually funded.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care – funding eligibility indicator Health, Standard 01/03/2005
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Geographic location

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269234
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Retired 10/02/2006
<i>Definition:</i>	A description of physical location.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – geographic location Health, Standard 01/03/2005 Service delivery outlet – geographic location Health, Standard 01/03/2005
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Gestational age

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	324353
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	The period of development of a product of conception from the time of fertilisation.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Related metadata references:</i>	Supersedes Estimated gestational age Health, Superseded 02/12/2009
<i>Data Element Concepts implementing this Property:</i>	Product of conception—gestational age Health, Standard 02/12/2009

Given name

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269222
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	A designation for an individual within the family group or by which the individual is socially identified.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (name) – given name Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/08/2005
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Given name sequence number

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287587
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	An order of given name or initials.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (name) – given name sequence number Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Glycoprotein IIb/IIIa receptor antagonist therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285107
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	An indicator of the use of glycoprotein IIb/IIIa receptor antagonist therapy.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – glycoprotein IIb/IIIa receptor antagonist status Health, Standard 04/06/2004
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Glycosylated haemoglobin level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	HbA1c
<i>METeOR identifier:</i>	269273
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the level of blood glucose.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – glycosylated haemoglobin level Health, Standard 01/03/2005
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Goal of care

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269203
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The expected outcome of planned care.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Community nursing service episode – goal of care Health, Standard 01/03/2005
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Government funding identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269238
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 31/08/2007
<i>Definition:</i>	An identifier allocated by a government department for the purpose of identifying those eligible for specific services.
<i>Property group:</i>	Identifier characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – government funding identifier Health, Standard 01/03/2005 Community services, Standard 31/08/2007
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Gross capital expenditure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269024
<i>Registration status:</i>	Health, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	Expenditure on the acquisition or enhancement of a non-financial asset .
<i>Property group:</i>	Financial characteristics

Collection and usage attributes

<i>Guide for use:</i>	National health data dictionary specific: Gross capital expenditure is capital expenditure as reported by the particular establishment having regard to state health authority and other authoritative guidelines as to the differentiation between capital and recurrent expenditure. (A concise indication of the basis on which capital and recurrent expenditure have been differentiated is to form part of national minimum data sets). National housing assistance data dictionary specific: Expenditure on the acquisition or enhancement of an asset (excluding financial assets). A non-financial asset is an entity functioning as a store of value, over which ownership may be derived over a period of time, and which is not a financial asset. Capital includes: acquisitions (purchase of properties); construction costs; redevelopment and improvement (of properties); land acquisitions and development; joint ventures.
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Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – gross capital expenditure (accrual accounting) Health, Standard 01/03/2005 Establishment – gross capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005 Establishment – gross capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005 Establishment – gross capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005 Establishment – gross capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005 Establishment – gross capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005 Establishment – gross capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005 Establishment – gross capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005
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Establishment – gross capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

Establishment – gross capital expenditure (computer equipment/installations) Health, Standard 01/03/2005

Establishment – gross capital expenditure (intangible assets) Health, Standard 01/03/2005

Establishment – gross capital expenditure (land and buildings) Health, Standard 01/03/2005

Establishment – gross capital expenditure (major medical equipment) Health, Standard 01/03/2005

Establishment – gross capital expenditure (other capital expenditure) Health, Standard 01/03/2005

Establishment – gross capital expenditure (plant and other equipment) Health, Standard 01/03/2005

Gross income

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269270
<i>Registration status:</i>	Health, Standard 04/05/2005 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	The total income before business and tax deductions are accounted for.
<i>Property group:</i>	Financial characteristics

Source and reference attributes

<i>Origin:</i>	Australian taxation office 2004. Definitions. Australian taxation office, Canberra. Viewed 22 October 2004
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Household – gross income Health, Standard 15/12/2005 Housing assistance, Retired 10/02/2006
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Group session status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	294406
<i>Registration status:</i>	Health, Standard 17/05/2005
<i>Definition:</i>	An indicator of services, care or assistance simultaneously being provided to more than one person.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service contact – group session status Health, Standard 04/05/2005
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Health professionals attended for diabetes mellitus

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269315
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the class of health professional that has been consulted for diabetes mellitus.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—health professionals attended for diabetes mellitus Health, Standard 01/03/2005
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Heart rate

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285117
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The number of heart beats per unit time, usually expressed as beats per minute.
<i>Property group:</i>	Physical characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – heart rate Health, Standard 04/06/2004
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Heart rhythm type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285127
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The rhythm of a beating heart.
<i>Property group:</i>	Physical characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Electrocardiogram – heart rhythm type Health, Standard 01/10/2008
	Person – heart rhythm type Health, Superseded 01/10/2008

Height

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Stature
<i>METeOR identifier:</i>	269299
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The standing height or recumbent length of a body.
<i>Property group:</i>	Physical characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—height Health, Standard 01/03/2005
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High-density lipoprotein cholesterol level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	310764
<i>Registration status:</i>	Health, Standard 27/10/2005
<i>Definition:</i>	The level of the serum cholesterol carried on high-density lipoproteins, approximately 20 to 30 percent of the total serum cholesterol.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—high-density lipoprotein cholesterol level Health, Standard 01/03/2005
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Hip circumference

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269302
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The distance around the human body at the level of maximum posterior extension of the buttocks.
<i>Property group:</i>	Physical characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—hip circumference Health, Standard 01/03/2005
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Histopathological grade

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288655
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	An indicator of how a tumour resembles the normal tissue from which it arose.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – histopathological grade Health, Standard 04/06/2004
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Hospital in the home care

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	373951
<i>Registration status:</i>	Health, Standard 24/03/2009
<i>Definition:</i>	Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Occupied bed – hospital in the home care Health, Standard 24/03/2009
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Hospital insurance status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269219
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of private insurance cover for hospital expenses.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Patient – hospital insurance status Health, Standard 01/03/2005
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Hours on-call

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269154
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The amount of time devoted to being available to provide advice, respond to any emergencies etc. over a specified period.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Medical practitioner – hours on-call Health, Standard 01/03/2005
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Hours worked in clinical role

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375155
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The amount of time worked in the registered profession undertaking diagnosis, care and treatment of patients.
<i>Context:</i>	Health labour force
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – hours worked in clinical role Health, Standard 10/12/2009
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Hours worked in health profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375152
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The amount of time spent at work in the health profession.
<i>Context:</i>	Health labour force
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – hours worked in health profession Health, Standard 10/12/2009
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Hours worked in non-clinical role

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375281
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The amount of time spent at work in the health profession, undertaking a role other than the diagnosis, care and treatment of patients. This includes time spent as an administrator, teacher/educator, research or other non-clinician role in the profession.
<i>Context:</i>	Health labour force
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – hours worked in non-clinical role Health, Standard 10/12/2009
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Hours worked in private sector

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	382891
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The amount of time spent working in non-government sector employment in the registered profession.
<i>Context:</i>	Health labour force
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – hours worked in private sector Health, Standard 10/12/2009
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Hours worked in public sector

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	382898
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The amount of time spent working in the registered profession in government sector employment.
<i>Context:</i>	Health labour force
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – hours worked in public sector Health, Standard 10/12/2009
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House/property identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269386
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 25/09/2005
<i>Definition:</i>	The numeric or alphanumeric reference number of a house or property that is unique within a street name.
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – house/property identifier Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – house/property identifier Health, Standard 04/05/2005 Community services, Standard 25/09/2005
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Human epidermal growth factor receptor-2 test result

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	370564
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The result of human epidermal growth factor receptor-2 (HER2) tests. HER2 is a protein involved in normal cell growth. It is found in high levels on some breast cancer cells.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – human epidermal growth factor receptor-2 test result Health, Standard 06/03/2009
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Human epidermal growth factor receptor-2 test type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	370578
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The test used to determine the results of human epidermal growth factor receptor-2 (HER2) at the time of diagnosis of the primary tumour.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – human epidermal growth factor receptor-2 test type Health, Standard 06/03/2009
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Human intent of injury

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	313828
<i>Registration status:</i>	Health, Standard 03/03/2005
<i>Definition:</i>	The human intent of an injury.

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Injury event – human intent of injury Health, Standard 24/11/2005
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Hypertension treatment with antihypertensive medication indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	304493
<i>Registration status:</i>	Health, Standard 22/09/2005
<i>Definition:</i>	An indicator of receipt of therapy for hypertension using antihypertensive medication.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Hypertension treatment status Health, Superseded 22/09/2005
<i>Data Element Concepts implementing this Property:</i>	Person – hypertension treatment with antihypertensive medication indicator Health, Standard 21/09/2005

Identifier type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269094
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The class of identifier based on the extent to which it applies across geographic or administrative boundaries.
<i>Property group:</i>	Identifier characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (identifier) – identifier type Health, Standard 01/03/2005
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Implantable cardiac defibrillator procedure date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359606
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when an implantable cardiac defibrillator is inserted to detect and treat (by way of an electrical shock) cardiac arrhythmias.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—implantable cardiac defibrillator procedure date Health, Standard 01/10/2008
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Implantable cardiac defibrillator procedure time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359672
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when an implantable cardiac defibrillator is inserted to detect and treat (by way of an electrical shock) cardiac arrhythmias.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—implantable cardiac defibrillator procedure time Health, Standard 01/10/2008
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Implementation of National standards for mental health services status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287789
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Indicator of National standards for mental health services implementation.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service unit – implementation of National standards for mental health services status Health, Standard 08/12/2004
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Independent living skills support services grants to non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287744
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of independent living skills support.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – independent living skills support services grants to non-government organisations Health, Standard 08/12/2004
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Indicator procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269365
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of procedure that is high volume and often associated with long waiting periods.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective surgery waiting list episode – indicator procedure Health, Standard 01/03/2005
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Indigenous status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269161
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	An indicator of identification as an Aboriginal and/or Torres Strait Islander.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – Indigenous status Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
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Informal carer existence indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	313244
<i>Registration status:</i>	Health, Standard 04/07/2007 Community services, Standard 02/05/2006
<i>Definition:</i>	An indicator of whether or not an informal carer exists.
<i>Property group:</i>	Informal assistance characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Carer availability status Health, Superseded 04/07/2007, Community services, Superseded 02/05/2006
<i>Data Element Concepts implementing this Property:</i>	Person – informal carer existence indicator Health, Standard 04/07/2007 Community services, Standard 02/05/2006

Initial visit since diagnosis indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	303970
<i>Registration status:</i>	Health, Standard 22/09/2005
<i>Definition:</i>	An indicator of whether a visit to a health professional in relation to a specific condition is the first visit since diagnosis.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Initial visit since diagnosis Health, Superseded 22/09/2005
<i>Data Element Concepts implementing this Property:</i>	Patient – initial visit since diagnosis indicator (diabetes mellitus) Health, Standard 21/09/2005

Injecting drug use status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269129
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the administration of psychoactive substances by injection.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Client – injecting drug use status Health, Standard 01/03/2005
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Insulin start date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269048
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which insulin injections commenced.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Patient—insulin start date Health, Standard 01/03/2005
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Intended length of hospital stay

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269327
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The expected duration of a stay in hospital.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – intended length of hospital stay Health, Standard 01/03/2005
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Intended years in profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375481
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The length of time intending to remain practicing in the registered profession.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – intended years in profession Health, Standard 10/12/2009
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Intention of treatment

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288666
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Reason for which treatment is provided for a particular condition.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – intention of treatment Health, Standard 04/06/2004
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Inter-hospital contracted patient status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269338
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator identifying a patient as being treated as part of a contracted hospital care agreement.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – inter-hospital contracted patient status Health, Standard 01/03/2005
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International postcode

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288969
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A descriptor for a postal delivery area, aligned with locality, suburb or place.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – international postcode Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – international postcode Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Interpreter service required status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269289
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Retired 10/02/2006
<i>Definition:</i>	An indicator of a need for a translation service.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—interpreter service required Health, Standard 08/02/2006 Community services, Standard 10/04/2006 Person—interpreter service required status (health) Health, Superseded 08/02/2006
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Intra-aortic balloon pump procedure date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359618
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when an intra-aortic balloon pump is inserted to improve the strength of the hearts contraction.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—intra-aortic balloon pump procedure date Health, Standard 01/10/2008
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Intra-aortic balloon pump procedure time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359686
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when an intra-aortic balloon pump is inserted to improve the strength of the hearts contraction.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—intra-aortic balloon pump procedure time Health, Standard 01/10/2008
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Intravenous fibrinolytic therapy date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	IV fibrinolytic therapy
<i>METeOR identifier:</i>	284981
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The date of intravenous (IV) fibrinolytic therapy.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – intravenous fibrinolytic therapy date Health, Superseded 01/10/2008
	Person – intravenous fibrinolytic therapy date Health, Standard 01/10/2008

Intravenous fibrinolytic therapy time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285193
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The time intravenous (IV) fibrinolytic therapy was first administered.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—intravenous fibrinolytic therapy time Health, Standard 04/06/2004
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Ischaemic and perfusion outcome result

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	349698
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Imbalances of relative blood flow to the left ventricular muscle tissue reflected through the ischaemic and perfusion outcomes of a functional stress test.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Related metadata references:</i>	Supersedes Functional stress test ischaemic result Health, Superseded 01/10/2008
<i>Data Element Concepts implementing this Property:</i>	Functional stress test – ischaemic and perfusion outcome result Health, Standard 01/10/2008

Jobseeker status in registered profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	383436
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	Whether a person is seeking employment in their registered profession.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – jobseeker status in registered profession Health, Standard 10/12/2009
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Killip classification

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285143
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Identifies the Killip class, as a measure of haemodynamic compromise.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – Killip classification Health, Standard 04/06/2004
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Labour augmentation type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269084
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the method used to assist progress of labour.
<i>Property group:</i>	Birth event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event – labour augmentation type Health, Standard 01/03/2005
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Labour force status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Employment status
<i>METeOR identifier:</i>	269067
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	An indicator of participation in paid employment or economic inactivity.
<i>Property group:</i>	Labour characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Health professional – labour force status Health, Standard 01/03/2005 Person – labour force status Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/08/2005 Registered health professional – labour force status Health, Standard 10/12/2009
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Labour induction type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269085
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the method used to induce labour.
<i>Property group:</i>	Birth event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event – labour induction type Health, Standard 01/03/2005
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Labour onset type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269058
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the manner in which labour commences.
<i>Property group:</i>	Birth event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event – labour onset type Health, Standard 01/03/2005
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Last contact date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269344
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which last contact between a service provider and a patient/client occurred.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Community nursing service episode – last contact date Health, Standard 01/03/2005
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Laterality of primary cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269179
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of which side of a paired organ is the origin of the primary cancer.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – laterality of primary cancer Health, Standard 01/03/2005
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Length of employment in profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375472
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The length of time spent working in the registered profession.
<i>Context:</i>	Registered health labour force
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – length of employment in profession in Australia Health, Standard 10/12/2009
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Length of stay

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269031
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The duration of an episode of care or service event that includes the provision of accommodation and/or residential care.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – length of stay (excluding leave days) Health, Standard 01/03/2005
	Episode of admitted patient care – length of stay (including leave days) Health, Standard 01/03/2005
	Episode of admitted patient care – length of stay (special/neonatal intensive care) Health, Standard 01/03/2005

Level of difficulty with activities in a life area

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	320312
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	An expression of the ease of which tasks and actions in a life area are performed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – level of difficulty with activities in a life area Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Level of satisfaction with participation in a life area

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	324441
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The level of satisfaction with participation in a life area, in relation to current life goals.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – level of satisfaction with participation in a life area Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Level of service delivery

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	334501
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Level of specialisation of a health service delivered within a defined speciality.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Palliative Care Intergovernmental Forum
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – level of service delivery Health, Standard 05/12/2007
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Lifestyle counselling type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344705
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of counselling or advice provided to modify lifestyle behaviour.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with acute coronary syndrome – lifestyle counselling type Health, Standard 01/10/2008
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Lipid-lowering therapy status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285153
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	An indicator of the use of lipid-lowering therapy.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—lipid-lowering therapy status Health, Standard 04/06/2004
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Listing date for care

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269112
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a patient/client is accepted onto a list for care/treatment.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective care waiting list episode – listing date for care Health, Standard 01/03/2005
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Living arrangement

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269314
<i>Registration status:</i>	Health, Standard 19/04/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	An arrangement of living alone or with others.
<i>Property group:</i>	Accommodation/living characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—living arrangement Health, Standard 19/04/2005 Community services, Standard 01/03/2005
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Location of impairment of body structure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	320262
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The site where a specified body structure differs from the accepted population standard.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – location of impairment of body structure Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Lot/section identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269059
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 25/09/2005
<i>Definition:</i>	The lot/section reference allocated to an address in the absence of street numbering.
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – lot/section identifier Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – lot/section identifier Health, Standard 04/05/2005 Community services, Standard 25/09/2005
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Low-density lipoprotein cholesterol level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	310787
<i>Registration status:</i>	Health, Standard 27/10/2005
<i>Definition:</i>	The level of the serum cholesterol carried on low-density lipoproteins, approximately 60 to 70 percent of the total serum cholesterol.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—low-density lipoprotein cholesterol level Health, Standard 01/03/2005
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Lower limb amputation due to vascular disease

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269165
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The removal of a toe, forefoot or leg (above or below knee), due to vascular disease.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—lower limb amputation due to vascular disease Health, Standard 01/03/2005
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Lymphovascular invasion

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	370612
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	Presence or absence of the invasion of the cancer cells into the blood vessels or lymphatic channels.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer—lymphovascular invasion Health, Standard 06/03/2009
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Main activity type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	356578
<i>Registration status:</i>	Health, Standard 05/12/2007 Community services, Recorded 04/03/2010
<i>Definition:</i>	A descriptor of the main activity type of an organisation.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Health industry relevant organisation – main activity type Health, Standard 05/12/2007
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Main language other than English spoken at home

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269176
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	The primary language spoken at home, excluding English.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – main language other than English spoken at home Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
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Major diagnostic category

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269328
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The classification of diagnoses (and Australian refined diagnosis related groups) by body system or aetiology.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – major diagnostic category Health, Standard 01/03/2005
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Marital status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269101
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	An indicator of involvement in a couple relationship or marriage.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – marital status Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
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Maternal medical condition

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269069
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Pre-existing and concurrent conditions that affect a pregnancy or its outcome.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Female (pregnant) – maternal medical condition Health, Standard 01/03/2005
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Maximum stenosis coronary artery

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344331
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The greatest point of an abnormal narrowing in the coronary artery.
<i>Property group:</i>	Physical characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person — maximum stenosis coronary artery Health, Standard 01/10/2008
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Melanoma thickness

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269185
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The measured depth of penetration of tumour cells below the basal layer of the skin.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – melanoma thickness Health, Standard 01/03/2005
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Mental health legal status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269297
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of whether care was provided under relevant state or territory mental health legislation compulsory treatment provisions.
<i>Property group:</i>	Legal characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care – mental health legal status Health, Standard 01/03/2005
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Mental health service duration

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285847
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The duration of a mental health service contact.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Mental health service contact – mental health service contact duration Health, Standard 08/12/2004
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Mental health services grants to non-government organisations from non-health departments

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	298935
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	Grants made to non-government organisations for the provision of mental health services.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	State or Territory Government – mental health services grants to non-government organisations by non-health departments Health, Standard 07/12/2005
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Method of drug use

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269130
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The manner in which a psychoactive substance is administered.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Client – method of drug use (principal drug of concern) Health, Standard 01/03/2005
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Microalbumin level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269284
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The amount of microalbumin detected in the urine.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – microalbumin level Health, Standard 01/03/2005
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Morphology of cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269181
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The histology and likely course of development of a tumour.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – morphology of cancer Health, Standard 01/03/2005
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Most common service delivery setting

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	297675
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The setting in which most service delivery occurs.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – most common service delivery setting Health, Standard 05/12/2007
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Most recent stroke date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	338258
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Date when most recent cerebrovascular accident / stroke occurred.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—most recent stroke date Health, Standard 01/10/2008
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Most valid basis of diagnosis of a cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269183
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The most reliable basis of a cancer diagnosis.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer—most valid basis of diagnosis of a cancer Health, Standard 01/03/2005
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Mother's original family name

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Mother's maiden name
<i>METeOR identifier:</i>	269229
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	The family name of an individual's mother before the mother's first marriage.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—mother's original family name Health, Standard 01/03/2005 Community services, Standard 01/03/2005
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Multi-disciplinary team status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269126
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the involvement of providers from more than one profession or occupation.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient service event – multi-disciplinary team status Health, Standard 01/03/2005
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Myocardial infarction

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269235
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Gross necrosis of the myocardium as a result of interruption of the blood supply to the area; it is almost always caused by atherosclerosis of the coronary arteries, upon which coronary thrombosis is usually superimposed.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person — myocardial infarction Health, Standard 01/03/2005
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Name conditional use flag

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287051
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 25/08/2005
<i>Definition:</i>	An indicator of specific conditions which should be applied to a recorded name.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Name context flag Health, Superseded 04/05/2005, Community services, Superseded 25/08/2005
<i>Data Element Concepts implementing this Property:</i>	Person (name) – name conditional use flag Health, Standard 04/05/2005 Community services, Standard 25/08/2005

Name suffix

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269224
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	An additional term following a name.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (name) – name suffix Health, Standard 01/03/2005 Community services, Standard 01/03/2005
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Name suffix sequence number

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288187
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	An order of additional terms at the conclusion of a name.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (name) – name suffix sequence number Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Name title

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269225
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	An honorific form of address commencing a name.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (name) – name title Health, Standard 01/03/2005 Community services, Standard 01/03/2005
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Name title sequence number

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288244
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The numeric order of an honorific form of address commencing a name.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (name) – name title sequence number Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Name type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269227
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A descriptor of the class of name.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (name) – name type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (name) – name type Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Nature of impairment of body structure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	320276
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The qualitative or quantitative change to the characteristics of a specified body structure compared with accepted population standards.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – nature of impairment of body structure Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Nature of main injury

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269100
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The nature of the injury chiefly responsible for the attendance at a health care facility.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Injury event – nature of main injury Health, Standard 01/03/2005
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Need for assistance with activities in a life area

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	324428
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	The need for personal assistance and/or supervision to perform tasks and actions in a life area.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – need for assistance with activities in a life area Health, Standard 29/11/2006 Community services, Standard 16/10/2006
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Neoadjuvant therapy indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	370010
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	An indicator of the receipt of neoadjuvant therapy such as radiotherapy or systemic therapy (chemotherapy, hormone therapy, immunotherapy).
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – neoadjuvant therapy indicator Health, Standard 06/03/2009
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Neonatal admitted care (Non-special-care)

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	373636
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	Care provided to non-special-care neonatal patients. This is neonatal care not provided in an intensive care facility nor in accommodation approved by the Commonwealth Health Minister for the purpose of the provision of special care.
<i>Property group:</i>	Material resource characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Available bed – neonatal admitted care (Non-special-care) Health, Standard 03/12/2008
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Neonatal morbidity

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269087
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A diseased condition or state during first 28 days of life.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Admitted patient (neonate) – neonatal morbidity Health, Standard 01/03/2005
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Net capital expenditure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269033
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Gross capital expenditure less trade-in values of replaced items and receipts from the sale of replaced or otherwise disposed items.
<i>Property group:</i>	Financial characteristics

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – net capital expenditure (accrual accounting) (buildings and building services) Health, Standard 01/03/2005
	Establishment – net capital expenditure (accrual accounting) (constructions) Health, Standard 01/03/2005
	Establishment – net capital expenditure (accrual accounting) (equipment) Health, Standard 01/03/2005
	Establishment – net capital expenditure (accrual accounting) (information technology) Health, Standard 01/03/2005
	Establishment – net capital expenditure (accrual accounting) (intangible assets) Health, Standard 01/03/2005
	Establishment – net capital expenditure (accrual accounting) (land) Health, Standard 01/03/2005
	Establishment – net capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005
	Establishment – net capital expenditure (accrual accounting) (other equipment) Health, Standard 01/03/2005
	Establishment – net capital expenditure (accrual accounting) (transport) Health, Standard 01/03/2005

New/repeat service event status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269292
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of whether a service event involves a problem not previously addressed at the same clinical service.
<i>Property group:</i>	Service provision event

Collection and usage attributes

<i>Guide for use:</i>	Examples of clinical services are included in the Guide for use for Non-admitted patient service event – service event type (clinical), code N[N].
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient service event – new/repeat service event status Health, Standard 01/03/2005
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Non-Australian state/province

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288616
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – non-Australian state/province Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – non-Australian state/province Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Non-invasive ventilation administration date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359630
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when non-invasive ventilation is administered through a Continuous Positive Airway Pressure (CPAP) machine.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person — non-invasive ventilation administration date Health, Standard 01/10/2008
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Non-invasive ventilation administration time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359642
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time of administration of non-invasive ventilation through a Continuous Positive Airway Pressure (CPAP) machine.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person — non-invasive ventilation administration time Health, Standard 01/10/2008
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Non-surgical cancer treatment completion date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288113
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The date on which non-surgical treatment for cancer was completed.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – non-surgical cancer treatment completion date Health, Standard 04/06/2004
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Non-surgical cancer treatment start date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288069
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The date on which non-surgical treatment for cancer was started.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – non-surgical cancer treatment start date Health, Standard 04/06/2004
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Number of cigarettes smoked

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269281
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the number of cigarettes smoked during a specified period.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—number of cigarettes smoked Health, Standard 01/03/2005
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Number of cigarettes smoked after 20 weeks of pregnancy

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375082
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The number of cigarettes smoked after the first twenty weeks of pregnancy.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Female (pregnant) – number of cigarettes smoked (after 20 weeks of pregnancy) Health, Standard 03/12/2008
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Number of cigarettes smoked first 20 weeks of pregnancy

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375323
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The number of cigarettes smoked during the first twenty weeks of pregnancy.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Female (pregnant) – number of cigarettes smoked (first 20 weeks of pregnancy) Health, Standard 03/12/2008
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Number of day centre attendances

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269214
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the number of patient/client visits to a day centre.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – number of day centre attendances Health, Standard 01/03/2005
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Number of days of hospital-in-the-home care

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269242
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the days of hospital-in-the-home care received.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – number of days of hospital-in-the-home care Health, Standard 01/03/2005
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Number of episodes of residential care

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287923
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The total number of episodes of completed residential care. This includes both formal and statistical episodes of residential care.
<i>Context:</i>	Specialised residential mental health services.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of residential care – number of episodes of residential care Health, Standard 08/12/2004
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Number of group session occasions of service for non-admitted patients.

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269119
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the non-admitted occasions of service provided as a group session.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – number of group session occasions of service for non-admitted patients Health, Standard 01/03/2005
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Number of group sessions

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269304
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of groups of patients/clients receiving services.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – number of group sessions Health, Superseded 04/07/2007
	Establishment – number of group sessions Health, Standard 04/07/2007

Number of hours staffed

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288870
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The average number of hours per day that appropriately trained staff are employed on-site.
<i>Property group:</i>	Performance indicators

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service – number of hours staffed Health, Standard 08/12/2004
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Number of individual session occasions of service for non-admitted patients

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	313837
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the non-admitted occasions of service provided as an individual session.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – number of individual session occasions of service for non-admitted patients Health, Standard 01/03/2005
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Number of leave days

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269218
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the number of days spent on leave from a health care service.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – number of leave days Health, Standard 01/03/2005
	Episode of residential care – number of leave days Health, Standard 01/03/2005

Number of leave periods

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269097
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of discrete periods of formal absence during an episode of care.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – number of leave periods Health, Standard 01/03/2005
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Number of non-admitted patient service events

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269288
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of service events provided to non-admitted patients.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – number of non-admitted patient service events Health, Standard 01/03/2005
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Number of occasions of service

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	316229
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the occasions of service provided.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment (residential aged care service) – number of occasions of service Health, Standard 01/03/2005
	Establishment – number of occasions of service Health, Standard 04/05/2005

Number of patient days

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269090
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of days of patient care.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Admitted patient hospital stay – number of patient days (of contracted care) Health, Standard 01/03/2005
	Establishment – number of patient days Health, Standard 01/03/2005

Number of positive regional lymph nodes

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	289189
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The total number of regional lymph nodes examined by a pathologist and reported as containing tumour. A regional lymph node is a lymph node that drains lymph from the region around a tumor.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – number of positive regional lymph nodes Health, Standard 04/06/2004
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Number of positive sentinel lymph nodes

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	370545
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The total number of sentinel lymph nodes examined by a pathologist and reported as containing tumour. Sentinel lymph nodes are the first nodes that filter fluid draining away from the area of cancer. The number of lymph nodes with metastasis is important for cancer staging
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – number of positive sentinel lymph nodes Health, Standard 06/03/2009
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Number of previous caesarean sections

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	298035
<i>Registration status:</i>	Health, Standard 29/11/2006
<i>Definition:</i>	A count of the number of previous caesarean sections.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Female – number of caesarean sections Health, Standard 29/11/2006
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Number of previous pregnancies

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269051
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of previous pregnancies.
<i>Context:</i>	Perinatal statistics: The number of previous pregnancies is an important component of the woman's reproductive history. Parity may be a risk factor for adverse maternal and perinatal outcomes.
<i>Property group:</i>	Health and wellbeing

Collection and usage attributes

<i>Guide for use:</i>	<p>In multiple pregnancies with more than one type of outcome, the pregnancies should be recorded in the following order:</p> <ul style="list-style-type: none">• all live births• stillbirth• spontaneous abortion• induced abortion• ectopic pregnancy <p>A pregnancy resulting in multiple births should be counted as one pregnancy.</p> <p>Where the outcome was one stillbirth and one live birth, count as stillbirth.</p> <p>If a previous pregnancy was a hydatidiform mole, code as spontaneous or induced abortion (or rarely, ectopic pregnancy), depending on the outcome.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Female – number of previous pregnancies Health, Standard 01/03/2005
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Number of psychiatric care days

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269361
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of days of in which specialised psychiatric care was received.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care – number of psychiatric care days Health, Standard 01/03/2005
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Number of psychiatric outpatient clinic/day program attendances

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269353
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the days on which a psychiatric outpatient clinic or a day program was attended.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Patient – number of psychiatric outpatient clinic/ day program attendances Health, Standard 01/03/2005
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Number of qualified days

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269081
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the days within an episode of admitted patient care that are designated as having a newborn qualification status .
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care (newborn) – number of qualified days Health, Standard 01/03/2005
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Number of regional lymph nodes examined

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	289159
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The total number of regional lymph nodes examined by a pathologist. A regional lymph node is a lymph node that drains lymph from the region around a tumor.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – number of regional lymph nodes examined Health, Standard 04/06/2004
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Number of sentinel lymph nodes examined

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	370554
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The total number of sentinel lymph nodes examined by the pathologist. A sentinel lymph node is the first lymph node to which cancer is likely to spread from the primary tumour.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Reference documents:</i>	National Cancer Institute, U.S National Institutes of Health http://www.cancer.gov/Templates/db_alpha.aspx?CdrID=45876
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – number of sentinel lymph nodes examined Health, Standard 06/03/2009
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Number of separations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269336
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of separations.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – number of separations Health, Standard 01/03/2005
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Number of service contact dates

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269340
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of the dates on which there is a service contact.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—number of service contact dates Health, Standard 01/03/2005
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Number of service contacts

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269134
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of service contacts between a service recipient and a service provider.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of treatment for alcohol and other drugs – number of service contacts Health, Standard 01/03/2005
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Number of supported public housing places

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	378052
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	The number of places in public housing supported by specialised mental health services, targeted to people affected by mental illness or psychiatric disability.
<i>Context:</i>	People affected by mental illness or psychiatric disability.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Supported public housing places Health, Standard 08/12/2004
<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service – number of supported public housing places Health, Standard 02/12/2009

Nursing diagnosis

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269198
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The nursing diagnosis most related to the reason for admission .
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care – nursing diagnosis Health, Standard 01/03/2005
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Nursing intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269201
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An action undertaken by a nurse in order to relieve or alter a person's responses to actual or potential health problems.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Community nursing service episode – nursing intervention Health, Standard 01/03/2005
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Occupation

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269099
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	A descriptor of the class of job based on similarities in the tasks undertaken.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Health professional – occupation Health, Standard 01/03/2005 Individual service provider – occupation (self-identified) Health, Standard 04/05/2005 Community services, Standard 30/09/2005 Person – occupation (main) Health, Superseded 04/07/2007 Community services, Superseded 27/03/2007 Housing assistance, Superseded 10/08/2007 Person – occupation (main) Health, Standard 04/07/2007 Community services, Standard 27/03/2007 Housing assistance, Standard 10/08/2007
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Occupation end date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	289049
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	When the class of job based on similarities in the tasks undertaken concludes.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Individual service provider – occupation end date Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Occupation start date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	289055
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	When the class of job based on similarities in the tasks undertaken commences.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Individual service provider – occupation start date Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Oestrogen receptor assay result

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	291318
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The results of an oestrogen receptor test. The test is used to find out if cancer cells have oestrogen receptors (proteins to which oestrogen will bind). If the cells have oestrogen receptors, they may need oestrogen to grow, and this may affect how the cancer is treated.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – oestrogen receptor assay result Health, Standard 04/06/2004
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Operating theatre time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269294
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The length of time spent in an operating theatre.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Admitted patient hospital stay – operating theatre time Health, Standard 01/03/2005
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Ophthalmological assessment outcome

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269301
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a person's ophthalmological assessment.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person — ophthalmological assessment outcome Health, Standard 01/03/2005
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Ophthalmoscopy performed indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	303979
<i>Registration status:</i>	Health, Standard 22/09/2005
<i>Definition:</i>	An indicator of whether an ophthalmoscopy has been undertaken.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Ophthalmoscopy performed Health, Superseded 22/09/2005
<i>Data Element Concepts implementing this Property:</i>	Person – ophthalmoscopy performed indicator Health, Standard 21/09/2005

Organisation end date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288650
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The date on which operations or practice were concluded.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – organisation end date Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Organisation identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269367
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	A sequence of characters which identify an organisation.
<i>Property group:</i>	Identifier characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Contracted hospital care – organisation identifier Health, Standard 01/03/2005 Division of general practice – organisation identifier Health, Standard 01/03/2005 Establishment – organisation identifier Health, Standard 01/03/2005 Establishment – organisation identifier (state/territory) Health, Standard 01/03/2005
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Organisation name

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288901
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The appellation by which an establishment, agency or organisation is known or called.
<i>Property group:</i>	Name characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Standards Australia
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation (name) – organisation name Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Organisation start date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288941
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The date on which operations or a service commenced.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – organisation start date Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Other and unspecified mental health services grants to non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	306256
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	Grants made to non-government organisations for provision of mental health services not elsewhere classified and grants not allocatable to specific service types.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Other and unspecified services grants to non-government organisations Health, Superseded 07/12/2005
<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – other and unspecified mental health services grants to non-government organisations Health, Standard 07/12/2005

Outcome of treatment

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	289298
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The outcome for which treatment is provided for a particular condition.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – outcome of treatment Health, Standard 04/06/2004
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Outpatient clinic type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	291073
<i>Registration status:</i>	Health, Standard 04/05/2005
<i>Definition:</i>	The nature of services which are provided by outpatient clinic services .
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – outpatient clinic type Health, Superseded 04/07/2007
	Establishment – outpatient clinic type Health, Standard 04/07/2007

Overdue patient status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Timeliness of care/service
<i>METeOR identifier:</i>	269076
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a patient whose wait for care exceeded the time determined as clinically desirable.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective surgery waiting list episode – overdue patient status Health, Standard 01/03/2005
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Overnight-stay admitted care

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	374147
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The care provided for a minimum of one night, to a patient who is admitted to and separated from the hospital on different dates.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Related metadata references:</i>	Supersedes Number of available beds for admitted patients/residents Health, Superseded 03/12/2008
<i>Data Element Concepts implementing this Property:</i>	Available bed – overnight-stay admitted care Health, Standard 03/12/2008

Pacemaker insertion date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359599
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when an artificial pacemaker is inserted to regulate the heart beat.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person — pacemaker insertion date Health, Standard 01/10/2008
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Pacemaker insertion time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359657
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when an artificial pacemaker is inserted to regulate the heart beat.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person — pacemaker insertion time Health, Standard 01/10/2008
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Palliative care strategic plan indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288321
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	An indicator of the existence of a written strategic plan for palliative care.
<i>Property group:</i>	Performance indicators

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Administrative health region – palliative care strategic plan indicator Health, Standard 05/12/2007
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Parity

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	302011
<i>Registration status:</i>	Health, Standard 29/11/2006
<i>Definition:</i>	A count of previous pregnancies resulting in a live birth or stillbirth.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Female – parity Health, Standard 29/11/2006
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Partner organisation type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	290699
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The type of organisation with which an organisation has a formal working partnership in place.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

Submitting organisation:

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – partner organisation type Health, Standard 05/12/2007
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Patient election status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	339067
<i>Registration status:</i>	Health, Standard 28/11/2006
<i>Definition:</i>	An indicator of whether a person has elected to be treated as either a public or private patient.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Elected accommodation status Health, Superseded 28/11/2006
<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – patient election status Health, Standard 28/11/2006

Patient listing status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Readiness for care
<i>METeOR identifier:</i>	269041
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator a person's readiness to commence an awaited procedure.
<i>Property group:</i>	Service/care urgency

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective surgery waiting list episode – patient listing status Health, Standard 01/03/2005
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Patient present status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269111
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of a patient's presence at a service event.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient service event – patient present status Health, Standard 01/03/2005
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Patient/client participation indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	286845
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	An indication of participation in a service contact.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Mental health service contact – patient/client participation indicator Health, Standard 08/12/2004
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Patients/clients in residence at year end

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269091
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A count of admitted patients/clients in residence at the end of the normal financial year.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – patients/clients in residence at year end Health, Standard 01/03/2005
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Percutaneous coronary intervention procedure type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359745
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of procedure performed during a percutaneous coronary intervention (PCI).
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—percutaneous coronary intervention procedure type Health, Standard 01/10/2008
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Period of residence in Australia

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269092
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The length of time lived in Australia.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—period of residence in Australia Health, Standard 01/03/2005
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Peripheral neuropathy indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269164
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of peripheral nerve disorders of any cause.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – peripheral neuropathy indicator Health, Standard 01/03/2005
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Peripheral vascular disease indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269093
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the presence of peripheral vascular disease.
<i>Context:</i>	Public health, health care and clinical settings.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—peripheral vascular disease indicator (foot) Health, Standard 01/03/2005
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Person identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269369
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	A sequence of characters which identify a person.
<i>Property group:</i>	Identifier characteristics

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – person identifier Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Person – person identifier (within establishment/agency) Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005
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Pharmacotherapy type prescribed in hospital

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344340
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of pharmacotherapy prescribed for the treatment of acute coronary syndrome in hospital including the emergency department.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with acute coronary syndrome – pharmacotherapy type prescribed in hospital Health, Standard 01/10/2008
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Pharmacotherapy type taken post discharge from hospital

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	351101
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Pharmacotherapy type taken following discharge from hospital.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with acute coronary syndrome – pharmacotherapy type taken post discharge from hospital Health, Standard 01/10/2008
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Physical activity sufficiency status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269095
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of whether a level of activity is sufficiently vigorous to confer a health benefit.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – physical activity sufficiency status Health, Standard 01/03/2005
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Physical departure date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	322593
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	The date on which a patient or client physically departs a service or facility.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Government Department of Health and Ageing
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Emergency department stay – physical departure date Health, Standard 24/03/2006
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Physical departure time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	322606
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	The time at which a patient or client physically departs a service or facility.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Government Department of Health and Ageing
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Emergency department stay – physical departure time Health, Standard 24/03/2006
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Place of occurrence

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269393
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The physical location in which an event occurred.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Injury event—place of occurrence Health, Standard 01/03/2005
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Postal delivery point identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269334
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	A sequence of assigned characters which uniquely identify a postal delivery point.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – postal delivery point identifier Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Service provider organisation (address) – postal delivery point identifier Health, Standard 04/05/2005 Community services, Standard 31/08/2005
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Postal delivery service type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269382
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of distribution service for mail and packages
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – postal delivery service type Health, Standard 01/03/2005
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Postal delivery service type identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269381
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The specification of the identification of a postal delivery service such as General Post Office Box, Community Mail Bag, etc. to clearly distinguish it from another when applicable.
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – postal delivery service type identifier Health, Standard 01/03/2005
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Postpartum perineal status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269054
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the condition of the perineum after birth.
<i>Property group:</i>	Birth event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Female (mother) – postpartum perineal status Health, Standard 01/03/2005
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Pre-vocational training services grants for non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288095
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of pre-vocational training services.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – pre-vocational training services grants for non-government organisations Health, Standard 08/12/2004
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Preferred language

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269244
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 10/04/2006
<i>Definition:</i>	The language most preferred for communication.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – preferred language Health, Standard 01/03/2005 Community services, Standard 10/04/2006
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Pregnancy completion date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269257
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a pregnancy was completed.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Pregnancy (last previous) – pregnancy completion date Health, Standard 01/03/2005
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Pregnancy indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	303950
<i>Registration status:</i>	Health, Standard 22/09/2005
<i>Definition:</i>	An indicator of a developing embryo or fetus within a body.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Dorland's Illustrated Medical Dictionary 30th ed. Philadelphia: Saunders

Relational attributes

<i>Related metadata references:</i>	Supersedes Current pregnancy status Health, Superseded 22/09/2005
<i>Data Element Concepts implementing this Property:</i>	Female – pregnancy indicator Health, Standard 21/09/2005

Pregnancy outcome

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269049
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The end result of a period of pregnancy.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Pregnancy (last previous) – pregnancy outcome Health, Standard 01/03/2005
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Premature cardiovascular disease family history status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269233
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Indicates whether there is a history of early cardiovascular conditions within the family.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – premature cardiovascular disease family history status Health, Standard 01/03/2005
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Presentation date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269321
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which the patient/client presented for the delivery of a service.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Health service event – presentation date Health, Standard 01/03/2005
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Presentation time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269146
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time at which a person presents for the delivery of a service.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Health service event – presentation time Health, Standard 01/03/2005
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Previous specialised treatment

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269308
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the receipt of prior care in the same specialty as the current treatment.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Patient – previous specialised treatment Health, Standard 01/03/2005
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Primary percutaneous coronary intervention date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359179
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date of the first percutaneous coronary intervention performed for reperfusion therapy of an ST-segment-elevation myocardial infarction.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Related metadata references:</i>	Supersedes First angioplasty balloon inflation or stenting date Health, Superseded 01/10/2008
<i>Data Element Concepts implementing this Property:</i>	Person – primary percutaneous coronary intervention date Health, Standard 01/10/2008

Primary percutaneous coronary intervention time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359212
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time of the first percutaneous coronary intervention performed for reperfusion therapy of an ST-segment-elevation myocardial infarction.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Related metadata references:</i>	Supersedes First angioplasty balloon inflation or stenting time Health, Superseded 01/10/2008
<i>Data Element Concepts implementing this Property:</i>	Person – primary percutaneous coronary intervention time Health, Standard 01/10/2008

Primary site of cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269180
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The anatomical position of origin of a tumour.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – primary site of cancer Health, Standard 01/03/2005
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Primary tumour status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	293238
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The extent of the primary tumour.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Sobin LH (Editors) (1997) International Union Against Cancer (UICC) TNM classification of malignant tumours, 5th edition. Wiley-Liss, New York

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – primary tumour status Health, Standard 13/06/2004
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Principal diagnosis

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269186
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The diagnosis mainly responsible for occasioning a service event or episode.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care – principal diagnosis Health, Standard 01/03/2005
	Non-admitted patient emergency department service episode - principal diagnosis Health, Standard 05/12/2007

Principal field of medicine

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375490
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The field of medicine in which the most hours were worked in the week prior to registration.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – principal field of medicine Health, Standard 10/12/2009
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Principal role

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269351
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 15/09/2007
<i>Definition:</i>	A descriptor of the role to which the most time is devoted.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Health professional – principal role Health, Standard 01/03/2005 Registered health professional – principal role Health, Standard 10/12/2009
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Principal source of funding

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	339074
<i>Registration status:</i>	Health, Standard 29/11/2006
<i>Definition:</i>	The source from which the majority of funding is anticipated.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Expected principal source of funding Health, Superseded 29/11/2006
<i>Data Element Concepts implementing this Property:</i>	Episode of care – principal source of funding Health, Standard 29/11/2006

Procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Clinical intervention; Surgical operation
<i>METeOR identifier:</i>	269052
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A series of steps performed by a healthcare professional through which a desired result is intended to be accomplished.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Reference documents:</i>	Dorland I & Newman W.A 2003. Dorland's illustrated medical dictionary, 30th ed. Philadelphia: Saunders.

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – procedure Health, Standard 01/03/2005
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Procedure commencement date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269251
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a procedure commenced.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care (procedure) – procedure commencement date Health, Standard 01/03/2005
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Proficiency in spoken English

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269192
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	An indicator of the level of skill in speaking English.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – proficiency in spoken English Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
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Progesterone receptor assay results

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	291334
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The results of a progesterone receptor test.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – progesterone receptor assay results Health, Standard 13/06/2004
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Proteinuria status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269290
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the presence of excessive protein in the urine.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—proteinuria status Health, Standard 01/03/2005
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Psychosocial support services grants for non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288670
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of psychosocial support services.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – psychosocial support services grants for non-government organisations Health, Standard 08/12/2004
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Purchase of goods and services

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	360134
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Expenditure incurred for the purchase of goods and services.
<i>Property group:</i>	Financial characteristics

Collection and usage attributes

Collection methods:

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Organisation – purchase of goods and services Health, Standard 05/12/2007
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Quality accreditation/certification standard indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269293
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of whether a service provider is accredited or compliant with relevant industry quality standards.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – quality accreditation/certification standard indicator Health, Standard 01/03/2005
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Radiation dose received

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	291463
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The amount of radiation received.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – radiation dose received Health, Standard 13/06/2004
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Radiotherapy treatment type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	291343
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The type of radiation therapy used for treatment.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – radiotherapy treatment type Health, Standard 13/06/2004
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Reason for non prescription of pharmacotherapy

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	347218
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Whether a pharmacotherapy was not indicated or contraindicated.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—reason for non prescription of pharmacotherapy Health, Standard 01/10/2008
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Reason for readmission following acute coronary syndrome episode

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285161
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	Identifies the main reason for the readmission, following a previous discharge from an acute coronary syndrome episode.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—reason for readmission following acute coronary syndrome episode Health, Standard 04/06/2004
	Person—reason for readmission following acute coronary syndrome episode Health, Standard 01/10/2008

Reason for removal from a waiting list

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269071
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The reason for removal of an entry from a waiting list.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective surgery waiting list episode – reason for removal from a waiting list Health, Standard 01/03/2005
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Recreation services grants to non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288692
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of recreation services.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – recreation services grants to non-government organisations Health, Standard 08/12/2004
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Recurrent expenditure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269132
<i>Registration status:</i>	Health, Standard 13/05/2005 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	Expenditure which does not result in the acquisition or enhancement of an asset.
<i>Property group:</i>	Financial characteristics

Collection and usage attributes

<i>Guide for use:</i>	National Housing Assistance Data Dictionary specific: Recurrent expenditure on goods and services is expenditure, which does not result in the creation or acquisition of fixed assets (new or second-hand). It consists mainly of expenditure on wages, salaries and supplements, purchases of goods and services and consumption of fixed capital (depreciation). When fees charged for goods and services are offset against recurrent expenditure, the result equates to final consumption expenditure in the Australian Bureau of Statistics' national accounts framework. Includes: <ul style="list-style-type: none">• Operating expenses• Tenancy manager revenue and expense components.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Reference documents:</i>	Australian Bureau of Statistics: Government Finance Statistics 1998, Cat. No. 5514.0

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – recurrent expenditure Health, Standard 08/12/2004
	Establishment – recurrent expenditure (administrative expenses) Health, Standard 01/03/2005
	Establishment – recurrent expenditure (Department of Veterans' Affairs funded) Health, Standard 02/12/2009
	Establishment – recurrent expenditure (Department of Veterans' Affairs funded) Health, Superseded 02/12/2009
	Establishment – recurrent expenditure (depreciation) Health, Standard 01/03/2005
	Establishment – recurrent expenditure (domestic services) Health, Standard 01/03/2005
	Establishment – recurrent expenditure (drug supplies) Health, Standard 01/03/2005
	Establishment – recurrent expenditure (food supplies) Health, Standard 01/03/2005

Establishment – recurrent expenditure (indirect health care) Health, Standard 01/03/2005

Establishment – recurrent expenditure (interest payments) Health, Standard 01/03/2005

Establishment – recurrent expenditure (medical and surgical supplies) Health, Standard 01/03/2005

Establishment – recurrent expenditure (National Mental Health Strategy payments) Health, Standard 08/12/2004

Establishment – recurrent expenditure (non-salary operating costs) Health, Standard 01/03/2005

Establishment – recurrent expenditure (other Commonwealth Government funded expenditure) Health, Standard 08/12/2004

Establishment – recurrent expenditure (other patient revenue funded expenditure) Health, Standard 08/12/2004

Establishment – recurrent expenditure (other recurrent expenditure) Health, Standard 01/03/2005

Establishment – recurrent expenditure (other revenue funded expenditure) Health, Standard 08/12/2004

Establishment – recurrent expenditure (other state or territory funded expenditure) Health, Standard 08/12/2004

Establishment – recurrent expenditure (patient transport cost) Health, Standard 01/03/2005

Establishment – recurrent expenditure (recoveries funded expenditure) Health, Standard 08/12/2004

Establishment – recurrent expenditure (repairs and maintenance) Health, Standard 01/03/2005

Establishment – recurrent expenditure (salaries and wages) Health, Standard 01/03/2005

Establishment – recurrent expenditure (state or territory health authority funded) Health, Standard 08/12/2004

Establishment – recurrent expenditure (superannuation employer contributions) Health, Standard 01/03/2005

Establishment – recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005

Specialised mental health service organisation – recurrent expenditure (residual mental health) Health, Standard 08/12/2004

Referral destination

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269147
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The service provider to which a referral is made.
<i>Property group:</i>	Referral event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – referral destination Health, Standard 01/03/2005
	Episode of residential care – referral destination (mental health care) Health, Standard 01/03/2005

Referral source

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269061
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 02/06/2005
<i>Definition:</i>	A person or organisation from which a person or group of people is referred.
<i>Property group:</i>	Referral event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – referral source Health, Standard 01/03/2005 Episode of treatment for alcohol and other drugs – referral source Health, Standard 01/03/2005
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Referral to ophthalmologist indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	304006
<i>Registration status:</i>	Health, Standard 22/09/2005
<i>Definition:</i>	An indicator of whether there was a referral to an ophthalmologist.
<i>Property group:</i>	Referral event

Source and reference attributes

<i>Submitting organisation:</i>	National diabetes data working group
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Relational attributes

<i>Related metadata references:</i>	Supersedes Referral to ophthalmologist Health, Superseded 22/09/2005
<i>Data Element Concepts implementing this Property:</i>	Person – referral to ophthalmologist indicator Health, Standard 21/09/2005

Referral to rehabilitation service date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269357
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a referral to a rehabilitation service is made.
<i>Property group:</i>	Referral event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Health service event—referral to rehabilitation service date Health, Standard 01/03/2005
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Region identifier

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269057
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 15/09/2007
<i>Definition:</i>	An identifier for a defined geographic or administrative area.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – region identifier Health, Standard 01/03/2005
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Region name

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	352846
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	A name for a defined geographic or administrative area.
<i>Property group:</i>	Identifier characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Administrative health region – region name Health, Standard 05/12/2007
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Region of first recurrence of cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	289045
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The region where there is a return or reappearance of the primary cancer after a disease free period intermission or remission.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – region of first recurrence of cancer Health, Standard 04/06/2004
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Regional lymph node metastasis status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	293233
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The absence or presence and the extent of regional lymph node metastasis.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Sobin LH (Editors) (1997) International Union Against Cancer (UICC) TNM classification of malignant tumours, 5th edition. Wiley-Liss, New York

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – regional lymph node metastasis status Health, Standard 13/06/2004
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Regular tobacco smoking indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	304521
<i>Registration status:</i>	Health, Standard 22/09/2005
<i>Definition:</i>	An indicator of current and/or past regular tobacco smoking.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—regular tobacco smoking indicator Health, Standard 21/09/2005
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Renal disease therapy

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269373
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The class of treatment undertaken for renal disease.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular data working group
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—renal disease therapy Health, Standard 01/03/2005
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Rescue percutaneous coronary intervention date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359575
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when percutaneous coronary intervention is performed following failed fibrinolysis.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—rescue percutaneous coronary intervention date Health, Standard 01/10/2008
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Rescue percutaneous coronary intervention time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359564
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when percutaneous coronary intervention is performed following failed fibrinolysis.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—rescue percutaneous coronary intervention time Health, Standard 01/10/2008
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Residential mental health care

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	373645
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The care provided for the purpose of specialised residential mental health care .
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Available bed – residential mental health care Health, Standard 03/12/2008
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Residual expenditure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	295450
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Expenditure that cannot be directly related to programs operated by a particular organisation or service unit (that is, can only be indirectly related to a particular organisation or service unit).
<i>Property group:</i>	Financial characteristics

Source and reference attributes

<i>Submitting organisation:</i>	National minimum data set working parties
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service – residual expenditure (academic positions) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (education and training) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (insurance) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (Mental Health Act Regulation or related legislation) Health, Standard 02/12/2009
	Specialised mental health service – residual expenditure (mental health promotion) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (mental health research) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (other indirect expenditure) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (patient transport services) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (program administration) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (property leasing costs) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (service development) Health, Standard 02/12/2009
	Specialised mental health service – residual expenditure (superannuation) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (support services) Health, Standard 08/12/2004
	Specialised mental health service – residual expenditure (workers compensation) Health, Standard 08/12/2004

Respite services grants to non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288749
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of respite services.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – respite services grants to non-government organisations Health, Standard 08/12/2004
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Retirement status in registered profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	383422
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	Whether a person is retired from their position of employment in the registered profession.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – retirement status in registered profession Health, Standard 10/12/2009
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Revascularisation percutaneous coronary intervention date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359586
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date when percutaneous coronary intervention is performed for subsequent restoration of blood flow.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—revascularisation percutaneous coronary intervention date Health, Standard 01/10/2008
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Revascularisation percutaneous coronary intervention time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359733
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when percutaneous coronary intervention is performed for subsequent restoration of blood flow.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—revascularisation percutaneous coronary intervention time Health, Standard 01/10/2008
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Revenue

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	358088
<i>Registration status:</i>	Health, Standard 05/12/2007 Housing assistance, Standardisation pending 30/11/2007
<i>Definition:</i>	Revenue is income that arises in the course of ordinary activities of an entity and is referred to by a variety of names including sales, fees, interest, dividends and royalties.
<i>Property group:</i>	Financial characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
<i>Origin:</i>	ABS 2003. Australian System of Government Finance Statistics: Concepts, Sources and Methods (Cat. no. 5514.0.55.001) EMBARGO: 11:30 AM (CANBERRA TIME) 10/10/2003. Australian Accounting Standards Board 118, July 2007, < www.aasb.com.au >.

Relational attributes

<i>Related metadata references:</i>	Supersedes Revenue Health, Superseded 05/12/2007, Housing assistance, Standard 22/10/2005
<i>Data Element Concepts implementing this Property:</i>	Establishment – revenue (other revenue) Health, Standard 05/12/2007 Establishment – revenue (patient) Health, Standard 05/12/2007 Establishment – revenue (recoveries) Health, Standard 05/12/2007 Organisation – revenue Health, Standard 05/12/2007

Same-day admitted care

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	373961
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The care provided to a same-day patient who is admitted and separated from the hospital on the same date.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Available bed – same-day admitted care Health, Standard 03/12/2008
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Scheduled admission date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269029
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which an admission is planned.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Admitted patient care waiting list episode – scheduled admission date Health, Standard 01/03/2005
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Sector

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269055
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 27/04/2007
<i>Definition:</i>	A categorisation of an organisation based on its funding, management and ownership arrangements.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – sector Health, Standard 01/03/2005
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Self-help support groups services grants for non-government organisations

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288802
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Grants made to non-government organisations for the provision of self-help services.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service organisation – self-help support groups services grants for non-government organisations Health, Standard 08/12/2004
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Separation date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269258
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which an episode of care ceases.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – separation date Health, Standard 01/03/2005
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Separation mode

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269121
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The method by which separation is achieved.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – separation mode Health, Standard 01/03/2005
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Separation time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269330
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time at which an episode of care ceases.
<i>Context:</i>	Admitted patient care.
<i>Property group:</i>	Exit/leave from service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of admitted patient care – separation time Health, Standard 01/03/2005
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Service commencement date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	313941
<i>Registration status:</i>	Health, Standard 07/12/2005
<i>Definition:</i>	The date on which a service event commences.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Government Department of Health and Ageing
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient emergency department service episode – service commencement date Health, Standard 07/12/2005
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Service commencement time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269045
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time at which a service event starts.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Health service event – service commencement time Health, Superseded 07/12/2005 Non-admitted patient emergency department service episode – service commencement time Health, Standard 07/12/2005
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Service contact date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269137
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which contact between a service provider and patient/client occurred.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Mental health service contact – service contact date Health, Standard 08/12/2004
	Service contact – service contact date Health, Standard 01/03/2005

Service delivery setting

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269375
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 02/05/2006
<i>Definition:</i>	The setting in which assistance or services are provided.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of treatment for alcohol and other drugs – service delivery setting Health, Standard 01/03/2005 Service provider organisation – service delivery setting Health, Standard 05/12/2007 Community services, Standard 29/04/2006 Specialised mental health service – service setting Health, Standard 01/03/2005
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Service episode length

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269331
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The length of time between patient presentation and service episode conclusion.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient emergency department service episode – service episode length Health, Standard 01/03/2005
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Service event type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269245
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of the class of treatment or care provided during a service event.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient service event – service event type (clinical) Health, Standard 01/03/2005
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Service mode

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269348
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The relative physical location of a patient to their service provider.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient service event – service mode Health, Standard 01/03/2005
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Session type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	286780
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	An indicator of whether a person or group of persons is provided with a service.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health of Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Mental health service contact – session type Health, Standard 08/12/2004
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Setting of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Birth setting
<i>METeOR identifier:</i>	269110
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of physical environment where the birth occurred.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event – setting (intended) Health, Superseded 08/12/2005
	Birth event – setting of birth Health, Standard 01/03/2005

Severe hypoglycaemia indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	304017
<i>Registration status:</i>	Health, Standard 22/09/2005
<i>Definition:</i>	An indicator of hypoglycaemia requiring assistance from another party.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Severe hypoglycaemia history Health, Superseded 22/09/2005
<i>Data Element Concepts implementing this Property:</i>	Person – severe hypoglycaemia indicator Health, Standard 21/09/2005

Sex

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269231
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005
<i>Definition:</i>	The biological distinction between male and female.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Australian Bureau of Statistics 1999. Standards for Social, Labour and Demographic Variables Demographic Variables, Sex

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—sex Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
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Solid tumour size

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269184
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The diameter of a solid tumour at the widest point.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with cancer – solid tumour size Health, Standard 01/03/2005
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Source of revenue

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	352332
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The origin from which revenue is received.
<i>Property group:</i>	Funding characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Health industry relevant organisation – source of revenue Health, Standard 05/12/2007
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Specialised mental health service target population group

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288951
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	The population group primarily targeted by a specialised mental health service.
<i>Context:</i>	Specialised mental health services.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Specialised mental health service – specialised mental health service target population group Health, Standard 08/12/2004
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Specialised service indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269158
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the capacity to provide specialised service.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – specialised service indicator Health, Standard 01/03/2005
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Specialist private sector rehabilitation care indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269325
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator that identifies whether the criteria for specialist private sector rehabilitation care is met.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of care – specialist private sector rehabilitation care indicator Health, Standard 01/03/2005
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Staging basis of cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	296959
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The type of evidence that confirms a diagnosis of a malignant tumour.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer staging – staging basis of cancer Health, Standard 04/06/2004
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Standards assessment indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	356459
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	An indicator of whether routine assessment against defined industry standards occurs.
<i>Property group:</i>	Performance indicators

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – standards assessment indicator Health, Standard 05/12/2007
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Standards assessment level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	359010
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The level of assessment undertaken or undergone by an organisation against defined industry standards
<i>Property group:</i>	Performance indicators

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – standards assessment level Health, Standard 05/12/2007
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Standards assessment method

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	287989
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	The method used for standards assessment.
<i>Property group:</i>	Performance indicators

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – standards assessment method Health, Standard 05/12/2007
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State/territory of birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269339
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The state/territory in which the birth occurred.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Birth event—state/territory of birth Health, Standard 01/03/2005
	Person—state/territory of birth Health, Standard 10/12/2009

Street name

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269385
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	The name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality.
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – street name Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – street name Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Street suffix

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269384
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	Term used to qualify the street name used for directional references.
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
<i>Origin:</i>	AS4590 Interchange of client information, Australia Post Address Presentation Standard.

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – street suffix Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – street suffix Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Street type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269383
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 30/09/2005
<i>Definition:</i>	A code that identifies the type of public thoroughfare.
<i>Context:</i>	Australian addresses.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – street type Health, Standard 01/03/2005 Community services, Standard 30/09/2005 Service provider organisation (address) – street type Health, Standard 04/05/2005 Community services, Standard 30/09/2005
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Stress test intensity

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344435
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Describes the level of exertion applied in a stress test.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Functional stress test – stress test intensity Health, Standard 01/10/2008
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Suburb/town/locality name

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269335
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Proposed 11/08/2009
<i>Definition:</i>	The full name of the general locality containing the specific address.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (address) – suburb/town/locality name Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Service provider organisation (address) – suburb/town/locality name Health, Standard 04/05/2005 Community services, Standard 31/08/2005 Workplace (address) – suburb/town/locality name Health, Standard 10/12/2009
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Surgical procedure date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288620
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The date on which the surgical procedure was performed.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – surgical procedure date Health, Standard 04/06/2004
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Surgical procedure for cancer

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288476
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The surgical procedure(s) used in the treatment of a cancer.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – surgical procedure for cancer Health, Standard 04/06/2004
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Surgical specialty

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269155
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A descriptor of an area of clinical expertise in surgery.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective surgery waiting list episode – surgical specialty (of scheduled doctor) Health, Standard 01/03/2005
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Systemic therapy agent name

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	288347
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The standard chemotherapeutic agent or anti-cancer drug used for treatment of a cancer.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – systemic therapy agent name (primary cancer) Health, Standard 04/06/2004
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Target site for cancer treatment

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	293145
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The site or region of the cancer that is being targeted at treatment.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Cancer treatment – target site for cancer treatment Health, Standard 13/06/2004
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Teaching status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269156
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of engagement in the implementation of an educational program.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Establishment – teaching status (university affiliation) Health, Standard 01/03/2005
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Technical nursing care requirement

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	313225
<i>Registration status:</i>	Health, Standard 13/10/2005
<i>Definition:</i>	Procedures and tasks for which specific nursing education is required as well as knowledge of expected therapeutic effect, possible side-effects, complications and appropriate actions relating to each.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – technical nursing care requirement Health, Standard 13/10/2005
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Telephone number

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269232
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	A sequence of digits.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – telephone number Health, Standard 01/03/2005 Community services, Standard 01/03/2005
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Telephone number type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269239
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	The class of telephone number.
<i>Property group:</i>	Location characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person (telephone) – telephone number type Health, Standard 01/03/2005 Community services, Standard 01/03/2005
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Time since quitting tobacco smoking

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269266
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The period of time since quitting tobacco smoking.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – time since quitting tobacco smoking Health, Standard 01/03/2005
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Timing of ACE-inhibitor prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	349377
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when an ACE-inhibitor is prescribed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – timing of ACE-inhibitor prescription Health, Standard 01/10/2008
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Timing of angiotensin II receptor blocker prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	350414
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when an angiotensin II receptor blocker is prescribed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—timing of angiotensin II receptor blocker prescription Health, Standard 01/10/2008
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Timing of antithrombin therapy prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	350503
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when antithrombin therapy is prescribed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – timing of antithrombin therapy prescription Health, Standard 01/10/2008
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Timing of aspirin prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	347824
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when aspirin, a medication having antiinflammatory, analgesic, and antipyretic effects, is prescribed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – timing of aspirin prescription Health, Standard 01/10/2008
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Timing of beta-blocker prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	349369
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when a beta-blocker, a medication to lower heart rate and blood pressure, reduce the risk of heart attack, help control angina symptoms and treat irregular heart rhythms is prescribed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – timing of beta-blocker prescription Health, Standard 01/10/2008
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Timing of clopidogrel prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	350427
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when clopidogrel, an inhibitor of platelet aggregation, is prescribed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – timing of clopidogrel prescription Health, Standard 01/10/2008
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Timing of glycoprotein IIb/IIIa inhibitor prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	349391
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when a glycoprotein IIb/IIIa inhibitor is prescribed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—timing of glycoprotein IIb/IIIa inhibitor prescription Health, Standard 01/10/2008
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Timing of statin prescription

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	350437
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The timing of care when a statin is prescribed.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—timing of statin prescription Health, Standard 01/10/2008
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Tobacco product smoked

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269276
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The type of tobacco smoked.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—tobacco product smoked Health, Standard 01/03/2005
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Tobacco smoking daily use status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269279
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of whether tobacco has ever been smoked on a daily basis.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – tobacco smoking daily use status Health, Standard 01/03/2005
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Tobacco smoking duration

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269280
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The length of time tobacco has been smoked.
<i>Property group:</i>	Lifestyle characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—tobacco smoking duration Health, Standard 01/03/2005
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Tobacco smoking frequency

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269277
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of how frequently tobacco is smoked.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – tobacco smoking frequency Health, Standard 01/03/2005
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Tobacco smoking indicator (after twenty weeks of pregnancy)

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375055
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	A self-reported indicator of tobacco smoking after 20 weeks of pregnancy.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Female (pregnant) – tobacco smoking indicator (after twenty weeks of pregnancy) Health, Standard 03/12/2008
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Tobacco smoking indicator (first twenty weeks of pregnancy)

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	365394
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	A self-reported indicator of tobacco smoking in the first twenty weeks of pregnancy.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Female (pregnant) – tobacco smoking indicator (first twenty weeks of pregnancy) Health, Standard 03/12/2008
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Tobacco smoking quit age

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269274
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The age at which tobacco smoking ceased.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—tobacco smoking quit age Health, Standard 01/03/2005
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Tobacco smoking start age

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269275
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The age at which tobacco smoking commenced.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—tobacco smoking start age Health, Standard 01/03/2005
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Tobacco smoking status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269267
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of current and/or past tobacco smoking.
<i>Property group:</i>	Lifestyle characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—tobacco smoking status Health, Standard 01/03/2005
	Person—tobacco smoking status (last three months) Health, Superseded 21/09/2005

Transport mode

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269043
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The act or method of moving an object or person.
<i>Property group:</i>	Transport characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient emergency department service episode – transport mode Health, Standard 01/03/2005
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Treatment cessation date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269254
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which the treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of treatment for alcohol and other drugs – treatment cessation date Health, Standard 01/03/2005
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Treatment commencement date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269255
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date of the first service contact in which an assessment and/or treatment occurred, whichever occurred first.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of treatment for alcohol and other drugs – treatment commencement date Health, Standard 01/03/2005
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Treatment type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269107
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The category of health care intervention or therapy.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Episode of treatment for alcohol and other drugs – treatment type Health, Standard 01/03/2005
	Episode of treatment for alcohol and other drugs – treatment type (other) Health, Superseded 13/10/2005

Triage category

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269109
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The classification of a patient assigned according to the urgency of their need for medical and/or nursing care.
<i>Context:</i>	Emergency department care
<i>Property group:</i>	Service/care urgency

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient emergency department service episode – triage category Health, Standard 01/03/2005
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Triage date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269259
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a patient is assessed to determine the urgency of their problem and priority for care.
<i>Property group:</i>	Service/care urgency

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient emergency department service episode – triage date Health, Standard 07/12/2005
	Triage – triage date Health, Superseded 07/12/2005

Triage time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269360
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time on which a patient is assessed to determine the urgency of their problem and priority for care.
<i>Property group:</i>	Service/care urgency

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient emergency department service episode – triage time Health, Standard 07/12/2005
	Triage – triage time Health, Superseded 07/12/2005

Triglyceride level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	TG; Triacylglycerol
<i>METeOR identifier:</i>	269204
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The amount of triglyceride in the blood.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – triglyceride level Health, Standard 01/03/2005
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Troponin assay type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285213
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	An indicator of the type of troponin assay.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – troponin assay type Health, Standard 04/06/2004
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Troponin level

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285243
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The amount of troponin.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – troponin level Health, Standard 04/06/2004
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Troponin level measured date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284987
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The date on which troponin was measured.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – troponin level measured date Health, Standard 04/06/2004
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Troponin level measured time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285205
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The time at which troponin was measured.
<i>Property group:</i>	Service provision event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – troponin level measured time Health, Standard 04/06/2004
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Type of acute coronary syndrome related clinical event

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	338250
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Identifies the clinical event which can impact on health outcomes from acute coronary syndrome.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person with acute coronary syndrome – type of acute coronary syndrome related clinical event Health, Standard 01/10/2008
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Type of health or health related function

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	352183
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Type of activity or program provided to prevent or cure disease, care for illness, impairment, disability or handicap, or to support this activity.
<i>Property group:</i>	Organisational characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Organisation – type of health or health related function Health, Standard 05/12/2007
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Type of visit to emergency department

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269300
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the reason for arrival at an emergency department.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Non-admitted patient emergency department service episode – type of visit to emergency department Health, Standard 01/03/2005
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Underlying cause of acute coronary syndrome

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	338303
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	Identifies the condition or acute event, other than the usual risk factors, that precipitated the acute coronary syndrome symptoms.
<i>Property group:</i>	Crisis event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—underlying cause of acute coronary syndrome Health, Standard 01/10/2008
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Underlying cause of death

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	296462
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The disease or injury which initiated the train of events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury. (WHO 2004)
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – underlying cause of death Health, Standard 01/10/2008
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Units of blood transfused

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344792
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The number of blood units transfused.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—units of blood transfused Health, Standard 01/10/2008
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Upper limit of normal range for creatine kinase isoenzyme

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	349625
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The value of creatine kinase isoenzyme that is the upper boundary of the normal reference range.
<i>Property group:</i>	Organisational characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Laboratory standard – upper limit of normal range for creatine kinase isoenzyme Health, Standard 01/10/2008
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Upper limit of normal range for creatine kinase myocardial band isoenzyme

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	284925
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The value of creatine kinase myocardial band (CK-MB) isoenzyme that is the upper boundary of the normal reference range.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Acute coronary syndrome data working group
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Laboratory standard – upper limit of normal range for creatine kinase myocardial band isoenzyme Health, Standard 04/06/2004
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Upper limit of normal range for microalbumin

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269283
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The value of microalbumin that is the upper boundary of the normal reference range.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Laboratory standard – upper limit of normal range for microalbumin Health, Standard 01/03/2005
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Upper limit of normal range of glycosylated haemoglobin

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269282
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The value of glycosylated haemoglobin (HbA1c) that is the upper boundary of the normal reference range.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Laboratory standard – upper limit of normal range of glycosylated haemoglobin Health, Standard 01/03/2005
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Upper limit of normal range of troponin assay

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	285227
<i>Registration status:</i>	Health, Standard 04/06/2004
<i>Definition:</i>	The value of 'troponin T' or 'troponin I' that is the upper boundary of the normal reference range.
<i>Property group:</i>	Organisational characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Laboratory standard – upper limit of normal range of troponin assay Health, Standard 04/06/2004
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Vascular condition status

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269070
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of conditions of blood vessels of the body.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – vascular condition status Health, Standard 01/03/2005
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Vascular procedure

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269072
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Interventions pertaining to the vascular system
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – vascular procedure Health, Standard 01/03/2005
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Ventricular ejection fraction test date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344270
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The date on which the ventricular ejection fraction is measured.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Ventricular ejection fraction test – test date Health, Standard 01/10/2008
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Ventricular ejection fraction test performed indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	347667
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	An indicator of whether a test was performed to measure the amount of blood pumped out of the ventricles per heart beat.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – ventricular ejection fraction test performed indicator Health, Standard 01/10/2008
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Ventricular ejection fraction test result

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	346986
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The result from the test to measure ventricular ejection fraction.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Ventricular ejection fraction – test result Health, Standard 01/10/2008
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Ventricular ejection fraction test time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	349813
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The time when the ventricular ejection fraction test is performed.
<i>Property group:</i>	Service provision event

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Ventricular ejection fraction – test time Health, Standard 01/10/2008
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Ventricular ejection fraction test type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	344247
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The type of test used to measure the amount of blood pumped out of a ventricle per heart beat.
<i>Property group:</i>	Health and wellbeing

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Ventricular ejection fraction test – test type Health, Standard 01/10/2008
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Visa type

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375179
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The category of visa (or travel authority) granted by Australia for foreign nationals (excluding New Zealand citizens) to travel to, enter and remain in Australia.
<i>Property group:</i>	Legal characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Further information regarding visas can be obtained from the Australian Department of Immigration and Citizenship or visit their website www.immi.gov.au

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – visa type Health, Standard 10/12/2009
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Visual acuity

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269073
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Sharpness or acuteness of vision.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Macquarie University 2003. The Macquarie Dictionary 3rd ed. Sydney: The Macquarie Library Pty Ltd

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – visual acuity Health, Standard 01/03/2005
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Waist circumference

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269145
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The distance around the human body between the ribs and the hips.
<i>Property group:</i>	Physical characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person – waist circumference Health, Standard 01/03/2005
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Waist circumference risk indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	Abdominal obesity risk indicator
<i>METeOR identifier:</i>	269195
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An indicator of the level of the risk of metabolic complications associated with excess abdominal adiposity.
<i>Property group:</i>	Health and wellbeing

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Adult – waist circumference risk indicator Health, Standard 01/03/2005
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Waist-to-hip ratio

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>Synonymous names:</i>	WHR
<i>METeOR identifier:</i>	269196
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The division of waist circumference by hip circumference.
<i>Property group:</i>	Physical characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Adult – waist-to-hip ratio Health, Standard 01/03/2005
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Waiting list removal date

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269113
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The date on which a person is removed from a waiting list.
<i>Property group:</i>	Entry into service event

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective surgery waiting list episode – waiting list removal date Health, Standard 01/03/2005
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Waiting time

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269063
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The time elapsed between a service request and a subsequent administrative or service event.
<i>Property group:</i>	Performance indicators

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Elective surgery waiting list episode – waiting time Health, Standard 01/03/2005
	Non-admitted patient emergency department service episode – waiting time Health, Standard 01/03/2005
	Non-admitted patient emergency department service episode – waiting time (to hospital admission) Health, Standard 01/03/2005

Weight

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269197
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A measurement of body mass.
<i>Property group:</i>	Physical characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Adult – weight Health, Superseded 14/07/2005
	Person – weight Health, Standard 01/03/2005

Work sector in registered health profession

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375310
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	Whether employment in a registered health profession is in the private or the public sector.
<i>Property group:</i>	Labour characteristics

Collection and usage attributes

<i>Comments:</i>	This property differentiates between establishments run by the government sector and establishments that receive some government funding but are run by the non-government sector.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – work sector in registered health profession Health, Standard 10/12/2009
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Work setting

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	375396
<i>Registration status:</i>	Health, Standard 10/12/2009
<i>Definition:</i>	The type of service setting or other organisation arrangement in which the work was undertaken.
<i>Property group:</i>	Labour characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Registered health professional – work setting Health, Standard 10/12/2009
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Working partnership indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	290692
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	An indicator of whether an agency has formal working partnership(s) with other service provider(s) or organisation(s).
<i>Property group:</i>	Organisational characteristics

Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Service provider organisation – working partnership indicator Health, Standard 05/12/2007
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Year of first arrival in Australia

Identifying and definitional attributes

<i>Metadata item type:</i>	Property
<i>METeOR identifier:</i>	269050
<i>Registration status:</i>	Health, Standard 04/05/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	The calendar year in which an individual first arrived in Australia.
<i>Property group:</i>	Demographic/social/cultural characteristics

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Data Element Concepts implementing this Property:</i>	Person—year of first arrival in Australia Health, Standard 04/05/2005 Community services, Standard 01/03/2005
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Classification schemes

Australian and New Zealand Standard Classification of Occupations, First edition, 2006

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	ANZSCO 1st edition
<i>METeOR identifier:</i>	350882
<i>Registration status:</i>	Health, Standard 04/07/2007 Community services, Standard 27/03/2007
<i>Definition:</i>	The Australian Bureau of Statistics (ABS) classification for occupations.
<i>Classification structure:</i>	<p>The structure of ANZSCO has five hierarchical levels - major group, sub-major group, minor group, unit group and occupation. The categories at the most detailed level of the classification are termed 'occupations'. These are grouped together to form 'unit groups', which in turn are grouped into 'minor groups'. Minor groups are aggregated to form 'sub-major groups' which in turn are aggregated at the highest level to form 'major groups'.</p> <p>These are the same hierarchical levels that are used in ASCO Second Edition and NZSCO 1999.</p>

Conceptual model

ANZSCO is a skill-based classification used to classify all occupations and jobs in the Australian and New Zealand labour markets.

To do this, ANZSCO identifies a set of occupations covering all jobs in the Australian and New Zealand labour markets, defines these occupations according to their attributes and groups them on the basis of their similarity into successively broader categories for statistical and other types of analysis. The individual objects classified in ANZSCO are jobs.

In ANZSCO, occupations are organised into progressively larger groups on the basis of their similarities in terms of both skill level and skill specialisation.

The conceptual model adopted for ANZSCO uses a combination of skill level and skill specialisation as criteria to design major groups which are meaningful and useful for most purposes. The eight major groups are formed by grouping together sub-major groups using aspects of both skill level and skill specialisation. In designing the major groups, intuitive appeal and usefulness in both statistical and administrative applications were also important considerations.

The skill level criterion is applied as rigorously as possible at the second level of the classification, the sub-major group level, together with a finer application of skill specialisation than that applied at the major group level. Each sub-major group is made up of a number of minor groups.

Minor groups are distinguished from each other mainly on the

basis of a finer application of skill specialisation than that applied at the sub-major group level. Within minor groups, unit groups are distinguished from each other on the basis of skill specialisation and, where necessary, skill level.

Virtually all unit groups are at one skill level. There are only eight unit groups which contain occupations at more than one skill level. In all but two of these unit groups, the vast majority of jobs classified to the unit group are at one skill level only. Data stored at unit group level can therefore be aggregated by skill level with a high degree of validity.

Within unit groups, the distinction between occupations amounts to differences between tasks performed in occupations. All occupations are at one skill level.

As a result, data classified at the major group level will provide only a broad indication of skill level. Data at the sub-major group level will provide a satisfactory indication of skill level for many analytical purposes. Data classified at the unit group level will provide an accurate indication of skill level. Unit groups can, therefore, be aggregated by skill level to provide an indicative measure of occupations classified by skill level.

Source and reference attributes

Origin: Australian Bureau of Statistics 2006. [Australian and New Zealand Standard Classification of Occupations, First Edition, Cat no. 1220.0](#) Canberra: ABS. Viewed 13 March 2007.

Relational attributes

Related metadata references: Supersedes [Australian Standard Classification of Occupations 2nd edition](#) Health, Superseded 04/07/2007, Community services, Superseded 27/03/2007, Housing assistance, Standard 01/03/2005

Value Domains based on this Classification Scheme: Occupation code (ANZSCO 1st edition) N[NNN]{NN} Health, Standard 04/07/2007
Community services, Standard 27/03/2007
Housing assistance, Standard 10/08/2007

Australian Classification of Health Interventions (ACHI) 5th edition

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	ACHI 5th edn
<i>METeOR identifier:</i>	335419
<i>Registration status:</i>	Health, Superseded 05/02/2008
<i>Definition:</i>	The National Centre for Classification in Health classification of health interventions.
<i>Classification structure:</i>	ACHI is comprised of: <ul style="list-style-type: none">• Tabular List of Interventions - contains seven character code in the format xxxxx-xx. Generally, the first five characters represent the 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 - is 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

<i>Origin:</i>	National Centre for Classification in Health (NCCH) 2006. The Australian Classification of Health Interventions (ACHI) – Fifth Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.
<i>Revision status:</i>	ACHI 5th Ed supersedes the fourth edition of ACHI. ACHI 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

<i>Related metadata references:</i>	Supersedes International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 4th edition Health, Superseded 07/12/2005
<i>Value Domains based on this Classification Scheme:</i>	Elective care type code N Health, Standard 07/12/2005 Indicator procedure code NN Health, Standard 01/03/2005 Procedure code (ACHI 5th edn) NNNNN-NN Health, Superseded 05/02/2008

Australian Classification of Health Interventions (ACHI) 7th edition

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	ACHI 7th edn
<i>METeOR identifier:</i>	391343
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	The National Centre for Classification in Health classification of health interventions.
<i>Classification structure:</i>	ACHI is comprised of: <ul style="list-style-type: none">• Tabular List of Interventions - contains seven character code in the format xxxxx-xx. Generally, the first five characters represent the 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 - is 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

<i>Origin:</i>	National Centre for Classification in Health (NCCH) 2010. The Australian Classification of Health Interventions (ACHI) – Seventh Edition - Tabular list of interventions and Alphabetic index of interventions. Sydney: NCCH, Faculty of Health Sciences, The University of Sydney.
<i>Revision status:</i>	ACHI 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

<i>Related metadata references:</i>	Supersedes Australian Classification of Health Interventions (ACHI) 6th edition Health, Superseded 22/12/2009
<i>Value Domains based on this Classification Scheme:</i>	Procedure code (ACHI 7th edn) NNNNN-NN Health, Standard 22/12/2009

Australian Refined Diagnosis Related Groups version 6

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	AR-DRG v 6
<i>METeOR identifier:</i>	391288
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	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

<i>Comments:</i>	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.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Australian Refined Diagnosis Related Groups version 5.1 Health, Superseded 22/12/2009
<i>Value Domains based on this Classification Scheme:</i>	Diagnosis related group code (AR-DRG v 6) ANNA Health, Standard 22/12/2009 Major diagnostic category code (AR-DRG v 6) NN Health, Standard 22/12/2009

Australian Standard Classification of Drugs of Concern 2000

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	ASCDC 2000
<i>METeOR identifier:</i>	270550
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The Australian Bureau of Statistics' classification for data relating to drugs which are considered to be of concern in Australian society.
<i>Classification structure:</i>	The main classification of the ASCEDC has a three level hierarchical structure. It is essentially a classification of type of drug of concern based on the chemical structure, mechanism of action and effect on physiological activity of the drugs of concern.

Collection and usage attributes

<i>Guide for use:</i>	Indexes in alphabetical and numerical order are available, see the <i>Origin:</i> attribute.
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Source and reference attributes

<i>Steward:</i>	Australian Bureau of Statistics (ABS)
<i>Origin:</i>	The Australian Standard Classification of Drugs of Concern (ASCDC). ABS Cat No. 1248.0 (2000).
<i>Revision status:</i>	Original 2000 - Standard.

Relational attributes

<i>Value Domains based on this Classification Scheme:</i>	Drug of concern (ASCDC 2000 extended) code NNNN Health, Standard 01/03/2005
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Australian Standard Classification of Languages 2005

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	ASCL 2005
<i>METeOR identifier:</i>	304118
<i>Registration status:</i>	Health, Standard 08/02/2006 Community services, Standard 30/09/2005 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	The Australian Bureau of Statistics (ABS) classification for the languages spoken by Australians.
<i>Classification structure:</i>	The ASCL has a three-level hierarchical structure. Languages are grouped together into progressively broader categories on the basis of their evolution from a common ancestral language, and on the basis of geographic proximity of areas where a particular language originated.

Collection and usage attributes

<i>Guide for use:</i>	The ASCL is intended for use in the collection, aggregation and dissemination of data relating to the language use of the Australian population, or subsets of the population. Indexes in alphabetical and numerical order are available, see the <i>Origin:</i> attribute.
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Source and reference attributes

<i>Origin:</i>	Australian Bureau of Statistics 2005. Australian Standard Classification of Languages (ASCL) 2005 . Cat No. 1267.0. 2nd Edition, Canberra: ABS. Viewed 29 July 2005
<i>Revision status:</i>	If you require further information about this classification please email: social.classifications@abs.gov.au or telephone the Standards Support Hotline on (02) 6252 5736.

Relational attributes

<i>Related metadata references:</i>	Supersedes Australian Standard Classification of Languages 1997 Health, Superseded 08/02/2006, Community services, Superseded 30/09/2005
<i>Value Domains based on this Classification Scheme:</i>	Language code (ASCL 2005) NN{NN} Health, Standard 08/02/2006 Community services, Standard 30/09/2005 Housing assistance, Standard 10/02/2006

Australian Standard Geographical Classification 2009

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	ASGC 2009
<i>METeOR identifier:</i>	386777
<i>Registration status:</i>	Health, Standard 02/10/2009 Community services, Standard 02/10/2009
<i>Definition:</i>	The Australian Bureau of Statistics classification for the classification of geographical locations.

Source and reference attributes

<i>Origin:</i>	Australian Bureau of Statistics 2006. Australian Standard Geographical Classification (ASGC). Cat No. 1216.0. Canberra: ABS. Viewed on 23/09/2009
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Relational attributes

<i>Related metadata references:</i>	Supersedes Australian Standard Geographical Classification 2008 Health, Superseded 02/10/2009, Community services, Superseded 02/10/2009
<i>Value Domains based on this Classification Scheme:</i>	Geographical location code (ASGC 2009) NNNNN Health, Standard 02/10/2009 Community services, Standard 30/09/2009

British Paediatric Association Classification of Diseases 1979

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	BPA 1979
<i>METeOR identifier:</i>	270559
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The British Paediatric Association classification system for the classification of diseases.

Relational attributes

<i>Value Domains based on this Classification Scheme:</i>	Congenital malformations code (BPA 1979) ANN.N[N] Health, Standard 01/03/2005
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International Classification of Diseases for Oncology

3rd edition

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	ICDO-3
<i>METeOR identifier:</i>	270553
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The World Health Organization's classification for coding the topography and the morphology of the neoplasm.

Source and reference attributes

<i>Origin:</i>	International Classification of Diseases for Oncology, Third Edition
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Relational attributes

<i>Value Domains based on this Classification Scheme:</i>	Morphology of cancer code (ICDO-3) NNNN/N Health, Standard 01/03/2005
	Primary site of cancer code (ICDO-3) ANN{.N[N]} Health, Standard 01/03/2005
	Topography code (ICDO-3) ANN Health, Standard 13/06/2004

International Classification of Functioning, Disability and Health 2001

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	ICF 2001
<i>METeOR identifier:</i>	270548
<i>Registration status:</i>	Health, Standard 23/02/2005 Community services, Standard 01/12/2004
<i>Definition:</i>	The World Health Organization's (WHO) system for classifying functioning, disability and health.

Collection and usage attributes

<i>Comments:</i>	The International Classification of Functioning, Disability and Health (ICF) was endorsed by the World Health Assembly in 2001 and is a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).
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Source and reference attributes

<i>Origin:</i>	World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO
<i>Reference documents:</i>	Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide Version 1.0 (AIHW 2003), at the following websites: <ul style="list-style-type: none">• WHO ICF website: http://www.who.int/classifications/icf/en/• Australian Collaborating Centre ICF website: http://www.aihw.gov.au/disability/icf/index.cfm

Relational attributes

<i>Value Domains based on this Classification Scheme:</i>	Activities and participation code (ICF 2001) AN[NNN] Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Activity difficulty level code (ICF 2001) N Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Activity need for assistance code N Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Body function code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Body structure code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006 Community services, Standard 16/10/2006 Environmental factor code (ICF 2001) AN[NNN] Health, Standard 29/11/2006
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Community services, Standard 16/10/2006
Extent of environmental factors influence code (ICF 2001) [X]N
Health, Standard 29/11/2006
Community services, Standard 16/10/2006
Impairment extent code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006
Impairment location code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006
Impairment nature code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006
Participation extent code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, (2nd edition)

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	ICD-10
<i>METeOR identifier:</i>	352607
<i>Registration status:</i>	Health, Standard 01/10/2008
<i>Definition:</i>	The World Health Organisation classification for diseases and related health problems
<i>Classification structure:</i>	ICD-10 is comprised of three volumes: <ul style="list-style-type: none">• Tabular List of Diseases• Instruction manual• Alphabetical index

Source and reference attributes

<i>Origin:</i>	World Health Organisation 2004. The International statistical classification of diseases and related health problems, Tenth revision, (2nd edn) . Geneva: World Health Organisation. (viewed 16/05/2007)
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Relational attributes

<i>Value Domains based on this Classification Scheme:</i>	Underlying cause of death code (ICD-10 2nd edn) ANN-ANN Health, Standard 01/10/2008
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International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 7th edition

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	ICD-10-AM 7th edn
<i>METeOR identifier:</i>	391301
<i>Registration status:</i>	Health, Standard 22/12/2009
<i>Definition:</i>	The National Centre for Classification in Health classification of diseases and related health problems
<i>Classification structure:</i>	ICD-10-AM is comprised of: <ul style="list-style-type: none">• 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

<i>Origin:</i>	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.
<i>Revision status:</i>	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

<i>Related metadata references:</i>	Supersedes International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification 6th edition Health, Superseded 22/12/2009
<i>Value Domains based on this Classification Scheme:</i>	Activity type code (ICD-10-AM 7th edn) ANNNN Health, Standard 22/12/2009

Congenital malformations code (ICD-10-AM 7th edn)
ANN{.N[N]} Health, Standard 22/12/2009

Diagnosis code (ICD-10-AM 7th edn) ANN{.N[N]} Health,
Standard 22/12/2009

External cause code (ICD-10-AM 7th edn) ANN{.N[N]} Health,
Standard 22/12/2009

Neonatal morbidity code (ICD-10-AM 7th edn) ANN{.N[N]}
Health, Standard 22/12/2009

Place of occurrence (ICD-10-AM 7th edn) ANN{.N[N]} Health,
Standard 22/12/2009

Pregnancy/childbirth and puerperium code (ICD-10-AM 7th
edn) ANN{.N[N]} Health, Standard 22/12/2009

Primary site of cancer code (ICD-10-AM 7th edn) ANN{.N[N]}
Health, Standard 22/12/2009

International Union against Cancer (UICC) TNM Classification of Malignant Tumours 6th edition

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>METeOR identifier:</i>	341286
<i>Registration status:</i>	Health, Standard 06/03/2009
<i>Definition:</i>	The International Union Against Cancer classification for malignant tumours.

Source and reference attributes

<i>Reference documents:</i>	Sobin LH, Wittekind C. TNM Classification of Malignant Tumours. 6th ed. Hoboken, New Jersey: John Wiley & Sons; 2002
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Relational attributes

<i>Related metadata references:</i>	Supersedes International Union against Cancer TNM Classification of Malignant Tumours 5th edition Health, Superseded 06/03/2009
<i>Value Domains based on this Classification Scheme:</i>	M stage (UICC TNM Classification of Malignant Tumours, 6th edn) code XX Health, Standard 06/03/2009 N stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX Health, Standard 06/03/2009 T stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XX[X] Health, Standard 06/03/2009 TNM stage (UICC TNM Classification of Malignant Tumours, 6th ed) code XXXX{[X]XX} Health, Standard 06/03/2009

North American Nursing Diagnosis Association (NANDA) Taxonomy 1997–1998

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	NANDA 1997-98
<i>METeOR identifier:</i>	270555
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The North American Nursing Diagnosis Association's (NANDA) 1997-1998 classification for nursing diagnoses.

Source and reference attributes

<i>Origin:</i>	North American Nursing Diagnosis Association (NANDA) Nursing Diagnoses: Definitions and Classification 1997-1998. (1997) NANDA
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Relational attributes

<i>Value Domains based on this Classification Scheme:</i>	Nursing diagnosis code (NANDA 1997-98) N.N[.N]{.N}{.N}{.N] Health, Standard 01/03/2005
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Postcode datafile

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>METeOR identifier:</i>	270561
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a party (person or organisation), as defined by Australia Post.
<i>Context:</i>	Postcode is an important part of a persons or organisations postal address and facilitates written communication. It is one of a number of geographic identifiers that can be used to determine a geographic location. Postcode may assist with uniquely identifying a person or organisation.

Collection and usage attributes

<i>Guide for use:</i>	The postcode book is updated more than once annually as postcodes are dynamic entities and are constantly changing.
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Source and reference attributes

<i>Origin:</i>	Australia Post Postcode book. Reference through: http://www1.auspost.com.au/postcodes/
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Relational attributes

<i>Value Domains based on this Classification Scheme:</i>	Australian postcode code (Postcode datafile) NNN[N] Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005 Australian postcode code (Postcode datafile) {NNNN} Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 10/02/2006
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Self-Instructional Manual for Tumour Registrars Book 8 Antineoplastic Drugs, 3rd edition

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>METeOR identifier:</i>	291502
<i>Registration status:</i>	Health, Standard 13/06/2004
<i>Definition:</i>	The Surveillance, Epidemiology, and End Results (SEER) Program classification for antineoplastic drugs.

Collection and usage attributes

<i>Comments:</i>	This manual is being completely revised. The drugs listed in SEER Book 8 may not include any antineoplastic agents developed since 1993.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Value Domains based on this Classification Scheme:</i>	Antineoplastic drug code (Self-Instructional Manual for Tumour Registrars Book 8 3rd edn) X[X(39)] Health, Standard 13/06/2004
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Standard Australian Classification of Countries 2008

Identifying and definitional attributes

<i>Metadata item type:</i>	Classification Scheme
<i>Synonymous names:</i>	SACC 2008
<i>METeOR identifier:</i>	370931
<i>Registration status:</i>	Health, Standard 01/10/2008 Community services, Standard 02/06/2008 Housing assistance, Standard 24/11/2008
<i>Definition:</i>	The Australian Bureau of Statistics classification for countries.

Collection and usage attributes

<i>Comments:</i>	The Standard Australian Classification of Countries 2008 (SACC) Edition 2 supersedes the Australian Standard Australian Classification of Countries 1998 (SACC) Edition 1.
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Source and reference attributes

<i>Origin:</i>	Australian Bureau of Statistics 2008. Standard Australian Classification of Countries 2008 (SACC). Cat No. 1269.0. Canberra: ABS (last viewed 2 June 2008)
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Relational attributes

<i>Related metadata references:</i>	Supersedes Standard Australian Classification of Countries 1998 Health, Superseded 01/10/2008, Community services, Superseded 02/06/2008, Housing assistance, Superseded 24/11/2008
<i>Value Domains based on this Classification Scheme:</i>	Country code (SACC 2008) NNNN Health, Standard 01/10/2008 Community services, Standard 02/06/2008 Housing assistance, Standard 24/11/2008

Glossary items

Activity—functioning, disability and health

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>Synonymous names:</i>	Activity
<i>METeOR identifier:</i>	327296
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 01/03/2005
<i>Definition:</i>	In the context of health, an activity is the execution of a task or action by an individual.
<i>Context:</i>	<p>'Activities and participation' is one of three components that define the concept 'Disability', along with 'Body functions and structures' and 'Environmental factors'. 'Activities and participation' is also encompassed within the concept 'Functioning'.</p> <p>The concept 'Activity', as defined here and as measured in the metadata item Activity difficulty level code (ICF) N, may be relevant to people and human services not related to disability.</p>

Collection and usage attributes

<i>Comments:</i>	<p>Activity limitations are difficulties an individual has in the execution of an activity.</p> <p>The performance of an activity is what the individual does in his or her current environment. The environment includes all aspects of the physical, social and attitudinal world. Activity limitation varies with the environment and is assessed in relation to a particular environment and in the absence or presence of assistance, including aids and equipment.</p> <p>In time, a related and more generic data element may be developed. In the meantime, the addition of 'functioning, disability and health' to the concept of 'ability' indicates that the current concept is based on the concept and framework developed by World Health Organization to assist in the classification and description of functioning and disability, as contained in the ICF.</p> <p>The ICF recognises two constructs that can be used with 'Activities and Participation': performance and capacity. 'Performance' is what the person does in their usual environment. 'Capacity' describes 'an individual's ability to execute a task or an action in a standardised environment, where a standardised environment may be:</p> <ul style="list-style-type: none">• an actual environment commonly used for assessment in test settings; or• in cases where this is not possible, an assumed environment which can be thought to have a uniform impact' (WHO 2001). <p>The standardised environment has not been generally operationalised. However, the recognition of these two constructs in the ICF underscores the importance of recording the environment in which activities are being performed.</p>
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This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N]}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites

- WHO ICF website
<http://www.who.int/classifications/icf/en>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.html>

Relational attributes

Related metadata references:

Supersedes [Activity - functioning, disability and health, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf](#) (17.9 KB)

Metadata items which use this glossary item:

Activities and participation code (ICF 2001) AN[NNN] Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Activity difficulty level code (ICF 2001) N Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Disability Health, Standard 29/11/2006

Community services, Standard 01/03/2005

Housing assistance, Standard 01/03/2005

Extent of environmental factors influence code (ICF 2001) [X]N Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Functioning and Disability DSS Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Address

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327278
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 08/05/2006
<i>Definition:</i>	The referential description of a location where an entity is located or can be otherwise reached or found.

Collection and usage attributes

Comments: Following are the attributes are commonly used in the formation of a full address:

- Address line; (address line is a composite data element containing many attributes of the specific location of a full address - see the current version of the Address line metadata item for further description and a list of its components for addresses located in Australia)
- Address type
- Australian state/territory identifier
- Country identifier
- Non-Australian State/province
- Postal delivery point identifier
- Postcode - Australian
- Postcode - international
- Suburb/town/locality

Some attributes of an address, located within Australia, also provide the elements to determine the **Statistical Local Area (SLA)**. This enables:

- comparison of the use of services by persons residing in different geographical areas,
- characterisation of catchment areas and populations for facilities for planning purposes, and
- documentation of provision of services to clients who reside in other states or territories. The address is also a relevant element in the unambiguous identification of a Health Care Client and a Health Care Provider.

Source and reference attributes

<i>Submitting organisation:</i>	Health Data Standards Committee
<i>Reference documents:</i>	AS5017 Health Care Client Identification, 2002, Sydney: Standards Australia AS4846 Health Care Provider Identification, 2004, Sydney: Standards Australia

Relational attributes

Related metadata references:

Supersedes [Address, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.3 KB)

Metadata items which use this glossary item:

Person (address) – address line, text [X(180)] Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Service provider organisation (address) – address line, text [X(180)] Health, Standard 04/05/2005

Community services, Standard 30/09/2005

Administrative and clerical staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327166
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Staff engaged in administrative and clerical duties. Medical staff and nursing staff, diagnostic and health professionals and any domestic staff primarily or partly engaged in administrative and clerical duties are excluded. Civil engineers and computing staff are included in this category.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (administrative and clerical staff) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}] Health, Standard 01/03/2005
	Establishment – recurrent expenditure (salaries and wages) (administrative and clerical staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Admission

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327206
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>Admission is the process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specified criteria that a patient requires same-day or overnight care or treatment. An admission may be formal or statistical.</p> <p>Formal admission:</p> <p>The administrative process by which a hospital records the commencement of treatment and/or care and/or accommodation of a patient.</p> <p>Statistical admission:</p> <p>The administrative process by which a hospital records the commencement of a new episode of care, with a new care type, for a patient within one hospital stay.</p>
<i>Context:</i>	Admitted patient care

Collection and usage attributes

<i>Comments:</i>	This treatment and/or care provided to a patient following admission occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).
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Source and reference attributes

<i>Submitting organisation:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Admission, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.0 KB)
<i>Metadata items which use this glossary item:</i>	<p>Accommodation type prior to admission code N Health, Standard 01/03/2005</p> <p>Acute hospital and private psychiatric hospital admission labour force status code N Health, Standard 01/03/2005</p> <p>Admission urgency status Health, Standard 01/03/2005</p> <p>Admission urgency status code N Health, Standard 01/03/2005</p> <p>Admitted patient Health, Standard 01/03/2005</p> <p>Admitted patient care NMDS Health, Superseded 07/12/2005</p> <p>Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006</p> <p>Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008</p> <p>Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009</p>

Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009

Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Admitted patient hospital stay Health, Standard 01/03/2005

Clinical urgency code N Health, Standard 01/03/2005

Episode of admitted patient care – admission urgency status Health, Standard 01/03/2005

Episode of admitted patient care – admission urgency status, code N Health, Standard 01/03/2005

Episode of admitted patient care – elected accommodation status Health, Superseded 28/11/2006

Episode of admitted patient care – elected accommodation status, code N Health, Superseded 23/10/2006

Episode of admitted patient care – intended length of hospital stay Health, Standard 01/03/2005

Episode of admitted patient care – intended length of hospital stay, code N Health, Standard 01/03/2005

Episode of admitted patient care – patient election status Health, Standard 28/11/2006

Episode of admitted patient care – patient election status, code N Health, Standard 23/10/2006

Episode of care – funding eligibility indicator (Department of Veterans Affairs), code N Health, Standard 01/03/2005

Establishment – specialised service indicator (geriatric assessment unit), yes/no code N Health, Standard 01/03/2005

Health or health related function code NNN Health, Standard 05/12/2007

Non-admitted patient Health, Standard 01/03/2005

Non-admitted patient emergency department service episode – waiting time (to hospital admission) Health, Standard 01/03/2005

Non-admitted patient emergency department service episode – waiting time (to hospital admission), total hours and minutes NNNN Health, Standard 01/03/2005

Nursing diagnosis Health, Standard 01/03/2005

Patient – previous specialised treatment Health, Standard 01/03/2005

Patient – previous specialised treatment, code N Health, Standard 01/03/2005

Person – accommodation type (prior to admission), code N Health, Standard 01/03/2005

Person – labour force status, acute hospital and private psychiatric hospital admission code N Health, Standard 01/03/2005

Person – labour force status, public psychiatric hospital admission code N Health, Standard 01/03/2005

Person – reason for readmission following acute coronary syndrome episode Health, Standard 01/10/2008

Person – reason for readmission following acute coronary syndrome episode Health, Standard 04/06/2004

Person – reason for readmission following acute coronary syndrome episode, code N[N] Health, Standard 01/10/2008

Person – reason for readmission following acute coronary syndrome episode, code N[N] Health, Superseded 01/10/2008

Previous specialised treatment code N Health, Standard 01/03/2005

Public psychiatric hospital admission labour force status code N Health, Standard 01/03/2005

Reason for readmission following acute coronary syndrome episode code N[N] Health, Standard 01/10/2008

Reason for readmission following acute coronary syndrome episode code N[N] Health, Superseded 01/10/2008

Scheduled admission date Health, Standard 01/03/2005

Adoption

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327208
<i>Registration status:</i>	Community services, Standard 01/03/2005 Health, Standard 01/03/2005
<i>Definition:</i>	Adoption is the legal process by which a person legally becomes a child of the adoptive parents and legally ceases to be a child of his/her existing parents.
<i>Context:</i>	Children and family services.

Collection and usage attributes

<i>Comments:</i>	The adoption order severs the legal relationship between the biological parents and the child. A new birth certificate is issued to the child bearing the name(s) of his/her adoptive parent(s) as the natural parent(s) and the new name of the child, where a change has occurred.
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare (AIHW)
<i>Origin:</i>	Adoptions Australia (AIHW). <i>Data collection standards, tables and counting rules</i> , 1998-99.

Relational attributes

<i>Related metadata references:</i>	Supersedes Adoption, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (12.3 KB)
<i>Metadata items which use this glossary item:</i>	Person (name) – family name, text X[X(39)] Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005 Person (name) – family name, text X[X(39)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005

Ambulatory care

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	354366
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Care provided to hospital patients who are not admitted to the hospital, such as patients of emergency departments and outpatient clinics . The term is also used to refer to care provided to patients of community-based (non-hospital) health care services.

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
<i>Origin:</i>	AIHW 2007. Mental health services in Australia 2004–05. AIHW cat. no. HSE 47. Canberra: AIHW (Mental Health Series no. 9).

Relational attributes

<i>Metadata items which use this glossary item:</i>	Health industry relevant organisation type code NNN Health, Standard 01/04/2009
	Health industry relevant organisation type code NNN Health, Superseded 01/04/2009
	Health or health related function code NNN Health, Standard 05/12/2007

Assistance with activities and participation

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327298
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 01/03/2005
<i>Definition:</i>	The help that a person receives or needs from another person, because of their difficulty in performing an activity or in participating in an area of life.
<i>Context:</i>	<p>'Assistance' is an important subset of Environmental factors that may facilitate (or hinder) the activities or participation of people with disability. Assistance is a key policy and service component in the disability and aged care services field in Australia. Further, it is recognised in the ICF as a crucial factor whose presence (or absence) must be noted when recording measures of functioning and disability.</p> <p>Recording measures of assistance needed or provided will provide further information about activity limitations.</p>

Collection and usage attributes

<i>Comments:</i>	<p>The concept can be used to describe aspects of the environment. Depending on which environment is present or being considered, the measure of assistance indicates what assistance is currently received (in the current or usual environment) and what would be needed (in an optimum environment). 'Need' more generally relates to environmental factors (including personal assistance, equipment and environmental modifications) that are present in an optimum environment but not in the person's current environment. That is, changes may be needed to environmental factors in order to improve a person's functioning and reduce their disability. While these ideas apply generally to 'Environmental Factors' and the related metadata item, Extent of environmental factors influence code [X]N, the concept of 'Assistance' focuses solely on the factor of personal assistance.</p> <p>Measures of assistance and need for assistance are under active development in a number of disciplines and service programs. Assistance may be measured in various ways, for instance in relation to duration, frequency and intensity of assistance. Related data elements are therefore likely to emerge in the future.</p> <p>This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).</p> <p>The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella</p>
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term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd Ed) ANN{.N[N]}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites

- WHO ICF website
<http://www.who.int/classifications/icf/en>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.html>

Relational attributes

Related metadata references:

Supersedes [Assistance with activities and participation, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf](#) (17.4 KB)

Metadata items which use this glossary item:

Activity difficulty level code (ICF 2001) N Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Average for the counting period

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	373642
<i>Registration status:</i>	Health, Standard 03/12/2008
<i>Definition:</i>	The average for the counting period is calculated by summing all the individual counts and dividing it by the number of periods for which a count was taken. For the reporting year, if a count was taken n times, the average is calculated as the SUM (Count1 + Count2 + ...Countn) DIVIDED by n. A reporting year is a financial year. It begins on 1 July and ends on 30 June of the following year.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Available bed – neonatal admitted care (Non-special-care), average number of beds N[NNN.N] Health, Standard 03/12/2008
	Available bed – overnight-stay admitted care, average number of beds N[NNN.N] Health, Standard 03/12/2008
	Available bed – residential mental health care, average number of beds N[NNN.N] Health, Standard 03/12/2008
	Available bed – same-day admitted care, average number of beds N[NNN.N] Health, Standard 03/12/2008

Birthweight

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327212
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>The first weight of the fetus or baby obtained after birth. The World Health Organization further defines the following categories:</p> <ul style="list-style-type: none">• extremely low birthweight: less than 1,000 grams (up to and including 999 grams),• very low birthweight: less than 1,500 grams (up to and including 1,499 grams),• low birthweight: less than 2,500 grams (up to and including 2,499 grams).
<i>Context:</i>	Perinatal

Collection and usage attributes

<i>Comments:</i>	<p>The definitions of low, very low, and extremely low birthweight do not constitute mutually exclusive categories. Below the set limits they are all-inclusive and therefore overlap (i.e. low includes very low and extremely low, while very low includes extremely low).</p> <p>For live births, birthweight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred. While statistical tabulations include 500 gram groupings for birthweight, weights should not be recorded in those groupings. The actual weight should be recorded to the degree of accuracy to which it is measured.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee
<i>Origin:</i>	International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Relational attributes

<i>Related metadata references:</i>	Supersedes Birthweight, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.0 KB)
<i>Metadata items which use this glossary item:</i>	Birth Health, Standard 01/03/2005
	Birth event – birth plurality, code N Health, Standard 01/03/2005
	Birth order Health, Standard 01/03/2005
	Birth status code N Health, Standard 01/03/2005
	Birth – birth weight, total grams NNNN Health, Standard 01/03/2005
	Female – number of previous pregnancies (spontaneous abortion), total NN Health, Standard 01/03/2005

Female – number of previous pregnancies (stillbirth), total N[N]
Health, Standard 01/03/2005

Pregnancy (last previous) – pregnancy completion date,
DDMMYYYY Health, Standard 01/03/2005

Blood pressure

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327210
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The pressure exerted by blood against the walls of the blood vessels - i.e. arteries, capillaries or veins.

Source and reference attributes

<i>Submitting organisation:</i>	Cardiovascular Data Working Group
<i>Origin:</i>	Australian Institute of Health and Welfare (AIHW) 2001. Heart, stroke and vascular diseases-Australian facts 2001. Canberra: AIHW. National Heart Foundation of Australia. National Stroke Foundation of Australia.

Relational attributes

<i>Related metadata references:</i>	Supersedes Blood pressure - concept, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005 .pdf (12.3 KB)
<i>Metadata items which use this glossary item:</i>	Adult – body mass index Health, Standard 01/03/2005 Person – blood pressure (diastolic) Health, Standard 01/03/2005 Person – blood pressure (diastolic) (measured), millimetres of mercury NN[N] Health, Standard 01/03/2005 Person – blood pressure (systolic) Health, Standard 01/03/2005 Person – blood pressure (systolic) (measured), millimetres of mercury NN[N] Health, Standard 01/03/2005 Person – hypertension treatment status (antihypertensive medication) Health, Superseded 21/09/2005 Person – hypertension treatment with antihypertensive medication indicator Health, Standard 21/09/2005

Body functions

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327294
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	Body functions are the physiological functions of body systems (including psychological functions).

Collection and usage attributes

<i>Guide for use:</i>	<p>Body functions are organised according to body systems. The term 'body' refers to the human organism as a whole and includes mental or psychological functions.</p> <p>Body functions are classified in neutral terms. To indicate that there is a problem with a body function requires the use of the impairment extent code to denote the extent or magnitude of the problem together with the body functions code</p>
<i>Comments:</i>	<p>This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).</p> <p>The ICF provides a framework for the description of human functioning and disability. The components of the ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]}.</p>

Source and reference attributes

<i>Origin:</i>	<p>World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO</p> <p>Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW</p>
<i>Reference documents:</i>	<p>Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites:</p> <ul style="list-style-type: none">• WHO ICF website http://www.who.int/classifications/icf/en/• Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

*Metadata items which use this
glossary item:*

Body function code (ICF 2001) AN[NNNN] Health, Standard
29/11/2006

Community services, Standard 16/10/2006

Functioning and Disability DSS Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Body structures

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327300
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	Body structures are anatomical parts of the body such as organs, limbs and their components.

Collection and usage attributes

Guide for use: Body structures are classified according to body systems. **Impairments of body structure** can involve anomaly, defect, loss and significant deviation. These are identified by use of the impairment extent, impairment location and impairment nature codes.

Comments: This glossary term is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd ed) ANN{.N[N]}.

Source and reference attributes

Origin: World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO
Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents: Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites

- WHO ICF website
<http://www.who.int/classifications/icf/en>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.html>

Relational attributes

Metadata items which use this glossary item: Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Carer consultant

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327330
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Carer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of carers and advocate for their needs.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (carer consultants) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}] Health, Standard 08/12/2004
	Establishment – recurrent expenditure (salaries and wages) (carer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Cessation of treatment episode for alcohol and other drugs

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327302
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Cessation of a treatment episode occurs when treatment is completed or discontinued; or there has been a change in the principal drug of concern, the main treatment type, or the treatment delivery setting.
<i>Context:</i>	Alcohol and other drug treatment services

Collection and usage attributes

<i>Guide for use:</i>	<p>A client is identified as ceasing a treatment episode if one or more of the following apply:</p> <ul style="list-style-type: none">• their treatment plan is completed,• they have had no contact with the treatment provider for a period of three months, nor is there a plan in place for further contact,• their principal drug of concern for alcohol and other drugs has changed,• their main treatment type for alcohol and other drugs has changed,• their treatment delivery setting for alcohol and other drugs has changed,• their treatment has ceased for other reasons (e.g. imprisoned, ceased treatment against advice, transferred to another service provider, died, etc.).
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Source and reference attributes

<i>Submitting organisation:</i>	Intergovernmental Committee on Drugs National Minimum Data Set working group
<i>Origin:</i>	

Relational attributes

<i>Related metadata references:</i>	Supersedes Cessation of treatment episode for alcohol and other drugs, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.8 KB)
<i>Metadata items which use this glossary item:</i>	Episode of treatment for alcohol and other drugs – treatment cessation date, DDMMYYYY Health, Standard 01/03/2005

Clinical intervention

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327220
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An intervention carried out to improve, maintain or assess the health of a person, in a clinical situation.
<i>Context:</i>	Health services: Information about the surgical and non-surgical interventions provides the basis for analysis of health service usage, especially in relation to specialised resources, for example theatres and equipment or human resources.

Collection and usage attributes

<i>Comments:</i>	Clinical interventions include invasive and non-invasive procedures, and cognitive interventions. Invasive: (a) Therapeutic interventions where there is a disruption of the epithelial lining generally, but not exclusively, with an implied closure of an incision (e.g. operations such as cholecystectomy or administration of a chemotherapeutic drug through a vascular access device); (b) Diagnostic interventions where an incision is required and/or a body cavity is entered (e.g. laparoscopy with/without biopsy, bone marrow aspiration). Non-invasive: Therapeutic or diagnostic interventions undertaken without disruption of an epithelial lining (e.g. lithotripsy, hyperbaric oxygenation; allied health interventions such as hydrotherapy; diagnostic interventions not requiring an incision or entry into a body part such as pelvic ultrasound, diagnostic imaging). Cognitive: An intervention which requires cognitive skills such as evaluating, advising, planning (e.g. dietary education, physiotherapy assessment, crisis intervention, bereavement counselling).
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Source and reference attributes

<i>Submitting organisation:</i>	National Health Data Committee.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Clinical intervention, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.9 KB)
<i>Metadata items which use this glossary item:</i>	Episode of admitted patient care – procedure Health, Standard 01/03/2005

Clinical review

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327214
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	The examination of a patient by a clinician after the patient has been added to the elective care waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician.
<i>Context:</i>	Admitted patient care.

Source and reference attributes

<i>Submitting organisation:</i>	Hospital Access Program Waiting List Working Group National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Clinical review, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.0 KB)
<i>Metadata items which use this glossary item:</i>	Elective care waiting list episode – category reassignment date Health, Standard 01/03/2005 Elective care waiting list episode – category reassignment date, DDMMYYYY Health, Standard 01/03/2005 Elective surgery waiting list episode – clinical urgency, code N Health, Standard 01/03/2005 Elective surgery waiting list episode – patient listing status, readiness for care code N Health, Standard 01/03/2005

Compensable patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327420
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>A compensable patient is a person who:</p> <ul style="list-style-type: none">• is entitled to claim damages under Motor Vehicle Third Party insurance or• is entitled to claim damages under worker's compensation or• has an entitlement to claim under public liability or common law damages.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Patient – compensable status, code N Health, Standard 01/03/2005
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Consultant psychiatrist

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327332
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists), average N[NNN{.N}] Health, Standard 08/12/2004
	Establishment – recurrent expenditure (salaries and wages) (consultant psychiatrists and psychiatrists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Consumer consultant

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327336
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Consumer consultants are persons employed (or engaged via contract) on a part-time or full-time paid basis to represent the interests of consumers and advocate for their needs.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (consumer consultants) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}] Health, Standard 08/12/2004
	Establishment – recurrent expenditure (salaries and wages) (consumer consultants) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Diagnosis

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327224
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A diagnosis is the decision reached, after assessment, of the nature and identity of the disease or condition of a patient or recipient of residential care (resident).
<i>Context:</i>	Health services: Diagnostic information provides the basis for analysis of health service usage, epidemiological studies and monitoring of specific disease entities.

Collection and usage attributes

<i>Comments:</i>	Classification systems which enable the allocation of a code to the diagnostic information: <ul style="list-style-type: none">• International Classification of Diseases, Tenth Revision, Australian Modification (ICD-10-AM),• British Paediatric Association Classification of Diseases,• North America Nursing Diagnosis Association,• International Classification of Primary Care International,• Classification of Impairments, Disabilities and Handicaps,• International Classification of Functioning.
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Source and reference attributes

<i>Submitting organisation:</i>	National Data Standards Committee
<i>Origin:</i>	

Relational attributes

<i>Related metadata references:</i>	Supersedes Diagnosis, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.7 KB)
<i>Metadata items which use this glossary item:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009 Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009 Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009 Person – visual acuity (left eye), code NN Health, Standard 01/03/2005

Person – visual acuity (right eye), code NN Health, Standard
01/03/2005

Diagnostic and health professional

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327164
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Qualified staff (other than qualified medical and nursing staff) engaged in duties of a diagnostic, professional or technical nature (but also including diagnostic and health professionals whose duties are primarily or partly of an administrative nature). This category includes all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (diagnostic and health professionals) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}] Health, Standard 01/03/2005
	Establishment – recurrent expenditure (salaries and wages) (diagnostic and health professionals) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Disability

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327304
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 01/03/2005 Housing assistance, Standard 01/03/2005
<i>Definition:</i>	<p>Disability is the umbrella term for any or all of: an impairment of body structure or function, a limitation in activities, or a restriction in participation.</p> <p>Disability is a multi-dimensional and complex concept and is conceived as a dynamic interaction between health conditions and environmental and personal factors (WHO 2001:6).</p>

Collection and usage attributes

<i>Comments:</i>	<p>Many different 'definitions' of disability are used in Australia, both in administrative data collections and in Acts of Parliament. The consistent identification of disability in national data collections has been recommended in a number of reports, for instance to enable:</p> <ul style="list-style-type: none">• the monitoring of access to generic services by people with disability;• the collection of more consistent data on disability support and related services, including data on service use by different groups;• population data and service data to be related, thereby improving the nation's analytical capacity in relation to the need for and supply of services; and• improved understanding of the relationship between disability, health conditions and other health outcomes. <p>Defining disability makes it possible to determine the number of people who are accessing services, both disability specific and generic, and also those with a disability in the general population with unmet need. Better definition of disability will aid better targeting of resources to those in need.</p> <p>Disability arises from the interaction between health conditions and environmental and personal factors. A health condition may be a disease (acute or chronic), disorder, injury or trauma. Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. Personal factors relate to the individual, such as age, sex and Indigenous status.</p> <p>The concept 'Disability' can be described using a combination of related metadata items as building blocks.</p> <p>The metadata items selected may vary depending on the definition of disability used. For example, in hospital rehabilitation, the focus may be on the impairment and activity</p>
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dimensions and in community-based care the focus may be primarily on participation. Some applications may require a broad scope for inclusion (e.g. discrimination legislation). Data collections relating to services will select combinations of the data elements, which best reflect the eligibility criteria for the service.

This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd Edn) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd Edn) ANN{.N[N]}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites

- WHO ICF website
<http://www.who.int/classifications/icf/en>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.html>

Relational attributes

Metadata items which use this glossary item:

Activities and participation code (ICF 2001) AN[NNN] Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Activity difficulty level code (ICF 2001) N Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Activity need for assistance code N Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Body function code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Body structure code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Environmental factor code (ICF 2001) AN[NNN] Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Extent of environmental factors influence code (ICF 2001) [X]N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Goal of care code NN Health, Standard 01/03/2005

Impairment extent code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Impairment location code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Impairment nature code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Participation extent code (ICF 2001) N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Participation satisfaction level code N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Domestic and other staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327168
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Domestic staff are staff engaged in the provision of food and cleaning services including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded. This category also includes all staff not elsewhere included (primarily maintenance staff, trades people and gardening staff).

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (domestic and other staff) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}] Health, Standard 01/03/2005
	Establishment – recurrent expenditure (salaries and wages) (domestic and other staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Elective surgery

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327226
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule book, with the exclusion of specific procedures frequently done by non-surgical clinicians.
<i>Context:</i>	Admitted patient care.

Source and reference attributes

<i>Submitting organisation:</i>	Hospital access program waiting list working group
<i>Origin:</i>	The National Health Data Committee.

Relational attributes

<i>Related metadata references:</i>	Supersedes Elective surgery, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.7 KB)
<i>Metadata items which use this glossary item:</i>	Coronary artery disease intervention code N Health, Standard 01/03/2005 Elective surgery code NN Health, Standard 01/03/2005

Emergency department

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327158
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Emergency department visit type code N Health, Standard 01/03/2005
	Establishment (public psychiatric or alcohol and drug hospital) – number of group session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN] Health, Standard 01/03/2005
	Establishment (public psychiatric or alcohol and drug hospital) – number of individual session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN] Health, Standard 01/03/2005
	Health or health related function code NNN Health, Standard 05/12/2007
	Health service event – presentation date, DDMMYYYY Health, Standard 01/03/2005
	Health service event – presentation time, hhmm Health, Standard 01/03/2005
	Health service event – service commencement date, DDMMYYYY Health, Superseded 07/12/2005
	Non-admitted patient emergency department service episode Health, Standard 01/03/2005
	Non-admitted patient service event Health, Standard 01/03/2005
	Triage Health, Retired 07/12/2005
	Triage Health, Standard 24/03/2006

Emergency department—public hospital

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327228
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>The dedicated area in a public hospital that is organised and administered to provide emergency care to those in the community who perceive the need for or are in need of acute or urgent care.</p> <p>The emergency department must be part of a hospital and be licensed or otherwise recognised as an emergency department by the appropriate state or territory authority.</p> <p>An emergency department provides triage, assessment, care and/or treatment for patients suffering from medical condition(s) and/or injury.</p>
<i>Context:</i>	Emergency department care.

Collection and usage attributes

<i>Comments:</i>	<p>This glossary term has been defined to support the National Minimum Data Set - Non-admitted patient emergency department care. It is not intended as a definitive statement of the role or purpose of an emergency department.</p> <p>The national definition of an emergency department and the care that is provided in an emergency department is characterised by jurisdictional and local differences. For example, there is no national agreement on the identification and classification of emergency department-related settings such as observation units, short stays units, or the use of 'admitted patient beds' located in an emergency department setting.</p> <p>Emergency department is therefore defined as a concept, and not necessarily as a physical premises, setting or site.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National reference group for non-admitted patient data development, 2001/02.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Emergency department - public hospital, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
<i>Metadata items which use this glossary item:</i>	Health or health related function code NNN Health, Standard 05/12/2007

Enrolled nurse

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327160
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Enrolled nurses are second level nurses who are enrolled in all states except Victoria where they are registered by the state registration board to practise in this capacity. Includes general enrolled nurse and specialist enrolled nurse (e.g. mothercraft nurses in some states).

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (enrolled nurses) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}] Health, Standard 01/03/2005
	Establishment – recurrent expenditure (salaries and wages) (enrolled nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Environmental factors

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327286
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.
<i>Context:</i>	Environmental factors are external to the individual and can have a positive or negative influence on a person's participation as a member of society, on performance of activities, or on a person's body function or structure.

Collection and usage attributes

<i>Guide for use:</i>	<p>In the ICF classification scheme Environmental factors are organised to focus on two different levels, individual and societal. Environmental factors interact with the Body structures/Body functions and Activities and participation components.</p> <p>A person's functioning and disability is conceived as the dynamic interaction between health conditions and environmental and personal factors.</p>
<i>Comments:</i>	<p>This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).</p> <p>The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}.</p>

Source and reference attributes

<i>Origin:</i>	World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
<i>Reference documents:</i>	Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites

- WHO ICF website
<http://www.who.int/classifications/icf/en>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.html>

Relational attributes

*Metadata items which use this
glossary item:*

Extent of environmental factors influence code (ICF 2001) [X]N
Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Person – extent of environmental factor influence, code (ICF 2001)
[X]N Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Episode of acute care

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>Synonymous names:</i>	Acute care episode for admitted patients
<i>METeOR identifier:</i>	327230
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>An episode of acute care for an admitted patient is one in which the principal clinical intent is to do one or more of the following:</p> <ul style="list-style-type: none">• 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 illness or injury,• protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal functions,• perform diagnostic or therapeutic procedures.
<i>Context:</i>	Admitted patient care.

Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Acute care episode for admitted patients, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.2 KB)
<i>Metadata items which use this glossary item:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005
	Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006
	Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008
	Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009
	Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009
	Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Episode of residential care end

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327194
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>Episode of residential care end is the administrative process by which a residential care service either records:</p> <p>Formal episode of residential care end:</p> <ul style="list-style-type: none">• the formal end of residential care and accommodation of a resident,• the end of residential care and accommodation of a resident who has commenced leave where there is no intention that the resident returns to residential care within seven days, or; <p>Statistical episode of residential care end:</p> <ul style="list-style-type: none">• the end of the reference period.
<i>Context:</i>	Specialised mental health services (Residential mental health care).

Relational attributes

<i>Related metadata references:</i>	Supersedes Episode of residential care end, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.0 KB)
<i>Metadata items which use this glossary item:</i>	Episode of residential care – episode end date Health, Standard 01/03/2005
	Episode of residential care – episode end date, DDMMYYYY Health, Standard 01/03/2005
	Episode of residential care – episode end mode Health, Standard 01/03/2005
	Episode of residential care – episode end mode, code N Health, Standard 01/03/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006
	Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008
	Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009
	Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005
	Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Residential mental health care NMDS 2007-2008 Health,
Superseded 05/02/2008

Residential mental health care NMDS 2008-2009 Health,
Superseded 04/02/2009

Residential mental health care NMDS 2009-2010 Health,
Superseded 05/01/2010

Residential mental health care NMDS 2010-2011 Health, Standard
05/01/2010

Episode of residential care start

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327192
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>The process whereby the residential care service accepts responsibility for the Resident's residential care and accommodation. Episode of residential care start is the administrative process by which a residential care service records either:</p> <p>Formal episode of residential care start:</p> <ul style="list-style-type: none">• the start of residential care and accommodation of a resident, and,• the unplanned return from leave of a resident (when there had been no intention of returning to overnight residential care within seven days); <p>or Statistical episode of residential care start:</p> <ul style="list-style-type: none">• the start of a reference period for a resident continuing their residential care and accommodation, from the previous reference period.
<i>Context:</i>	Specialised mental health services (Residential mental health care).

Relational attributes

<i>Related metadata references:</i>	Supersedes Episode of residential care start, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (13.3 KB)
<i>Metadata items which use this glossary item:</i>	Episode of residential care – episode start date Health, Standard 01/03/2005
	Episode of residential care – episode start date, DDMMYYYY Health, Standard 01/03/2005
	Episode of residential care – episode start mode Health, Standard 01/03/2005
	Episode of residential care – episode start mode, code N Health, Standard 01/03/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 07/12/2005
	Mental health establishments NMDS 2005-2006 Health, Superseded 21/03/2006
	Mental health establishments NMDS 2006-2007 Health, Superseded 23/10/2006
	Mental health establishments NMDS 2007-2008 Health, Superseded 05/02/2008
	Mental health establishments NMDS 2009-2010 Health, Superseded 02/12/2009

Residential mental health care NMDS 2005-2006 Health,
Superseded 07/12/2005

Residential mental health care NMDS 2006-2007 Health,
Superseded 23/10/2006

Residential mental health care NMDS 2007-2008 Health,
Superseded 05/02/2008

Residential mental health care NMDS 2008-2009 Health,
Superseded 04/02/2009

Residential mental health care NMDS 2009-2010 Health,
Superseded 05/01/2010

Residential mental health care NMDS 2010-2011 Health, Standard
05/01/2010

Establishment based student nurse

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327186
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Student nurses are persons employed by the establishment currently studying in years one to three of a three year certificate course. This includes any person commencing or undertaking a three year course of training leading to registration as a nurse by the state or territory registration board. This includes full time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post basic training courses.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – recurrent expenditure (salaries and wages) (student nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
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Family

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	351499
<i>Registration status:</i>	Community services, Standard 31/08/2007 Health, Standard 31/08/2007
<i>Definition:</i>	Two or more people related by blood, marriage (registered or de facto), adoption, step or fostering who may or may not live together.

Source and reference attributes

<i>Reference documents:</i>	Australian Bureau of Statistics. Family, household and income unit variables. Cat No. 1286.0. Canberra: ABS. Viewed on 01/03/2007.
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Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – number of group session occasions of service for non-admitted patients Health, Standard 01/03/2005 Informal carer Health, Standard 04/07/2007 Community services, Standard 03/05/2007 Person (name) – family name, text X[X(39)] Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005 Person (name) – family name, text X[X(39)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005 Person (name) – given name Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 01/08/2005 Person (name) – given name, text [X(40)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005 Person – informal carer existence indicator, code N Health, Standard 04/07/2007 Community services, Standard 29/04/2006 Person (name) – given name, text [X(40)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005
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Metadata items which use this glossary item:

Functioning

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327292
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 01/03/2005
<i>Definition:</i>	Functioning is the umbrella term for any or all of: body functions, body structures, activities and participation. Functioning is a multidimensional concept denoting the neutral aspects of the interaction between an individual (with a health condition) and that individual's environmental and personal factors.
<i>Context:</i>	An individual's functioning in a specific domain is an interaction or complex relationship between health conditions and environmental and personal factors. Functioning and disability are dual concepts in a broad framework, with disability focussing on the more negative aspects of this interaction.

Collection and usage attributes

<i>Comments:</i>	<p>This glossary term is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).</p> <p>The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}.</p>
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Source and reference attributes

<i>Origin:</i>	World Health Organization (WHO) 2001. ICF: International Classification of Functioning, Disability and Health Geneva: WHO Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
<i>Reference documents:</i>	Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites <ul style="list-style-type: none">• WHO ICF website http://www.who.int/classifications/icf/en• Australian Collaborating Centre ICF website http://www.aihw.gov.au/disability/icf/index.html

Relational attributes

Related metadata references:

Supersedes [Functioning, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf](#) (15.4 KB)

Metadata items which use this glossary item:

Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Geographic indicator

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327306
<i>Registration status:</i>	Health, Standard 01/03/2005 Community services, Standard 01/03/2005
<i>Definition:</i>	<p>A classification scheme that divides an area into mutually exclusive sub-areas based on geographic location.</p> <p>Some geographic indicators are:</p> <ul style="list-style-type: none">• Australian Standard Geographical Classification (ASGC, ABS Cat No. 1216.0),• administrative regions,• electorates,• Accessibility/Remoteness Index of Australia (ARIA),• Rural, Remote and Metropolitan Area Classification (RRMA), and• country.
<i>Context:</i>	To enable the analysis of data on a geographical basis. Facilitates analysis of service provision in relation to demographic and other characteristics of the population of a geographic area.

Collection and usage attributes

<i>Comments:</i>	Person (address) – Australian postcode (Postcode datafile), code [NNNN] is not included in the above listing, as it is, strictly speaking, not a geographic indicator. Sometimes postcodes are used in the analysis of data on a geographical basis, which involves a conversion to Statistical Local Area (an Australian Bureau of Statistics geographical structure). This conversion results in some inaccuracy of information. However, in some data sets Person (address) – Australian postcode (Postcode datafile), code [NNNN]; is the only geographic identifier, therefore the use of other more accurate indicators (for example, conversion from address line to Statistical Local Area) is not always possible.
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Source and reference attributes

<i>Origin:</i>	Australian Institute of Health and Welfare.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Geographic indicator, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (14.0 KB)
<i>Metadata items which use this glossary item:</i>	Australian state/territory identifier Health, Standard 01/03/2005 Community services, Standard 01/03/2005 Housing assistance, Standard 22/10/2005

Homeless

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327244
<i>Registration status:</i>	Community services, Standard 01/03/2005 Health, Standard 01/03/2005
<i>Definition:</i>	<p>A person is homeless if he or she does not have access to safe, secure and stable housing. Hence even if a person has a physical home, they would be considered homeless if:</p> <ul style="list-style-type: none">• they were not safe at home,• they had no legal right to continued occupation of their home (security of tenure), or• the home lacked the amenities or resources necessary for living.
<i>Context:</i>	<p>There is considerable concern over the number of homeless people in society and the assistance they require. Collecting information on homeless people is problematic, as the concept of 'homelessness' encompasses elements in addition to whether, someone resides in a dwelling or not.</p>

Source and reference attributes

<i>Submitting organisation:</i>	SAAP National Data Collection Agency Australian Institute of Health and Welfare
<i>Origin:</i>	SAAP (Supported Accommodation Assistance Program) National Data Collection Agency 2001. <i>National Data Collection Data Dictionary</i> . Version 2. Unpublished

Relational attributes

<i>Related metadata references:</i>	Supersedes Homelessness, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (13.0 KB)
<i>Metadata items which use this glossary item:</i>	Person (address) – suburb/town/locality name, text [A(50)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005

Hospital boarder

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>Synonymous names:</i>	Boarder
<i>METeOR identifier:</i>	327242
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.
<i>Context:</i>	Admitted patient care.

Collection and usage attributes

<i>Guide for use:</i>	<p>A boarder thus defined is not admitted to the hospital. However, a hospital may register a boarder.</p> <p>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 a qualified or unqualified day.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National Health Data Committee.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Hospital boarder, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.1 KB)
<i>Metadata items which use this glossary item:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005
	Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006
	Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008
	Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009
	Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009
	Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009
	Hospital service Health, Standard 01/03/2005

Hospital-in-the-home care

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327308
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Provision of care to hospital admitted patients in their place of residence as a substitute for hospital accommodation. Place of residence may be permanent or temporary.
<i>Context:</i>	Admitted patient care.

Collection and usage attributes

<i>Comments:</i>	<p>The criteria for inclusion as hospital-in-the-home include but are not limited to:</p> <ul style="list-style-type: none">• without hospital in the home care being available patients would be accommodated in the hospital,• the treatment forms all or part of an episode of care for an admitted patient (as defined in the metadata item Admitted patient),• the hospital medical record is maintained for the patient,• there is adequate provision for crisis care. <p>Selection criteria for the assessment of suitable patients include but are not limited to:</p> <ul style="list-style-type: none">• the hospital deems the patient requires health care professionals funded by the hospital to take an active part in their treatment,• the patient does not require continuous 24 hour assessment, treatment or observation,• the patient agrees to this form of treatment,• the patient's place of residence is safe and has carer support available,• the patient's place of residence is accessible for crisis care,• the patient's place of residence has adequate communication facilities and access to transportation.
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Hospital-in-the-home care, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
<i>Metadata items which use this glossary item:</i>	Admitted patient Health, Standard 01/03/2005 Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded
05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded
04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded
22/12/2009

Admitted patient care NMDS 2010-2011 Health, Standard
22/12/2009

Available bed – overnight-stay admitted care, average number of
beds N[NNN.N] Health, Standard 03/12/2008

Episode of admitted patient care Health, Standard 01/03/2005

Episode of admitted patient care – number of days of hospital-in-
the-home care Health, Standard 01/03/2005

Episode of admitted patient care – number of days of hospital-in-
the-home care, total {N[NN]} Health, Standard 01/03/2005

Episode of care (community setting) – first service delivery date,
DDMMYYYY Health, Standard 01/03/2005

Health or health related function code NNN Health, Standard
05/12/2007

Number of days of hospital-in-the-home care Health, Standard
01/03/2005

Occupied bed – hospital in the home care, average number of
beds N[NNN.N] Health, Standard 24/03/2009

Impairment of body structure

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327288
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 16/10/2006
<i>Definition:</i>	Impairments of body structure are problems in body structure such as a loss or significant departure from population standards or averages.
<i>Context:</i>	Body structures are classified in ICF in neutral terms. To indicate that there is a problem with a body structure requires the use of the body structures code for the structure affected and the impairment extent code to denote the extent or magnitude of the problem. The impairment nature and impairment location codes can be used to expand the description of a problem with a body structure.

Source and reference attributes

<i>Origin:</i>	World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW
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Comments

This glossary term is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).

The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example, as Episode of care principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}.

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites

- WHO ICF website
<http://www.who.int/classifications/icf/en>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.html>

Relational attributes

Metadata items which use this glossary item:

Body structures Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Impairment nature code (ICF 2001) N Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Person – body structure, code (ICF 2001) AN[NNNN] Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Informal carer

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	353420
<i>Registration status:</i>	Health, Standard 04/07/2007 Community services, Standard 03/05/2007
<i>Definition:</i>	An informal carer includes any person, such as a family member, friend or neighbour, who is giving regular, ongoing assistance to another person.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Person – informal carer existence indicator Health, Standard 04/07/2007 Community services, Standard 02/05/2006 Person – informal carer existence indicator, code N Health, Standard 04/07/2007 Community services, Standard 29/04/2006
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Intensive care unit

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327234
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	An intensive care unit (ICU) is a designated ward of a hospital which is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.
<i>Context:</i>	Admitted patient care.

Collection and usage attributes

<i>Comments:</i>	<p>There are five different types and levels of ICU defined according to three main criteria: the nature of the facility, the care process and the clinical standards and staffing requirements. All levels and types of ICU must be separate and self-contained facilities in hospitals and, for clinical standards and staffing requirements, substantially conform to relevant guidelines of the Australian Council on Healthcare Standards (ACHS). The five types of ICU are briefly described below:</p> <ul style="list-style-type: none">• Adult intensive care unit, level 3: 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.• Adult intensive care unit, level 2: must be capable of providing complex, multisystem life support and be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for a period of at least several days, or for longer periods in remote areas or care of a similar nature (see ACHS guidelines).• Adult intensive care unit, level 1: must be capable of providing basic multisystem life support usually for less than a 24-hour period. It must be capable of providing mechanical ventilation and simple invasive cardiovascular monitoring for a period of at least several hours; or care of a similar nature.• Paediatric intensive care unit: must be capable of providing complex, multisystem life support for an indefinite period; be a tertiary referral centre for children needing intensive care;
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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.

- Neonatal intensive care unit, level 3: must be capable of providing complex, multisystem life support for an indefinite period. It must be capable of providing mechanical ventilation and invasive cardiovascular monitoring; or care of a similar nature. Definitions for high-dependency unit and coronary care unit are under development.

Source and reference attributes

Submitting organisation: National Intensive Care Working Group.

Relational attributes

Related metadata references: Supersedes [Intensive care unit, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf](#) (15.9 KB)

Metadata items which use this glossary item:

Episode of admitted patient care – length of stay (special/neonatal intensive care), total days N[NN] Health, Standard 01/03/2005

Establishment – gross capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Establishment – gross capital expenditure (major medical equipment) Health, Standard 01/03/2005

Establishment – net capital expenditure (accrual accounting) (major medical equipment) Health, Standard 01/03/2005

Health establishment accrual accounting capital expenditure code N Health, Standard 01/03/2005

Leave period

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327156
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Leave period is a temporary absence from hospital, with medical approval for a period no greater than seven consecutive days.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Episode of admitted patient care – number of leave periods Health, Standard 01/03/2005
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Live birth

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327248
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A live birth is defined by the World Health Organization to be the complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.
<i>Context:</i>	Perinatal Source document: <i>International Classification of Diseases and Related Health Problems</i> , 10th Revision, Vol 1, World Health Organization, 1992.

Source and reference attributes

<i>Submitting organisation:</i>	National Perinatal Data Development Committee National Perinatal Data Advisory Committee.
<i>Origin:</i>	National Health Data Committee

Relational attributes

<i>Related metadata references:</i>	Supersedes Live birth, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.8 KB)
<i>Metadata items which use this glossary item:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009 Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009 Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009 Birth event – birth plurality, code N Health, Standard 01/03/2005 Birth – birth weight, total grams NNNN Health, Standard 01/03/2005 Female – number of previous pregnancies (live birth), total NN Health, Standard 01/03/2005

Neonate

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327284
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A live birth who is less than 28 days old.
<i>Context:</i>	Perinatal.

Collection and usage attributes

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

<i>Submitting organisation:</i>	National Perinatal Data Development Committee National Perinatal Data Advisory Committee
<i>Origin:</i>	National Health Data Committee International Classification of Diseases and Related Health Problems, 10th Revision, WHO, 1992

Relational attributes

<i>Related metadata references:</i>	Supersedes Neonate, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.1 KB)
<i>Metadata items which use this glossary item:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006 Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008 Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009 Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009 Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009

Newborn qualification status

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327254
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Qualification status indicates whether the patient day within a newborn episode of care is either qualified or unqualified.
<i>Context:</i>	Admitted patient care: To provide accurate information on care provided in newborn episodes of care through exclusion of unqualified patient days.

Collection and usage attributes

<i>Guide for use:</i>	<p>A newborn qualification status is assigned to each patient day within a newborn episode of care.</p> <p>A newborn patient day is qualified if the infant meets at least one of the following criteria:</p> <ul style="list-style-type: none">• is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient,• is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Minister for the purpose of the provision of special care,• is admitted to, or remains in hospital without its mother. <p>A newborn patient day is unqualified if the infant does not meet any of the above criteria.</p> <p>The day on which a change in qualification status occurs is counted as a day of the new qualification status.</p> <p>If there is more than one qualification status in a single day, the day is counted as a day of the final qualification status for that day.</p>
<i>Comments:</i>	<p>All babies born in hospital are admitted patients.</p> <p>The newborn baby's qualified days are eligible for health insurance benefits purposes and the patient day count under the Australian Health Care Agreements. In this context, newborn qualified days are equivalent to acute days and may be denoted as such.</p> <p>The days when a newborn baby does not meet these criteria are classified as unqualified (if they are nine days old or less) and should not be counted as patient days under the Australian Health Care Agreements and are not eligible for health insurance benefit purposes.</p>

Relational attributes

<i>Related metadata references:</i>	Supersedes Newborn qualification status, version 2, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (15.1 KB)
<i>Metadata items which use this glossary item:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded
05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded
04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded
22/12/2009

Admitted patient care NMDS 2010-2011 Health, Standard
22/12/2009

Date of change to qualification status Health, Standard
01/03/2005

Episode of admitted patient care (newborn) – date of change to
qualification status Health, Standard 01/03/2005

Episode of admitted patient care (newborn) – date of change to
qualification status, DDMMYYYY Health, Standard 01/03/2005

Hospital care type code N[N].N Health, Standard 01/03/2005

Number of qualified days Health, Standard 01/03/2005

Non-financial asset

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327196
<i>Registration status:</i>	Health, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
<i>Definition:</i>	A non-financial asset is an entity functioning as a store of value, over which ownership may be derived over a period of time, and which is not a financial asset.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Gross capital expenditure Health, Standard 01/03/2005 Housing assistance, Standard 10/02/2006
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Occupational Therapist

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327340
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Occupational Therapists.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (occupational therapists) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (occupational therapists), average N[NNN{.N}] Health, Standard 08/12/2004
	Establishment – recurrent expenditure (salaries and wages) (occupational therapists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Ophthalmologist

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327364
<i>Registration status:</i>	Health, Standard 21/09/2005
<i>Definition:</i>	An ophthalmologist is a physician specialising in diagnosing and prescribing treatment for defects, injuries and diseases of the eye, and who is skilled at delicate eye surgery.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Person – referral to ophthalmologist indicator Health, Standard 21/09/2005
	Person – referral to ophthalmologist indicator (last 12 months), code N Health, Standard 21/09/2005

Organ procurement—posthumous

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327258
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Organ procurement - posthumous is an activity undertaken by hospitals in which human tissue is procured for the purpose of transplantation from a donor who has been declared brain dead.
<i>Context:</i>	Hospital activity.

Collection and usage attributes

<i>Comments:</i>	<p>This activity is not regarded as care or treatment of an admitted patient, but is registered by the hospital. Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, are recorded in accordance with the Australian coding standards.</p> <p>Declarations of brain death are made in accordance with relevant state/territory legislation.</p>
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Relational attributes

<i>Related metadata references:</i>	Supersedes Organ procurement - posthumous, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (12.1 KB)
<i>Metadata items which use this glossary item:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005
	Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006
	Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008
	Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009
	Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009
	Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009
	Hospital service—care type Health, Standard 01/03/2005
	Hospital service—care type, code N[N].N Health, Standard 01/03/2005

Other diagnostic and health professional

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327338
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff).

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (other diagnostic and health professionals) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (other diagnostic and health professionals), average N[NNN{.N}] Health, Standard 08/12/2004
	Establishment – recurrent expenditure (salaries and wages) (other diagnostic and health professionals) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Other medical officer

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327342
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	A person who is a medical officer employed or engaged by the organisation who is not registered as a psychiatrist within the state or territory nor is a formal trainee within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (other medical officers) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (other medical officers), average N[NNN{.N}] Health, Standard 08/12/2004
	Establishment – recurrent expenditure (salaries and wages) (other medical officers) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Other personal care staff

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327162
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	This category includes attendants, assistants or home assistance, home companions, family aides, ward helpers, warders, orderlies, ward assistants and nursing assistants engaged primarily in the provision of personal care to patients or residents, who are not formally qualified or undergoing training in nursing or allied health professions.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (other personal care staff) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}] Health, Standard 01/03/2005
	Establishment – recurrent expenditure (salaries and wages) (other personal care staff) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Outpatient clinic service

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	336980
<i>Registration status:</i>	Health, Standard 04/07/2007
<i>Definition:</i>	An examination, consultation, treatment or other service provided in an outpatient setting in a specialty unit or under an organisational arrangement administered by a hospital.
<i>Context:</i>	Non-admitted patient service activity, excluding emergency department. Does not include services provided through community health settings (such as community and child health centre).

Collection and usage attributes

<i>Guide for use:</i>	This glossary item relates to activity of a clinic. See the Outpatient care National Minimum Data Set Scope statement for observations about use of the term 'clinic' in hospitals.
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Source and reference attributes

<i>Submitting organisation:</i>	Non-admitted patient NMDS Development Working Party, 2006
<i>Origin:</i>	NCCH consultants report to Outpatients NMDS Development Working Group, September 2004.

Relational attributes

<i>Related metadata references:</i>	Supersedes Outpatient clinic service Health, Superseded 04/07/2007
<i>Metadata items which use this glossary item:</i>	Health or health related function code NNN Health, Standard 05/12/2007 Outpatient clinic type Health, Standard 04/05/2005

Overnight-stay patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327256
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A patient who, following a clinical decision, receives hospital treatment for a minimum of one night, i.e. who is admitted to and separated from the hospital on different dates.
<i>Context:</i>	Admitted patient care

Collection and usage attributes

<i>Comments:</i>	<p>An overnight-stay patient in one hospital cannot be concurrently an overnight-stay patient in another hospital, unless they are receiving contracted care. If not under a hospital contract, a patient must be separated from one hospital and admitted to the other hospital on each occasion of transfer.</p> <p>An overnight-stay patient of a hospital (originating hospital) who attends another hospital (the destination hospital) on a contracted basis is to be regarded by the originating hospital as an overnight-stay patient, as if the patient had not left for contracted hospital care.</p> <p>Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient is regarded as part of the overnight episode.</p> <p>A non-admitted (emergency/outpatient) service provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.</p> <p>Patients who leave of their own accord, die or are transferred on their first day in hospital are not overnight-stay patients.</p>
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Overnight-stay patient, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.1 KB)
<i>Metadata items which use this glossary item:</i>	Episode of admitted patient care – length of stay (excluding leave days) Health, Standard 01/03/2005 Establishment – number of patient days, total N[N(7)] Health, Standard 01/03/2005

Palliative care agency

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	356474
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	A palliative care agency is an organisation or organisational sub-unit that provides specialist palliative care and receives Australian or state/territory government funding (including Australian Health Care Agreement funding), or does not provide specialist palliative care but receives Australian Health Care Agreement funding to provide care incorporating a palliative approach or palliative care-related services.

Collection and usage attributes

<i>Guide for use:</i>	<p>'Specialist palliative care' services work substantively in the area of palliative care they would usually provide consultative and ongoing care for people with a life-limiting illness and provide support for primary carers and family members, provide multi-disciplinary healthcare and employ healthcare professionals who have qualifications or experience in palliative care.</p> <p>Care may be provided in admitted patient and/or community settings. Community settings include outpatient facilities.</p> <p>A palliative care agency represents the level of an organisation that is responsible for the care provided to clients (i.e. care coordination) regardless of whether the agency provides this care directly or purchases the care on behalf of clients.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Palliative Care Intergovernmental Forum
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Relational attributes

<i>Metadata items which use this glossary item:</i>	<p>Palliative care performance indicators DSS Health, Standard 05/12/2007</p> <p>Service provider organisation – level of service delivery, palliative care code N Health, Standard 05/12/2007</p> <p>Service provider organisation – service delivery setting, palliative care agency code N Health, Standard 05/12/2007</p>
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Participation—functioning, disability and health

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>Synonymous names:</i>	Participation
<i>METeOR identifier:</i>	327312
<i>Registration status:</i>	Health, Standard 29/11/2006 Community services, Standard 06/06/2005
<i>Definition:</i>	In the context of health, participation is involvement in a life situation.
<i>Context:</i>	<p>Involvement refers to the lived experience of people in the actual context in which they live. This context includes 'Environmental Factors' - all aspects of the physical, social and attitudinal world.</p> <p>The individual's degree of involvement can be reflected by this glossary item when combined with Participation extent code (ICF 2001) X and Participation satisfaction level code X.</p> <p>'Activities and participation' is one of three components that define the concept 'Disability', along with 'Body functions and structures' and 'Environmental factors'. 'Activities and participation' is also encompassed within the concept 'Functioning'.</p> <p>The concept 'Participation', as defined here and as measured in the metadata items Participation extent code (ICF 2001) X and Participation satisfaction level code X, may be relevant to people and human services not related to disability.</p>

Collection and usage attributes

<i>Comments:</i>	<p>Participation restrictions are problems an individual may experience in involvement in life situations.</p> <p>In time, a related and more generic data element may be developed. In the meantime, the addition of 'functioning, disability and health' to the name of this glossary item indicates that the current concept is based on the concept and framework developed by World Health Organization to assist in the classification and description of functioning and disability, as contained in the International Classification of Functioning, Disability and Health (ICF).</p> <p>This glossary item is based on the International Classification of Functioning, Disability and Health (ICF). The ICF was endorsed by the World Health Assembly in 2001 as a reference member of the WHO Family of International Classifications and of the Australian Family of Health and Related Classifications (endorsed by the National Health Information Management Group in 2002).</p> <p>The ICF provides a framework for the description of human functioning and disability. The components of ICF are defined in relation to a health condition. A health condition is an 'umbrella term for disease (acute or chronic), disorder, injury or trauma' (WHO 2001). A health condition may be recorded, for example,</p>
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as Episode of care principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} and Episode of care additional diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]}.

Source and reference attributes

Origin:

World Health Organization (WHO) 2001. International Classification of Functioning, Disability and Health. Geneva: WHO

Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide Version 1.0. Canberra: AIHW

Reference documents:

Further information on the ICF can be found in the ICF itself and the ICF Australian User Guide (AIHW 2003) and the following websites

- WHO ICF website
<http://www.who.int/classifications/icf/en>
- Australian Collaborating Centre ICF website
<http://www.aihw.gov.au/disability/icf/index.html>

Relational attributes

Related metadata references:

Supersedes [Participation - functioning, disability and health, version 1, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf](#) (17.2 KB)

Metadata items which use this glossary item:

Activities and participation code (ICF 2001) AN[NNN] Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Extent of environmental factors influence code (ICF 2001) [X]N Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Functioning and Disability DSS Health, Standard 29/11/2006
Community services, Standard 16/10/2006

Participation extent code (ICF 2001) N Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Participation satisfaction level code N Health, Standard 29/11/2006

Community services, Standard 16/10/2006

Psychiatrist

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327334
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Medical officers who are registered to practice psychiatry under the relevant state or territory Medical Registration Board; or who are fellows of the Royal Australian and New Zealand College of Psychiatrists or registered with Health Insurance Commission as a specialist in Psychiatry.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – recurrent expenditure (salaries and wages) (consultant psychiatrists and psychiatrists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004
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Psychiatry registrar or trainee

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327344
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	A medical officer who is a formal trainee within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (psychiatry registrars and trainees) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (psychiatry registrars and trainees), average N[NNN{.N}] Health, Standard 08/12/2004
	Establishment – recurrent expenditure (salaries and wages) (psychiatry registrars and trainees)(financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Psychologist

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327346
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	A person who is registered to practice psychology with the relevant state and territory registration board.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (psychologists) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (psychologists), average N[NNN{.N}] Health, Standard 08/12/2004
	Establishment – recurrent expenditure (salaries and wages) (psychologists) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Public health

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>Synonymous names:</i>	Public health
<i>METeOR identifier:</i>	352234
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Organised response by society to protect and promote health, and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions is the population as a whole, or population subgroups (NPHP 1998).
<i>Context:</i>	Public health functions

Collection and usage attributes

<i>Guide for use:</i>	To be used for collecting information on public health expenditure and activities.
<i>Collection methods:</i>	Collected through the National Public Health Expenditure Project and the Government Health Expenditure NMDS.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare.
<i>Origin:</i>	National Public Health Partnership 1998.
<i>Reference documents:</i>	(NPHP) National Public Health Partnership 1998. Public Health in Australia: the public health landscape: person, society, environment. Melbourne: NPHP.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Health or health related function code NNN Health, Standard 05/12/2007
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Record linkage

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327264
<i>Registration status:</i>	Community services, Standard 01/03/2005 Health, Standard 01/03/2005
<i>Definition:</i>	A process, technique or method that enables the bringing together of two or more records that are believed to belong to the same individual.
<i>Context:</i>	Record linkage may facilitate improved service provision, treatment or case management to individual clients.

Collection and usage attributes

<i>Comments:</i>	<p>Linkage can occur across data systems or within data systems and may be done by using a range of identifiers.</p> <p>For statistical purposes, including planning, research or the measurement of service or program outcomes, record linkage facilitates separating multiple items clustered around individuals from total counts (for example, double counting of clients can be reduced when calculating total numbers of clients across several agencies).</p> <p>The proposed use of a linkage key in the Home and Community Care program (HACC) Minimum Data Set is intended to make it possible to count the number of HACC clients (without counting clients more than once) and the services which they receive. The Commonwealth-State Territory Disability Agreement National Minimum Data Set is using the statistical linkage key based on that for the HACC Minimum Data Set.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
<i>Origin:</i>	Commonwealth Department of Health and Family Services 1998 Home and Community Care (HACC) Data Dictionary Version 1.0 Canberra: DHFS

Relational attributes

<i>Related metadata references:</i>	Supersedes Record linkage, version 2, DEC, NCSDD, NCSIMG, Superseded 01/03/2005.pdf (13.6 KB)
<i>Metadata items which use this glossary item:</i>	Person (name) – family name, text X[X(39)] Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005 Person (name) – given name, text [X(40)] Health, Superseded 04/05/2005 Community services, Superseded 25/08/2005 Person (name) – given name, text [X(40)] Health, Standard 04/05/2005 Community services, Standard 25/08/2005 Housing assistance, Standard 20/06/2005

Registered nurse

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327182
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Registered nurses include persons with at least a three year training certificate and nurses holding post graduate qualifications. Registered nurses must be registered with the state/territory registration board. This is a comprehensive category and includes community mental health, general nurse, intellectual disability nurse, midwife (including pupil midwife), psychiatric nurse, senior nurse, charge nurse (now unit manager), supervisory nurse and nurse educator. This category also includes nurses engaged in administrative duties no matter what the extent of their engagement, for example, directors of nursing and assistant directors of nursing.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (registered nurses) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}] Health, Standard 01/03/2005
	Establishment – recurrent expenditure (salaries and wages) (registered nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
	Non-admitted patient emergency department service episode – triage category, code N Health, Superseded 22/12/2009
	Non-admitted patient emergency department service episode – triage category, code N Health, Standard 22/12/2009

Resident

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327198
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person who receives residential care intended to be for a minimum of one night.
<i>Context:</i>	Specialised mental health services (Residential mental health care).

Collection and usage attributes

<i>Comments:</i>	A resident in one residential mental health service cannot be concurrently a resident in another residential mental health service. A resident in a residential mental health service can be concurrently a patient admitted to a hospital.
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Relational attributes

<i>Related metadata references:</i>	Supersedes Resident, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (11.9 KB)
<i>Metadata items which use this glossary item:</i>	Admitted patient mental health care NMDS Health, Superseded 07/12/2005
	Admitted patient mental health care NMDS Health, Superseded 23/10/2006
	Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008
	Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009
	Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010
	Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010
	Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005
	Episode of care – mental health legal status, code N Health, Standard 01/03/2005
	Episode of care – number of psychiatric care days Health, Standard 01/03/2005
	Episode of care – number of psychiatric care days, total N[NNNN] Health, Standard 01/03/2005
	Episode of residential care Health, Standard 01/03/2005
	Episode of residential care – episode end date Health, Standard 01/03/2005
	Episode of residential care – episode end date, DDMMYYYY Health, Standard 01/03/2005

Episode of residential care – episode start date Health, Standard 01/03/2005

Episode of residential care – episode start date, DDMMYYYY Health, Standard 01/03/2005

Episode of residential care – number of leave days, total N[NN] Health, Standard 01/03/2005

Episode of residential care – referral destination (mental health care) Health, Standard 01/03/2005

Episode of residential care – referral destination (mental health care), code N Health, Standard 01/03/2005

Establishment – number of available beds for admitted patients/residents Health, Superseded 03/12/2008

Establishment – number of available beds for admitted patients/residents, average N[NNN] Health, Superseded 03/12/2008

Health industry relevant organisation type code NNN Health, Superseded 01/04/2009

Health or health related function code NNN Health, Standard 05/12/2007

Residential mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Residential mental health care NMDS 2006-2007 Health, Superseded 23/10/2006

Residential mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Residential mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Residential mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Residential stay – episode start date Health, Standard 01/03/2005

Residential stay – episode start date, DDMMYYYY Health, Standard 01/03/2005

Residential mental health care service

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	373049
<i>Registration status:</i>	Health, Standard 02/12/2009
<i>Definition:</i>	<p>A residential mental health service is a service that is considered by the state, territory or commonwealth funding authorities as a service that:</p> <ul style="list-style-type: none">• has the workforce capacity to provide specialised mental health services; and• employs suitably trained mental health staff to provide rehabilitation, treatment or extended care on-site:<ul style="list-style-type: none">to consumers residing on an overnight basis;in a domestic-like environment; and• encourages the consumer to take responsibility for their daily living activities. <p>These services include those that employ mental health trained staff on-site 24 hours per day and other services with less intensive staffing (but the trained staff must be on site for a minimum of 6 hours a day and at least 50 hours per week).</p> <p>Suitably trained residential mental health care staff may include:</p> <ul style="list-style-type: none">• individuals with Vocational Education and Training (VET) qualifications in community services, mental health or disability sectors;• individuals with tertiary qualifications in medicine, social work, psychology, occupational therapy, counselling, nursing or social sciences; and• individuals with experience in mental health or disability relevant to providing mental health consumers with appropriate services.
<i>Context:</i>	Specialised residential mental health services.

Source and reference attributes

<i>Submitting organisation:</i>	Australian Institute of Health and Welfare
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Relational attributes

<i>Related metadata references:</i>	Supersedes Residential mental health care service Health, Superseded 02/12/2009
<i>Metadata items which use this glossary item:</i>	Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010 Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010 Available bed – residential mental health care Health, Standard 03/12/2008

Available bed – residential mental health care, average number of beds N[NNN.N] Health, Standard 03/12/2008

Episode of care – mental health legal status, code N Health, Standard 01/03/2005

Health or health related function code NNN Health, Standard 05/12/2007

Residential mental health care Health, Standard 03/12/2008

Residential mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Specialised mental health service setting code N Health, Standard 08/12/2004

Revenue (other revenue)

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>Synonymous names:</i>	Other revenue
<i>METeOR identifier:</i>	357543
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	<p>All other revenue received by the establishment that is not included under patient revenue or recoveries (but not including revenue payments received from state or territory governments). This would include revenue such as investment income from temporarily surplus funds and income from charities, bequests and accommodation provided to visitors.</p> <p>See text relating to offsetting practices. Gross revenue should be reported (except in relation to payments for inter-hospital transfers of goods and services).</p>

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
<i>Origin:</i>	Establishment – revenue (other revenue), METeOR Identification 269591, NHIG, Standard 01/03/2005

Relational attributes

<i>Metadata items which use this glossary item:</i>	Organisation – revenue Health, Standard 05/12/2007
	Organisation – revenue, total Australian currency NNNNN.N Health, Standard 05/12/2007

Revenue (patient)

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>Synonymous names:</i>	Patient revenue
<i>METeOR identifier:</i>	357539
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	Patient revenue comprises all revenue received by, and due to, an establishment in respect of individual patient liability for accommodation and other establishment charges. All patient revenue is to be grouped together regardless of source of payment (Commonwealth, health fund, insurance company, direct from patient) or status of patient (whether inpatient or non-inpatient, private or compensable). Gross revenue should be reported.

Source and reference attributes

<i>Submitting organisation:</i>	Health Expenditure Advisory Committee
<i>Origin:</i>	Establishment – revenue (patient) METeOR Identifier 269518 NHIG, Standard 01/03/2005

Relational attributes

<i>Metadata items which use this glossary item:</i>	Organisation – revenue Health, Standard 05/12/2007 Organisation – revenue, total Australian currency NNNNN.N Health, Standard 05/12/2007
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Revenue (recoveries)

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	357541
<i>Registration status:</i>	Health, Standard 05/12/2007
<i>Definition:</i>	<p>All revenue received that is in the nature of a recovery of expenditure incurred. This would include:</p> <ul style="list-style-type: none">• income received from the provision of meals and accommodation to members of staff of the hospital (assuming it is possible to separate this from income from the provision of meals and accommodation to visitors);• income received from the use of hospital facilities by salaried medical officers exercising their rights of private practice and by private practitioners treating private patients in hospital; and• other recoveries such as those relating to inter-hospital services where the revenue relates to a range of different costs and cannot be clearly offset against any particular cost.

Generally, gross revenues should be reported but, where inter-hospital payments for transfers of goods and services are made, offsetting practices are acceptable to avoid double counting. Where a range of inter-hospital transfers of goods and services is involved and it is not possible to allocate the offsetting revenue against particular expenditure categories, then it is acceptable to bring that revenue in through recoveries.

Source and reference attributes

<i>Origin:</i>	Establishment – revenue (recoveries) METeOR Identifier 269417, NHIG, Standard 01/03/2005
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Relational attributes

<i>Metadata items which use this glossary item:</i>	Organisation – revenue Health, Standard 05/12/2007 Organisation – revenue, total Australian currency NNNNN.N Health, Standard 05/12/2007
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Salaried medical officer

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327188
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Medical officers employed by the hospital on a full time or part time salaried basis. This excludes visiting medical offices engaged on an honorary, sessional or fee for service basis. This category includes salaried medical officers who are engaged in administrative duties regardless of the extent of that engagement (for example, clinical superintendent and medical superintendent)

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (salaried medical officers) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}] Health, Standard 01/03/2005
	Establishment – recurrent expenditure (salaries and wages) (salaried medical officers) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005
	Establishment – recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005

Same-day patient

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327270
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>A same-day patient is a patient who is admitted and separates on the same date, and who meets one of the following minimum criteria:</p> <ul style="list-style-type: none">• that the patient receive same-day surgical and diagnostic services as specified in bands 1A, 1B, 2, 3, and 4 but excluding uncertified type C Professional Attention Procedures within the Health Insurance Basic Table as defined in s.4 (1) of the <i>National Health Act 1953</i> (Commonwealth),• that the patient receive type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the <i>National Health Act 1953</i> (Commonwealth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.
<i>Context:</i>	Admitted patient care.

Collection and usage attributes

<i>Comments:</i>	<p>Same-day patients may be either intended to be separated on the same day, or intended overnight-stay patients who left of their own accord, died or were transferred on their first day in the hospital.</p> <p>Treatment provided to an intended same-day patient who is subsequently classified as an overnight-stay patient shall be regarded as part of the overnight episode.</p> <p>Non-admitted (emergency or outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.</p> <p>Data on same-day patients are derived by a review of admission and separation dates.</p>
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Source and reference attributes

<i>Origin:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Same-day patient, version 1, DEC, NHDD, NHIMG, Superseded 01/03/2005 .pdf (14.5 KB)
<i>Metadata items which use this glossary item:</i>	Admitted patient care NMDS Health, Superseded 07/12/2005 Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006

Admitted patient care NMDS 2007-2008 Health, Superseded
05/02/2008

Admitted patient care NMDS 2008-2009 Health, Superseded
04/02/2009

Admitted patient care NMDS 2009-2010 Health, Superseded
22/12/2009

Admitted patient care NMDS 2010-2011 Health, Standard
22/12/2009

Admitted patient mental health care NMDS Health, Superseded
07/12/2005

Admitted patient mental health care NMDS Health, Superseded
23/10/2006

Admitted patient mental health care NMDS 2007-2008 Health,
Superseded 05/02/2008

Admitted patient mental health care NMDS 2008-2009 Health,
Superseded 04/02/2009

Admitted patient mental health care NMDS 2009-2010 Health,
Superseded 05/01/2010

Admitted patient mental health care NMDS 2010-2011 Health,
Standard 05/01/2010

Episode of admitted patient care – intended length of hospital
stay Health, Standard 01/03/2005

Episode of admitted patient care – length of stay (excluding leave
days) Health, Standard 01/03/2005

Episode of admitted patient care – length of stay (including leave
days), total N[NN] Health, Standard 04/07/2007

Episode of admitted patient care – length of stay (including leave
days), total N[NN] Health, Superseded 04/07/2007

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

Establishment – number of patient days, total N[N(7)] Health,
Standard 01/03/2005

Separation

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327268
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	<p>Separation is the process by which an episode of care for an admitted patient ceases. A separation may be formal or statistical.</p> <p>Formal separation: The administrative process by which a hospital records the cessation of treatment and/or care and/or accommodation of a patient.</p> <p>Statistical separation: The administrative process by which a hospital records the cessation of an episode of care for a patient within the one hospital stay.</p>
<i>Context:</i>	Admitted patient care.

Collection and usage attributes

<i>Comments:</i>	<p>This treatment and/or care provided to a patient prior to separation occurs over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).</p> <p>While this concept is also applicable to non-Admitted patient care and welfare services, different terminology to 'separation' is often used in these other care settings.</p>
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Source and reference attributes

<i>Submitting organisation:</i>	National Health Data Committee
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Relational attributes

<i>Related metadata references:</i>	Supersedes Separation, version 3, DEC, NHDD, NHIMG, Superseded 01/03/2005.pdf (14.4 KB)
<i>Metadata items which use this glossary item:</i>	<p>Admitted patient care NMDS Health, Superseded 07/12/2005</p> <p>Admitted patient care NMDS 2006-2007 Health, Superseded 23/10/2006</p> <p>Admitted patient care NMDS 2007-2008 Health, Superseded 05/02/2008</p> <p>Admitted patient care NMDS 2008-2009 Health, Superseded 04/02/2009</p> <p>Admitted patient care NMDS 2009-2010 Health, Superseded 22/12/2009</p> <p>Admitted patient care NMDS 2010-2011 Health, Standard 22/12/2009</p> <p>Admitted patient hospital stay Health, Standard 01/03/2005</p> <p>Admitted patient mental health care NMDS Health, Superseded 23/10/2006</p>

Admitted patient mental health care NMDS Health, Superseded 07/12/2005

Admitted patient mental health care NMDS 2007-2008 Health, Superseded 05/02/2008

Admitted patient mental health care NMDS 2008-2009 Health, Superseded 04/02/2009

Admitted patient mental health care NMDS 2009-2010 Health, Superseded 05/01/2010

Admitted patient mental health care NMDS 2010-2011 Health, Standard 05/01/2010

Community mental health care NMDS 2005-2006 Health, Superseded 07/12/2005

Episode of admitted patient care Health, Standard 01/03/2005

Episode of admitted patient care – number of leave days Health, Standard 01/03/2005

Episode of admitted patient care – number of leave periods, total N[N] Health, Standard 01/03/2005

Episode of admitted patient care – separation date, DDMMYYYY Health, Standard 01/03/2005

Episode of admitted patient care – separation mode Health, Standard 01/03/2005

Episode of admitted patient care – separation mode, code N Health, Standard 01/03/2005

Episode of care – principal diagnosis, code (ICD-10-AM 3rd edn) ANN{.N[N]} Health, Superseded 28/06/2004

Episode of care – principal diagnosis, code (ICD-10-AM 4th edn) ANN{.N[N]} Health, Superseded 07/12/2005

Episode of care – principal diagnosis, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Episode of care – principal diagnosis, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Episode of care – principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Establishment – number of individual session occasions of service for non-admitted patients (alcohol and drug), total N[NNNNNN] Health, Standard 01/03/2005

Establishment – number of individual session occasions of service for non-admitted patients (community health services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment – number of individual session occasions of service for non-admitted patients (district nursing services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment – number of individual session occasions of service for non-admitted patients (emergency services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment – number of individual session occasions of service for non-admitted patients (endoscopy and related procedures), total N[NNNNNN] Health, Standard 01/03/2005

Establishment – number of individual session occasions of service for non-admitted patients (mental health), total N[NNNNNN] Health, Standard 01/03/2005

Establishment – number of individual session occasions of service for non-admitted patients (other medical/surgical/diagnostic), total N[NNNNNN] Health, Standard 01/03/2005

Establishment – number of individual session occasions of service for non-admitted patients (other outreach services), total N[NNNNNN] Health, Standard 01/03/2005

Establishment – number of individual session occasions of service for non-admitted patients (pathology), total N[NNNNNN] Health, Standard 01/03/2005

Establishment – number of individual session occasions of service for non-admitted patients (pharmacy), total N[NNNNNN] Health, Standard 01/03/2005

Establishment – number of separations Health, Standard 01/03/2005

Establishment – number of separations (financial year), total N[NNNNN] Health, Standard 01/03/2005

Person – congenital malformation Health, Standard 01/03/2005

Person – congenital malformation, code (BPA 1979) ANN.N[N] Health, Standard 01/03/2005

Person – congenital malformation, code (ICD-10-AM 3rd edn) ANN{.N[N]} Health, Superseded 28/06/2004

Person – congenital malformation, code (ICD-10-AM 4th edn) ANN{.N[N]} Health, Superseded 07/12/2005

Person – congenital malformation, code (ICD-10-AM 5th edn) ANN{.N[N]} Health, Superseded 05/02/2008

Person – congenital malformation, code (ICD-10-AM 6th edn) ANN{.N[N]} Health, Superseded 22/12/2009

Person – congenital malformation, code (ICD-10-AM 7th edn) ANN{.N[N]} Health, Standard 22/12/2009

Separation mode Health, Standard 01/03/2005

Separation mode code N Health, Standard 01/03/2005

Severe hypoglycaemia

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327322
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Hypoglycaemia requiring assistance from another party.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Person – severe hypoglycaemia history Health, Superseded 21/09/2005
	Person – severe hypoglycaemia indicator Health, Standard 21/09/2005
	Person – severe hypoglycaemia indicator, code N Health, Standard 21/09/2005

Social Worker

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327348
<i>Registration status:</i>	Health, Standard 08/12/2004
<i>Definition:</i>	Persons who have completed a course of recognised training and are eligible for membership of the Australian Association of Social Workers.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (social workers) Health, Standard 08/12/2004
	Establishment – full-time equivalent staff (paid) (social workers), average N[NNN{.N}] Health, Standard 08/12/2004
	Establishment – recurrent expenditure (salaries and wages) (social workers) (financial year), total Australian currency N[N(8)] Health, Standard 08/12/2004

Student nurse

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327328
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A person employed by a health establishment who is currently studying in years one to three of a three-year certificate course. This includes any person commencing or undertaking a three-year course of training leading to registration as a nurse by the State or Territory registration board. This includes full-time general student nurse and specialist student nurse, such as mental deficiency nurse, but excludes practising nurses enrolled in post-basic training courses.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (student nurses) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (student nurses), average N[NNN{.N}] Health, Standard 01/03/2005

Trainee/pupil nurse

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327190
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	Trainee/pupil nurse includes any person commencing or undertaking a 1-year course of training leading to registration as an enrolled nurse on the state/territory registration board (includes all trainee nurses).

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – full-time equivalent staff (paid) (trainee/pupil nurses) Health, Standard 01/03/2005
	Establishment – full-time equivalent staff (paid) (trainee/pupil nurses), average N[NNN{.N}] Health, Standard 01/03/2005
	Establishment – recurrent expenditure (salaries and wages) (trainee/pupil nurses) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Triage

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	334003
<i>Registration status:</i>	Health, Standard 24/03/2006
<i>Definition:</i>	Process by which a patient is briefly assessed upon arrival in the emergency department to determine the urgency of their problem and priority for care.
<i>Context:</i>	Emergency department care

Source and reference attributes

<i>Reference documents:</i>	Hospital Demand Management Group, Metropolitan Health and Aged Care Services Division, State Government Department of Human Services, Victoria. http://www.health.vic.gov.au/hdms/triage.htm
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Relational attributes

<i>Metadata items which use this glossary item:</i>	Non-admitted patient emergency department service episode – triage date, DDMMYYYY Health, Standard 07/12/2005 Non-admitted patient emergency department service episode – triage time, hhmm Health, Standard 07/12/2005 Triage category code N Health, Standard 01/03/2005
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Visiting medical officer

Identifying and definitional attributes

<i>Metadata item type:</i>	Glossary Item
<i>METeOR identifier:</i>	327170
<i>Registration status:</i>	Health, Standard 01/03/2005
<i>Definition:</i>	A visiting medical officer is a medical practitioner appointed by the hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee for service basis. This category includes the same Australian Standard Classification of Occupations codes as the salaried medical officers category.

Relational attributes

<i>Metadata items which use this glossary item:</i>	Establishment – recurrent expenditure (visiting medical officer payments) Health, Standard 01/03/2005
	Establishment – recurrent expenditure (visiting medical officer payments) (financial year), total Australian currency N[N(8)] Health, Standard 01/03/2005

Companion guide

What are the national data dictionaries?

The national data dictionaries contain standard data definitions and data elements for use in any Australian health or community services data collection. They are the authoritative source of information about endorsed national metadata standards and provide the basis for consistent national collection and reporting. The national metadata standards are approved by the Australian government and all state and territory relevant health and community services departments as well as the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW). This work is funded under the Australian Health Minister's Advisory Council (AHMAC) and the Community Services and Disability Minister's Advisory Council (CSDMAC).

Where possible, metadata standards in the dictionary are consistent with other national standard classifications to ensure overall comparability of national data. The Australian Bureau of Statistics is the source of many key socioeconomic classifications used in data collections, for example, the Australian Standard Classification of Languages (ASCL), the Australian Standard Geographic Classification (ASGC) and the Australian and New Zealand Standard Classifications of Occupations (ANZSCO).

The data dictionaries have been downloaded from METeOR, which is an online metadata registry for developing, registering and disseminating metadata based on the second edition of the international standard ISO/IEC 11179 Information Technology-Metadata registries (MDR) in 2003. For more information about METeOR see the 'METeOR' section on page [2727](#). The national health and community services data dictionaries are also available online at www.meteor.aihw.gov.au.

Governance

The national health and community services data dictionaries are, respectively, initiatives under the National Health Information Agreement, auspiced by the AHMAC, and the National Community Services Information Agreement, auspiced by the CSDMAC.

Under these agreements, all parties agree to ensure that the collection, compilation and interpretation of national information are appropriate and are 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 and community services information.

The national health and community services data standards are agreed to by the respective state, territory and Australian Government departments of health and community services, the ABS and the AIHW.

Why use metadata standards?

Making data count

Metadata standards promote the quality, accuracy, interpretability, reliability, relevance, interchangeability, transparency, currency, accessibility, coherence and comparability of data and information.

Without metadata standards there is the potential for data to fail to measure what it is supposed to measure, or not be comparable across collections or over time.

Metadata standards enable consistent and comparable reporting of information about services, including describing what services are available, where they are located and how much they cost. Such standards also achieve consistency when reporting about people, for instance, who delivered a service and when, who received the service, and what happened to them as a result.

By making endorsed metadata standards readily available, users are assured that they can use these standards with confidence and that they will enable the maximum reuse of their data for future research: 'create once, use often'.

How are metadata standards developed?

Creating metadata standards is part of data development

Data development is the process of building a data set for a specific purpose. For example, one might wish to build a data set that supports research into cancer diagnoses, treatment and outcomes, or one that supports statistical reporting about the operations of hospital emergency departments.

Data development demands a clear understanding of why the data are needed – for example, to underpin the design and evaluation of health policy, or to assess the performance of health services, or to support research into patterns of disease.

It also requires an assessment of the practicalities of collecting the data. Building almost any data set will demand the assembly of data from multiple sources. Thus there must be an understanding of the diverse information systems from which data are drawn; and there must be an effort to apply or develop common standards for concepts, classifications, terminologies, data values and so on.

The quality of data, including its consistency and comparability, is enhanced when metadata standards are used to support the collection and use of a data set.

Metadata standards development process

The data development process is outlined below.

1. Project proposal stage

A submission is made to the relevant data committee outlining the following:

- the purpose and scope of the project
- a business case for adoption

- details of national consultation, including the composition of the data working group, (comprising members with expertise in the subject area of the data development project)
- the nominated project manager responsible for managing the data development project
- expected timeframes for completion of the data development project.

2. Data development stage

The project manager works with the AIHW's METeOR and Metadata Unit and the data working group to develop the metadata items that will be stored in the national metadata registry system, METeOR.

Data collected for national reporting purposes must be defined in a standardised way. The standard adopted for health data is the International Standards Organisation's metadata registry standard (ISO/CEN 11179:2003).

For more information about the data development process, see the AIHW publication *A guide to data development*, available at:

<http://www.aihw.gov.au/publications/index.cfm/title/10422>.

3. Metadata standards review stage

The AIHW's METeOR and Metadata Unit undertakes a quality assurance review of the proposed metadata standards. This involves assessing all metadata standards for issues such as technical integrity, compliance with ISO 11179 and consistency with other standards, and the clarity of the content.

During this stage, the project manager receives feedback, makes adjustments and reports back to the data working group if required.

4. Endorsement of metadata standards

Once a final metadata assessment has been conducted, and the METeOR and Metadata Unit has provided a certification of the quality of the metadata standards, the metadata is submitted to the relevant endorsing body for final endorsement as a national standard.

Registration status progression

The registration status is the value assigned to a metadata item as it progresses through the standards development and review process.

The registration statuses in METeOR are:

Proposed

- A developer has submitted this item for consideration by the METeOR registrar.

Recorded

- The METeOR registrar has conducted an initial technical review and determined that the item meets basic quality criteria.

Candidate

- The item has been compliance checked by the METeOR registrar and is ready for further development or review by the data developer.

Standardisation pending

- The item has undergone a final compliance check by the METeOR registrar and the data working group has recommended the item to a registration authority for approval as a standard.

Standard

- The item has been endorsed by a registration authority as a national data standard.

Superseded

- A registration authority has superseded this item with another standard.

Retired

- The item has been nominated by registration authority as retired.

Not progressed

- The item will no longer be considered by the registrar, a data committee or a registration authority.

Who benefits from using metadata standards?

Information managers use standard formats and definitions to support the receipt, transfer, storage and management of data.

Program managers use data standards as the basis for describing information requests (that is, data required under formal service or funding agreements, and contracts); measuring service activity, client flows, client characteristics and service usage; understanding demand; better planning of services; describing unmet need (need comparability of population and survey data); and understanding ways to integrate service delivery, resulting in better targeting and usage of services and ultimately cost savings.

Researchers use data standards as the common language to support survey work, as well as to integrate data from other sources.

Policy makers need aggregated information for future policy, management and funding decisions, that is, information to support comparisons across jurisdictions, programs and sectors.

Statisticians use data standards for interpreting and analysing data; analysing results; linking data sets for statistical purposes; and carrying out time series analysis (over a period of time) and longitudinal studies (over a period of time within groups).

Metadata structure

The metadata standards are based on the 2003 version of the ISO/IEC 11179 international standard for metadata registries. Part three of the standard is a model for a metadata registry and the formulation of metadata items.

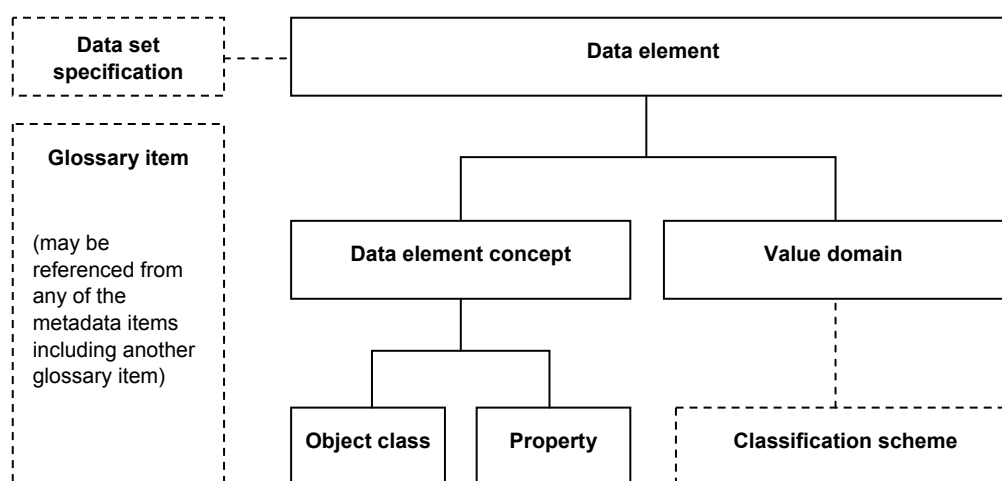
There are six types of metadata defined by ISO/IEC 11179 that have been applied to METeOR and the data dictionaries:

- object class
- property

- data element concept
- data element
- value domain
- classification scheme.

The structure underlying a data element in the dictionary is illustrated in Figure 1.

Types of metadata



Dashed lines show metadata types that are additional to or different from the ISO/IEC standard.

Figure 1: The 11179 model of metadata representation.

Components of data elements

The things that we want to know about include ideas (knowledge), persons, organisations, the environment and events. These things are termed *Object classes*. Some examples of object classes are 'Person', 'Dwelling' and 'Service provider organisation'. A characteristic of the object class is known as a *Property*. It is normally the item of interest. For example, the object class 'Person' can have properties such as 'Sex' and 'Date of birth'.

A *Data element concept* is defined as a concept created by the union of an object class and a property. Only one object class and one property can be joined for each data element concept, for example, 'Person – date of birth'.

As can be seen from Figure 1, a *Data element* is formed when a data element concept is represented in the real world by a set of values (a *Value domain*).

A value domain specifies how something is to be represented. A value domain can specify:

- the range of permitted values, for example, a measure of weight in grams represented by three numeric characters
- all permissible values as a set of codes, for example, 'Code 1 Female', 'Code 2 Male'
- the values referenced from a nationally or internationally endorsed classification, such as all codes in the ASCL 2005, or all activity codes listed in the International statistical

classification of diseases and related health problems, Tenth revision, Australian modification, 5th edition (ICD-AM).

A *Glossary item* defines the meaning of a term within a specific context. Examples of glossary items include 'Adoption' and 'Family'. These are not currently defined as object classes but their meaning must be clarified as part of the data development process.

Data set specifications

A data set specification (DSS) is a grouping of a number of data elements and the conditions under which they are collected. A DSS defines:

- the scope of the collection, that is, the population that is the target of the data development
- the level at which the data will be collected and reported
- whether the inclusion of each data element is mandatory, optional or conditional, and the sequence in which data elements are included.

National minimum data sets

A national minimum data set (NMDS) is a type of DSS, made up of a minimum set of data elements agreed by the national health or community services information groups for mandatory collection and reporting at a national level. An NMDS may include data elements that are also included in another NMDS.

An NMDS is contingent upon a national agreement to collect uniform data and to supply it as part of the national collection, but does not preclude agencies and service providers from collecting additional data to meet their own specific needs.

An example of an NMDS is the Juvenile Justice NMDS, which is used to obtain information about young people under juvenile justice supervision in Australia.

Non-mandatory data set specifications

DSSs are data sets that are not mandated for national collection and reporting, but are recommended as best practice.

For example, the Diabetes (clinical) Data Set Specification is a non-mandatory data set which aims to ensure national consistency in relation to defining, monitoring and recording information on patients diagnosed with diabetes.

Integration of data elements in data dictionaries

The national health and community services data dictionaries contain about one hundred integrated data items that can be used consistently across the health and community services sectors. This is especially important for services that straddle sector boundaries such as aged care, mental health, drug and alcohol services, and services for people with a disability.

Examples of integrated data items are:

Address data items

[Address line, text \[X\(180\)\]](#)

[Australian postcode, code \(Postcode datafile\) {NNNN}](#)

Australian state/territory identifier, code N

Street name, text [A(30)]

Suburb/town/locality name, text [A(50)]

Personal and demographic data items

Activity and participation life area, code (ICF 2001) AN[NNN]

Age, total years N[NN]

Person – country of birth, code (SACC 2008) NNNN

Date of birth, DDMMYYYY

Family name, text X[X(39)]

Given name, text [X(40)]

Indigenous status, code N

Informal carer existence indicator, code N

Interpreter service required, yes/no code N

Labour force status, code N

Main language other than English spoken at home, code (ASCL 2005) NN{NN}

Marital status, code N

Mother's original family name, text [X(40)]

Occupation (main), code (ANZSCO 1st edition) N[NNN]{NN}

Person identifier, XXXXXX[X(14)]

Preferred language, code (ASCL 2005) NN{NN}

Proficiency in spoken English, code N

Sex, code N

Year of first arrival in Australia, date YYYY

Service provider organisation data items

Organisation end date, DDMMYYYY

Organisation name, text [X(200)]

Organisation start date, DDMMYYYY

Date items

Accuracy indicator, code AAA

Formulation of good data standards

- 1 A metadata item must have, at least, a name and a definition.**
- 2 A metadata item can have an explicitly stated context within which the definition has meaning.**
- 3 The name of the standard version of the metadata item must follow certain criteria:**
 - the name must be unique within the context of the metadata item
 - the name must be stated in the singular
 - the name must reflect the concept being defined
 - the name must avoid the use of abbreviations or acronyms other than those widely accepted (for example radar, laser, pH)
 - the name should avoid the use of words that imply a preselected single instance.

4 Definition rules and guidelines

A definition must:

- be stated in the singular
- state what the concept is, not only what it is not
- be stated as a descriptive phrase or sentence(s)
- contain only commonly understood abbreviations
- be expressed without embedding definitions of other data or underlying concepts.

A data definition should:

- be expressed without embedding rationale, functional usage, domain information or procedural information
- state the essential meaning of the concept
- be precise and unambiguous
- be concise
- be able to stand alone
- avoid circular reasoning
- use the same terminology and consistent logical structure for related definitions
- contain information appropriate for the type of metadata item being defined
- use a preferred term to represent the definition of a concept specified elsewhere in the document
- pass the substitution test.

5 Context should be closely linked to definition.

6 Information must be included in a metadata item attribute only if it is appropriate for that attribute or metadata item.

- Context
 - Metadata can exist within a specific context.
 - Only information that is relevant to the environment or framework within which the definition for the metadata item is valid must be included in the Context attribute.
 - The contexts of two metadata items must be compatible when the definition of one metadata item references a term defined in another.
- Guide for use

Guide for use information must be included in any metadata item only if it is intended to provide advice or interpretation on how to use the particular metadata item or data collected using the metadata item.

 - In metadata items other than Data elements, Guide for use information should be about how to use the item itself and not about any data that can be collected or used.
 - Data elements can also include information about how to use or interpret the data in the Guide for use.
- Collection methods

The Collection methods attribute must only include information about how data is to be collected. The following metadata items must not have a metadata attribute of Collection methods

 - Object class
 - Property
 - Data element concept
 - Value domain
 - Glossary item.
- Permissible values in a Value domain must
 - be exhaustive within the set
 - be made into an exhaustive set of values by adding an 'Other' to aggregate all other possibilities not covered by the stated set of values
 - be mutually exclusive within the set
 - be a true representation of the concept defined in the data element.
- When allocating code values
 - avoid the use of a code value for 'Other' that is contiguous with the last code in the sequence of permissible values or that, in any other way, do not provide for inclusions in the future
 - wherever possible, avoid the use of a coded value for 'Other' that may be commonly used as a supplementary value.
- Supplementary values
 - Supplementary values must not be included in a Value domain unless it is necessary.

- Do not include valid Permissible values in the Supplementary values attribute of a Value domain.
- Avoid the use of values that are contiguous with the last code in the permissible value sequence.
- To limit variations in the meaning within a specific data collection, use a default supplementary value meaning of 'Not stated/inadequately described'.
- When using more than one supplementary value, use a logical set.
- It is appropriate that the Supplementary value field size is the same number of characters as the permissible value.
- Consistent use of supplementary codes/values across the data elements in a data set should be applied.
- In non-enumerated Value domains (that is those without defined value meanings such as in a measurement) the supplementary value used should not be a valid permissible value.

7 Always use a standard format for referencing publications and not a mixture of referencing methods.

METeOR

METeOR is the AIHW's online metadata registry.

METeOR currently integrates and presents information about:

- the *National health data dictionary*
- the *National community services data dictionary*
- the *National housing assistance data dictionary*
- national minimum data sets
- data set specifications.

METeOR includes the following tools:

- data search and browse tools that allow navigation of data standards of varying levels of endorsement and across the health, community services and housing 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.

METeOR is based on the 2003 version of the ISO/IEC 11179, titled 'Information technology – metadata registries (MDR)'. This standard was applied to provide a detailed registry architecture in which metadata standards can be better defined, navigated and managed throughout the data development lifecycle. METeOR is an Internet-based application accessible through the following web address: www.meteor.aihw.gov.au.

Data elements listed by technical name

Administrative health region – palliative care strategic plan indicator, yes/no code N	65
Administrative health region – region name, text [A(80)].....	64
Admitted patient (neonate) – neonatal morbidity, code (ICD-10-AM 7th edn) ANN{.N[N]}	1041
Admitted patient care waiting list episode – scheduled admission date, DDMMYYYY.....	1450
Admitted patient hospital stay – number of patient days (of contracted care), total N[NN]	1673
Admitted patient hospital stay – operating theatre time, total minutes NNNN	997
Adult – body mass index (measured), ratio NN[N].N[N].....	166
Adult – body mass index (self-reported), ratio NN[N].N[N]	169
Adult – waist circumference risk indicator, Caucasian adult code N.....	1742
Adult – waist-to-hip ratio, N.NN.....	1744
Available bed – neonatal admitted care (Non-special-care), average number of beds N[NNN.N]	138
Available bed – overnight-stay admitted care, average number of beds N[NNN.N].....	130
Available bed – residential mental health care, average number of beds N[NNN.N].....	133
Available bed – same-day admitted care, average number of beds N[NNN.N]	135
Birth event – anaesthesia administered, code N	82
Birth event – analgesia administered, code N.....	84
Birth event – baby resuscitation method, code N.....	1439
Birth event – birth method, code N.....	977
Birth event – birth plurality, code N.....	148
Birth event – birth presentation, code N	1218
Birth event – complication (postpartum), code (ICD-10-AM 7th edn) ANN{.N[N]}.....	1209
Birth event – complication, code (ICD-10-AM 7th edn) ANN{.N[N]}	272
Birth event – labour augmentation type, code N.....	1698
Birth event – labour induction type, code N	1712
Birth event – labour onset type, code N.....	1112
Birth event – setting of birth (actual), code N.....	33
Birth event – setting of birth (intended), code N	889
Birth event – state/territory of birth, code N	1575
Birth – Apgar score (at 1 minute), code NN	92
Birth – Apgar score (at 5 minutes), code NN.....	93
Birth – birth order, code N	146
Birth – birth status, code N	1577
Birth – birth weight, total grams NNNN	872
Cancer staging – cancer staging scheme source edition number, code N[N].....	1567
Cancer staging – cancer staging scheme source, code N	1565
Cancer staging – staging basis of cancer, code A.....	1563

Cancer treatment – cancer treatment type, code N	212
Cancer treatment – intention of treatment, code N	893
Cancer treatment – non-surgical cancer treatment completion date, DDMMYYYY	202
Cancer treatment – non-surgical cancer treatment start date, DDMMYYYY	203
Cancer treatment – outcome of treatment, code N.N.....	1138
Cancer treatment – radiation dose received, total Gray N[NNNN]	1279
Cancer treatment – radiotherapy treatment type, code N.....	1265
Cancer treatment – surgical procedure date, DDMMYYYY	389
Cancer treatment – surgical procedure for cancer, procedure code (ACHI 7th edn) NNNNN-NN.....	1599
Cancer treatment – systemic therapy agent name (primary cancer), antineoplastic drug code (Self-Instructional Manual for Tumour Registrars Book 8 3rd edn) X[X(39)]	1601
Cancer treatment – target site for cancer treatment, code (ICD-10-AM 7th edn) ANN{.N[N]}.....	214
Cancer treatment – target site for cancer treatment, code (ICDO-3) ANN	215
Child – body mass index (measured), ratio NN[N].N[N]	172
Child – body mass index (self-reported), ratio NN[N].N[N].....	175
Client – injecting drug use status, code N	883
Client – method of drug use (principal drug of concern), code N	979
Community nursing service episode – first contact date, DDMMYYYY	368
Community nursing service episode – goal of care, code NN.....	656
Community nursing service episode – last contact date, DDMMYYYY	376
Community nursing service episode – nursing intervention, code N.....	1104
Contracted hospital care – contracted care commencement date, DDMMYYYY	296
Contracted hospital care – contracted care completed date, DDMMYYYY.....	297
Contracted hospital care – organisation identifier, NNX[X]NNNNN	291
Date – accuracy indicator, code AAA.....	338
Division of general practice – organisation identifier, NNN	443
Elective care waiting list episode – category reassignment date, DDMMYYYY.....	239
Elective care waiting list episode – elective care type, code N	1747
Elective care waiting list episode – listing date for care, DDMMYYYY	926
Elective surgery waiting list episode – anticipated accommodation status, code N	90
Elective surgery waiting list episode – clinical urgency, code N.....	264
Elective surgery waiting list episode – extended wait patient indicator, code N	530
Elective surgery waiting list episode – indicator procedure, code NN	815
Elective surgery waiting list episode – overdue patient status, code N.....	1148
Elective surgery waiting list episode – patient listing status, readiness for care code N.....	1157
Elective surgery waiting list episode – reason for removal from a waiting list, code N.....	1277
Elective surgery waiting list episode – surgical specialty (of scheduled doctor), code NN	1597
Elective surgery waiting list episode – waiting list removal date, DDMMYYYY.....	1403

Elective surgery waiting list episode – waiting time (at a census date), total days N[NNN]	1752
Elective surgery waiting list episode – waiting time (at removal), total days N[NNN]	1755
Electrocardiogram – electrocardiogram date, DDMMYYYY	367
Electrocardiogram – electrocardiogram time, hhmm	1613
Electrocardiogram – ST-segment-elevation in lead V4R indicator, yes/no code N	450
Electrocardiogram – bundle-branch block status, code N	197
Electrocardiogram – change location, code N	453
Electrocardiogram – change type, code N	455
Electrocardiogram – heart rhythm type, code N[N]	764
Electrocardiogram – lead V4R presence indicator, yes/no code N	452
Electrocardiogram – new Q waves indicator, yes/no code N	448
Emergency department stay – physical departure date, DDMMYYYY	472
Emergency department stay – physical departure time, hhmm	474
Episode of admitted patient care (mental health care) – referral destination, code N	1392
Episode of admitted patient care (newborn) – date of change to qualification status, DDMMYYYY	355
Episode of admitted patient care (newborn) – number of qualified days, total N[NNNN]	1086
Episode of admitted patient care (procedure) – procedure commencement date, DDMMYYYY	384
Episode of admitted patient care – admission date, DDMMYYYY	67
Episode of admitted patient care – admission mode, code N	998
Episode of admitted patient care – admission time, hhmm	70
Episode of admitted patient care – admission urgency status, code N	1719
Episode of admitted patient care – condition onset flag, code N	274
Episode of admitted patient care – diagnosis related group, code (AR-DRG v 6) ANNA	438
Episode of admitted patient care – intended length of hospital stay, code N	887
Episode of admitted patient care – inter-hospital contracted patient status, code N	895
Episode of admitted patient care – length of stay (excluding leave days), total N[NN]	913
Episode of admitted patient care – length of stay (including leave days), total N[NN]	914
Episode of admitted patient care – length of stay (including leave days) (antenatal), total N[NN]	916
Episode of admitted patient care – length of stay (including leave days) (postnatal), total N[NN]	918
Episode of admitted patient care – length of stay (special/neonatal intensive care), total daysN[NN]	1072
Episode of admitted patient care – major diagnostic category, code (AR-DRG v 6) NN	949
Episode of admitted patient care – number of days of hospital-in-the-home care, total {N[NN]}	1074
Episode of admitted patient care – number of leave days, total N[NN]	1674
Episode of admitted patient care – number of leave periods, total N[N]	1082
Episode of admitted patient care – patient election status, code N	71

Episode of admitted patient care – procedure, code (ACHI 7th edn) NNNNN-NN	1244
Episode of admitted patient care – referral source, public psychiatric hospital code NN.....	1482
Episode of admitted patient care – separation date, DDMMYYYY	1451
Episode of admitted patient care – separation mode, code N	1000
Episode of admitted patient care – separation time, hhmm	1455
Episode of care (community setting) – first service delivery date, DDMMYYYY	370
Episode of care (procedure) – contracted procedure flag, code N	292
Episode of care – additional diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]}	49
Episode of care – behaviour-related risk factor intervention purpose, code N.....	142
Episode of care – behaviour-related risk factor intervention, code NN.....	140
Episode of care – funding eligibility indicator (Department of Veterans Affairs), code N	403
Episode of care – mental health legal status, code N	962
Episode of care – number of psychiatric care days, total N[NNNN].....	1677
Episode of care – nursing diagnosis (other), code (NANDA 1997-98) N.N[.N]{.N}{.N}{.N}	1100
Episode of care – nursing diagnosis (principal), code (NANDA 1997-98) N.N[.N]{.N}{.N}{.N}	1102
Episode of care – principal diagnosis, code (ICD-10-AM 7th edn) ANN{.N[N]}	1237
Episode of care – principal source of funding, hospital code NN.....	632
Episode of care – specialist private sector rehabilitation care indicator, code N	1561
Episode of residential care – episode end date, DDMMYYYY	499
Episode of residential care – episode end mode, code N	501
Episode of residential care – episode start date, DDMMYYYY	503
Episode of residential care – episode start mode, code N	505
Episode of residential care – number of episodes of residential care, total N[NNN]	1078
Episode of residential care – number of leave days, total N[NN].....	907
Episode of residential care – referral destination (mental health care), code N.....	1390
Episode of treatment for alcohol and other drugs – cessation reason, code N[N].....	1267
Episode of treatment for alcohol and other drugs – client type, code N.....	258
Episode of treatment for alcohol and other drugs – drug of concern (other), code (ASCDC 2000 extended) NNNN	1130
Episode of treatment for alcohol and other drugs – drug of concern (principal), code (ASCDC 2000 extended) NNNN	1239
Episode of treatment for alcohol and other drugs – number of service contacts, total N[NN].....	1092
Episode of treatment for alcohol and other drugs – referral source, code NN.....	1479
Episode of treatment for alcohol and other drugs – service delivery setting, code N.....	1681
Episode of treatment for alcohol and other drugs – treatment cessation date, DDMMYYYY	353
Episode of treatment for alcohol and other drugs – treatment commencement date, DDMMYYYY	356
Episode of treatment for alcohol and other drugs – treatment type (main), code N.....	946
Episode of treatment for alcohol and other drugs – treatment type (other), code [N].....	1133

Establishment (community mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)].....	1361
Establishment (mental health) – full-time equivalent staff (paid), total N[NNN{.N}]	577
Establishment (mental health) – recurrent expenditure (non-salary operating costs) (financial year), total Australian currency N[N(8)].....	1291
Establishment (mental health) – recurrent expenditure (total salaries and wages) (financial year), total Australian currency N[N(8)]	1294
Establishment (public psychiatric or alcohol and drug hospital) – number of group session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN]	713
Establishment (public psychiatric or alcohol and drug hospital) – number of group session occasions of service for non-admitted patients (outreach and community), total N[NNNNNN]	715
Establishment (public psychiatric or alcohol and drug hospital) – number of individual session occasions of service for non-admitted patients (emergency and outpatient), total N[NNNNNN]	827
Establishment (public psychiatric or alcohol and drug hospital) – number of individual session occasions of service for non-admitted patients (outreach and community), total N[NNNNNN]	829
Establishment (residential aged care service) – number of occasions of service (outreach/community), total N[NN].....	1108
Establishment (residential aged care service) – number of occasions of service (outpatient), total N[NN].....	1109
Establishment – accrued mental health care days, total N[N(7)]	24
Establishment – Australian state/territory identifier, code N.....	114
Establishment – establishment type, sector and services provided code AN.N{.N}	523
Establishment – full-time equivalent staff (paid) (administrative and clerical staff), average N[NNN{.N}]	580
Establishment – full-time equivalent staff (paid) (carer consultants), average N[NNN{.N}].....	585
Establishment – full-time equivalent staff (paid) (consultant psychiatrists and psychiatrists), average N[NNN{.N}].....	587
Establishment – full-time equivalent staff (paid) (consumer consultants), average N[NNN{.N}]	589
Establishment – full-time equivalent staff (paid) (diagnostic and health professionals), average N[NNN{.N}]	591
Establishment – full-time equivalent staff (paid) (domestic and other staff), average N[NNN{.N}]	594
Establishment – full-time equivalent staff (paid) (enrolled nurses), average N[NNN{.N}]	597
Establishment – full-time equivalent staff (paid) (occupational therapists), average N[NNN{.N}]	600
Establishment – full-time equivalent staff (paid) (other diagnostic and health professionals), average N[NNN{.N}].....	602
Establishment – full-time equivalent staff (paid) (other medical officers), average N[NNN{.N}]	604

Establishment – full-time equivalent staff (paid) (other personal care staff), average N[NNN{.N}]	606
Establishment – full-time equivalent staff (paid) (psychiatry registrars and trainees), average N[NNN{.N}]	609
Establishment – full-time equivalent staff (paid) (psychologists), average N[NNN{.N}].....	611
Establishment – full-time equivalent staff (paid) (registered nurses), average N[NNN{.N}]	613
Establishment – full-time equivalent staff (paid) (salaried medical officers), average N[NNN{.N}]	616
Establishment – full-time equivalent staff (paid) (social workers), average N[NNN{.N}]	619
Establishment – full-time equivalent staff (paid) (student nurses), average N[NNN{.N}].....	621
Establishment – full-time equivalent staff (paid) (trainee/pupil nurses), average N[NNN{.N}]	623
Establishment – full-time equivalent staff (paid), average N[NNN{.N}]	583
Establishment – geographical location, code (ASGC 2009) NNNNN	636
Establishment – gross capital expenditure (accrual accounting) (buildings and building services) (financial year), total Australian currency N[N(8)]	683
Establishment – gross capital expenditure (accrual accounting) (constructions) (financial year), total Australian currency N[N(8)]	685
Establishment – gross capital expenditure (accrual accounting) (equipment) (financial year), total Australian currency N[N(8)]	687
Establishment – gross capital expenditure (accrual accounting) (information technology) (financial year), total Australian currency N[N(8)].....	689
Establishment – gross capital expenditure (accrual accounting) (intangible assets) (financial year), total Australian currency N[N(8)]	691
Establishment – gross capital expenditure (accrual accounting) (land) (financial year), total Australian currency N[N(8)]	693
Establishment – gross capital expenditure (accrual accounting) (major medical equipment) (financial year), total Australian currency N[N(8)].....	695
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Feedback and contact details

The development of the data dictionaries is an ongoing process, reliant on the support and input of a range of data development groups to expand its scope and utility.

The data committees welcome feedback on existing metadata standards in the data dictionaries, and also submissions (either for new data items, modifications to existing items, or information on your data development activities).

Please feel free to contact the AIHW by any of the means listed below.

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