



Hospital Morbidity Data System

REFERENCE MANUAL

PART A: Contacts, Hospital
Responsibilities, Data
Element Definitions

2018-2019 V1.1



Policy, Standards & Assurance

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1.0 INTRODUCTION



HOSPITAL MORBIDITY DATA SYSTEM

OVERVIEW

The Hospital Morbidity Data System (HMDS) is one of the largest data collections managed by the WA Health System and the collection increases every year in line with population growth.

In accordance with the National Health Information Agreement, the WA health system, as are all State and Territories, is mandated to provide an annual submission to the Australian Institute of Health and Welfare (AIHW) of all admitted activity information for the State. In turn, under the *Health Services Act 2016*, the WA health system mandates all health service providers (HSPs) to submit complete, accurate and timely admitted activity data to the HMDS in accordance with agreed data management protocols.

PURPOSE OF THE COLLECTION

The HMDS provides WA health system with the necessary information for planning, allocating and evaluating health services within Western Australia. Some of the other key purposes of the collection include provision of information for:

- Mandatory reporting to the Commonwealth
- Monitoring and assessing state health service utilisation (public and private)
- Strategic planning, resource allocation and performance measurement of all levels of health care
- Safety and Quality
- Health service funding and resource allocation
- Epidemiological and medical research
- Data linkage

INPATIENT DATA COLLECTIONS UNIT AND DATA QUALITY TEAM RESPONSIBILITIES

The Hospital Morbidity Data Collection (HMDC) is managed by the Inpatient Data Collections (IDC) Unit and validated by the Data Quality Team (DQT) within the Purchasing and System Performance Division (PSP).

To ensure that the HMDC remains reliable and relevant, IDC and DQT are responsible for:

- Providing support to ensure compliance with data specifications, data submission and data edit protocol schedules and monitoring the arrival of data files.
- Maintaining the security and confidentiality of the HMDS.
- Ensuring edit validations are designed, documented, tested and implemented onto the HMDS database.
- Enforcing data quality and providing data quality expertise.
- Promoting liaison between IDC, DQT and all hospitals.
- Managing code tables for establishments, specialties, suburbs and postcodes, country of birth and languages.
- Contribute to and provide audit checks for hospitals, including communication of strategies and recommendations for improvement.
- Conduct quality assurance reviews of coded data on a regular basis to monitor compliance against relevant policy.
- Respond to regular and ad hoc data requests and queries.

- Provide effective explanation of morbidity data items and their use and provide expert statistical advice to hospitals.
- Supporting data users internal and external to the Department of Health.
- Developing analytical tools.
- Maintaining metadata.

UNIT OF MEASUREMENT

The unit of measurement with the HMDS is an episode of care. An episode of care starts with a formal or statistical admission to hospital and ends with a formal or statistical discharge or separation from hospital.

HMDS INCLUSIONS

The HMDS includes all episodes of care that occur in the following Western Australian health services:

- Public acute hospitals
- Public psychiatric hospitals
- Private acute hospitals (licensed by the WA Health System)
- Private psychiatric hospitals (licensed by the WA Health System)
- Private day surgeries (licensed by the WA Health System)

HMDS EXCLUSIONS

The HMDS does not include episodes of care (or equivalent unit of measurement) pertaining to:

- Patients attending emergency, outpatient or community health services
- Patients in residential aged care facilities
- Patients classified as flexible care or residential aged care residing in publicly funded hospitals
- Patients in community residential care facilities
- Patients treated in Defence Force or other non-Western Australian health services
- Still births
- Mothers electing to deliver at home and newborns delivered at home (excluding newborns requiring formal admission to hospital post delivery)
- Patients admitted for services that do not meet admission criteria as per the *Admissions Readmissions, Discharge and Transfer Policy MP 0058/17*

All reporting health service providers should ensure that any data reported to the HMDS complies with the above inclusions and exclusions.

DEVELOPMENT OF HMDS

The HMDS is subject to continual review to ensure that all data are relevant, measurable, of reasonable quality and is able to meet state and national reporting requirements.

Changes may be applied to the collection at the beginning of the financial year in response to version changes and/or state or national mandates.

HMDS REFERENCE MANUAL 2018 - 19

A summary of the changes since the last published HMDS Reference Manual are:

- Updated METeOR identifiers to latest editions.
- Revised data element definitions and examples to support current admission policy updates, including wording changes to data items e.g. Sex, ICU Hours.
- Updates to all policy links and references

The manual provides direction and guidelines for hospitals regarding the submission of data and the definitions of required data items.

The manual has *Part A: Data Element Definitions* and *Part B: HMDS Reference Documents*.

DATA RELEASE

As stated in the Data Stewardship and Custodianship Policy, the Director General (DG) of the WA health system is the delegated owner of all data and information collected, stored, used and disclosed within the various entities. The DG delegates a number of these responsibilities to senior officers to administer and/or manage.

The Manager, Inpatient Data Collections, is the delegated Data Custodian for Hospital Morbidity Data and ensures accurate and accountable release of data. Please see the [Data Stewardship and Custodian Policy](#) MP0011/16 within the Information Management Policy Framework.

ABBREVIATIONS

Abbreviation	Definition
ABF	Activity Based Funding
ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACCD	Australian Consortium for Classification Development
ACHI	Australian Classification of Health Interventions
ACHS	Australian Council of Health Care Standards
ACS	Australian Coding Standards
AHPRA	Australian Health Practitioner Regulation Agency
AIHW	Australian Institute of Health and Welfare
AR-DRG	Australian Refined Diagnosis Related Groups
ARDT	Admission, Readmission, Discharge and Transfer Policy for WA Health Services
BIPAP	Bi-Level Positive Airway Pressure
CCU	Critical Care Unit
COF	Condition Onset Flag
CPAP	Continuous Positive Airways Pressure
DG	Director General
DoH	Department of Health (either Western Australia or Australian Government)
DRG	Diagnosis Related Group
DVA	Department of Veterans Affairs
FSH	Fiona Stanley Hospital
FTP	File Transfer Protocol
HA22 Form	Hospital Admission 22 Form
HCARe	Health Care and Related Information System
HDU	High Dependency Unit
HITH	Hospital In The Home
HMDC	Hospital Morbidity Data Collection
HMDS	Hospital Morbidity Data System

HSA	Hospital Services Arrangement
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICECI	International Classification of External Causes of Injury
ICU	Intensive Care Unit
IDC	Inpatient Data Collections
IHPA	Independent Hospital Pricing Authority
IPPB	Intermittent Positive Pressure Breathing
KPI	Key Performance Indicator
MBRN	Medical Board Registration Number
MDC	Major Diagnostic Category
METeOR	Metadata Online Repository, Australian Institute of Health and Welfare
MHCT	Mental Health Care Type
MPS	Multi-Purpose Service
nfd	Not further defined
NHDD	National Health Data Dictionary
NHFB	National Health Funding Body
NHTP	Nursing Home Type Patient
NMDS	National Minimum Data Set
OD	Operational Directive
OSQH	Office of Safety and Quality in Healthcare
PSP	Purchasing and System Performance Division
RITH	Rehabilitation In The Home
TMS	Theatre Management System
TOPAS	The Open Patient Administration System
UMRN	Unit Medical Record Number
webPAS	Web-based Patient Administration System

KEY TERMINOLOGY

The following provides definitions of a number of key terms frequently used in the HMDS to classify a particular type of patient or administrative process. You will find reference to these key terms throughout this Manual.

HOSPITAL BOARDER

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

Hospital boarders do not receive admitted care but may be registered on the hospital's patient administration system (PAS). Hospital boarders are excluded from activity counts.

Boarders can include:

- Family members of an admitted child who are provided with accommodation.
- Healthy newborn babies who are more than 9 days old, not requiring acute care and belonging to a mother who is currently admitted to the hospital.
- Healthy newborn babies who are more than 9 days old, not requiring acute care and belonging to a mother who is transferred to another hospital.
- Technically, boarders are not admitted to hospital; however the hospital is permitted to register them.

Please also refer to the *WA Health Fees and Charges Manual*.

EPISODE OF CARE

An episode of care refers to the period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type. A patient may be seen and/or treated in outpatients or emergency immediately prior to admission, however for the purposes of the admitted activity data collection, this does not constitute part of the episode of care.

FORMAL ADMISSION

A formal admission is an administrative process that initiates the record of the patient's treatment and accommodation within a hospital. A formal admission represents the start of an episode of care.

STATISTICAL ADMISSION

A statistical admission is an administrative process that occurs within an episode of care and captures the commencement of a particular type of care (Care Type). A single episode of care is one admission with one care type. A period of hospitalisation may comprise of multiple episodes of care.

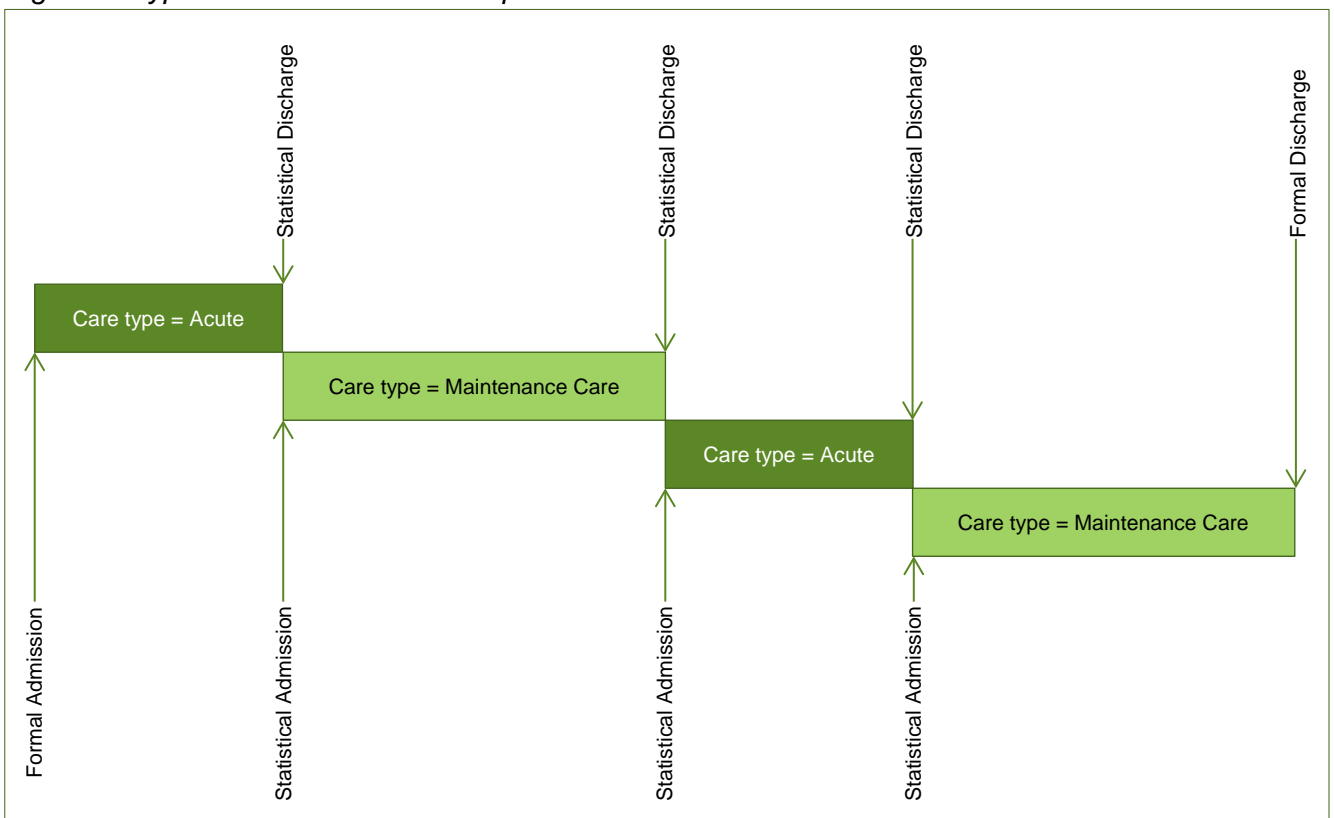
FORMAL SEPARATION

A formal separation/discharge is an administrative process that ceases the record of the patient's treatment and accommodation within a hospital. A formal separation represents the end of a patient's episode of care.

STATISTICAL SEPARATION

A statistical separation/discharge is an administrative process that occurs within an episode of care and captures the end date the patient received a particular type of care (Care Type). A single episode of care will have one admission. Figure 1: Types of Admissions and Separations demonstrates how a period of hospitalisation commencing with a formal admission to hospital and ending with a formal separation can be divided by statistical admissions and separations to capture several episodes of care under different Care Types. Each Statistical Separation must have a progress/discharge summary or equivalent documentation completed by the treating clinician and filed in the health record or equivalent electronic system.

Figure 1: Types of Admissions and Separations



OVERNIGHT PATIENT

An Overnight patient is a patient who is admitted to the hospital where the intention (on admission) is that they will stay a minimum of one night in hospital.

SAME-DAY PATIENT

A Same-Day patient (sometimes referred to as “Day only”) is a patient who is admitted to a hospital with the intention (on admission) that they will be discharged on the same-day that they are admitted (e.g. Admission Date and Separation Date are the same).

QUALIFIED NEWBORNS

A newborn is a child who is aged 9 days or less on admission.

A newborn is deemed a “Qualified Newborn” if they meet at least one of the following criteria:

- Is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient; AND/OR
- Is admitted to a Level 2 (L2) Nursery or Neonatal Intensive Care Unit (NICU), approved by the Commonwealth Health Minister for the purpose of the provision of special care. (Admission to a L2 Nursery or NICU is based on the requirement to receive this level of care, not because of bed availability); AND/OR
- Remains in hospital without its mother; OR
- Is admitted to the hospital without its mother.

At 10 days of age or any day after, a patient must meet the acute admission criteria to stay admitted with a Care Type of “Newborn”. If the patient meets the criteria of an acute admission and was born during the admission, the Client Status should be “Qualified” at 10 days of age and the Care Type remains as “Newborn”. The patient remains as Qualified Newborn until they no longer meet the acute admission criteria. When the patient stops meeting the criteria a statistical type change is performed to an appropriate Care Type. If a patient is admitted at 10 days of age or older and admitted from home or another facility and meets the admission criteria for an acute admission, the Care Type should be Acute and the Client Status should be Admitted client.

For further information refer to Section 6 Data Element Definitions, Client Status.

UNQUALIFIED NEWBORNS

A newborn is a child who is aged 9 days or less.

A newborn is deemed an “Unqualified Newborn” if they meet at least one of the following criteria:

- Is a single live birth or the first live born infant in a multiple birth, whose mother is currently an admitted patient; AND/OR
- Is not admitted to an intensive care facility (L2 Nursery or NICU) in a hospital, being a facility approved by the Commonwealth Health Minister for the purpose of the provision of special care.

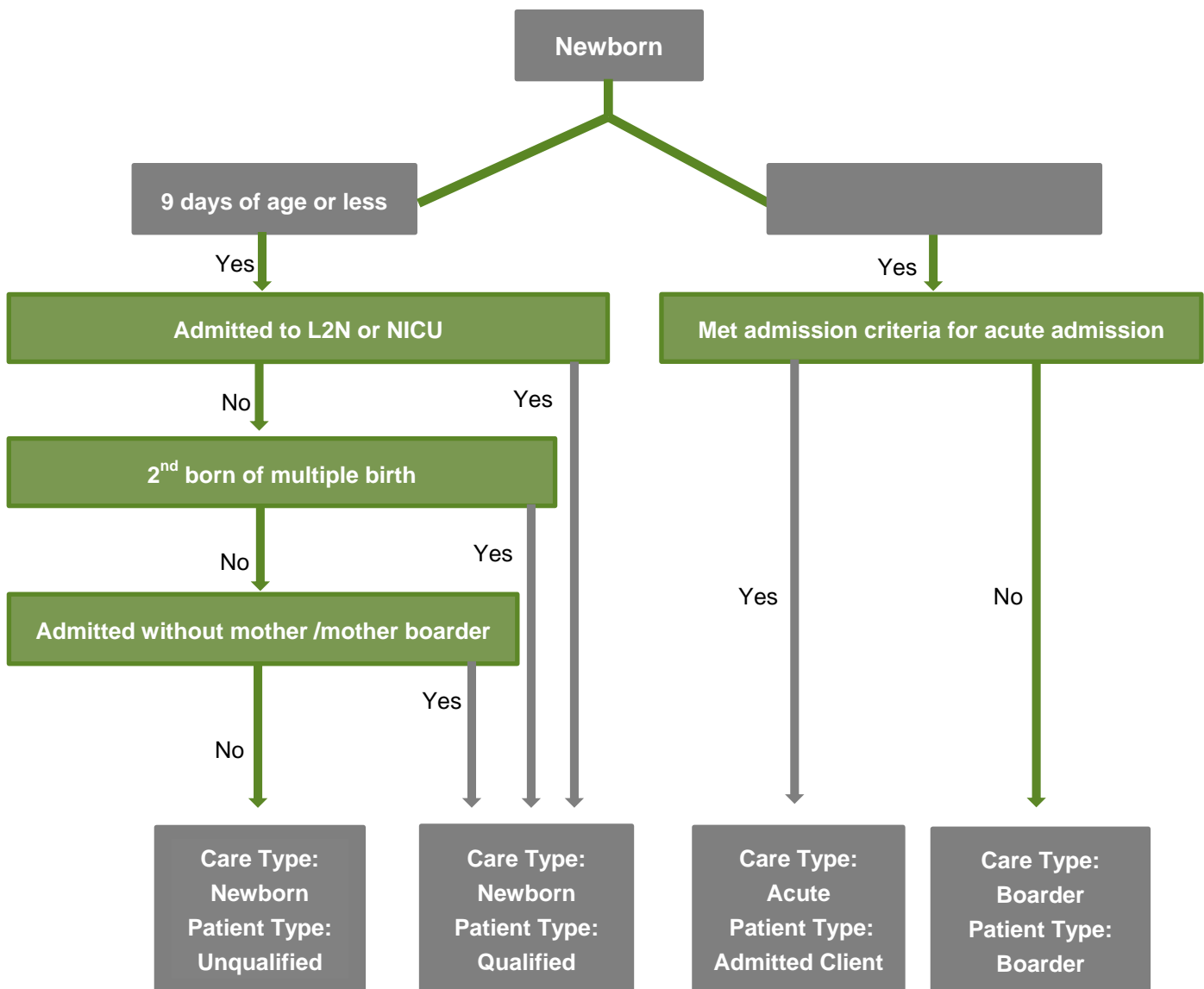
If an unqualified newborn remains in hospital after day 9 and does not meet admission criteria, the newborn then becomes a Boarder patient and a statistical discharge must be performed to change the patient’s Care Type and Client Status.

If an unqualified newborn remains in hospital after day 9 and meets admission criteria, then the Care Type remains Newborn and the Client Status becomes Qualified.

Unqualified newborns are not included in the Medicare Agreement or eligible for health insurance benefits. Any funding requirements for an unqualified newborn are already catered for in the funding for the mother’s inpatient stay.

For further information refer to Data Element Definitions, Client Status.

Figure 2: **Newborns, Care Type and Patient Type:**





2.0 CONTACT DETAILS



CONTACT DETAILS

INPATIENT DATA COLLECTIONS

Manager, Inpatient Data Collections Ph: (08) 9222 4362

Manager, Data Quality Ph: (08) 9222 2472

Data submission Ph: (08) 9222 2339
Ph: (08) 9222 4290
Ph: (08) 9222 2472

Discharge extracts:

Email: morbidity.data@health.wa.gov.au

Private Hospital HA22 inpatient submissions:

Email: RoyalSt_PAQHMDSDataQuality@health.wa.gov.au

**You must have access to MYFT to use the above email address.

**If you are a private site and have a renewed licence to operate issued since 2015/16, data submissions must be made via MyFT (see web address below to register)

<https://myft.health.wa.gov.au/courier/web/1000/@/wmLogin.html>

Please contact Manager, Data Quality above if you are having difficulties registering or require more information.

HMDS data quality and edit queries Ph: (08) 9222 2339
Ph: (08) 9222 4290
Ph: (08) 9222 4158

Email: hmds.edits@health.wa.gov.au

Clinical coding queries Ph: (08) 9222 4153

Email: coding.query@health.wa.gov.au

WA Clinical Coding Authority Ph: (08) 9222 4153

Email: clinical.coding@health.wa.gov.au

Data extracts Ph: (08) 9222 4362

Email: InpatientDataCollections@health.wa.gov.au

Ad hoc data requests Ph: (08) 9222 4362

Email: InpatientDataCollections@health.wa.gov.au

KEY WEBSITES

STATE

WA Health System

<https://ww2.health.wa.gov.au>

WA Clinical Coding Authority

https://ww2.health.wa.gov.au/Articles/A_E/Clinical-Coding-Authority



HMDS Reference Manual

See 'Policies and guides' at:

https://ww2.health.wa.gov.au/Articles/A_E/Clinical-Coding-Authority

Information Management Policy Framework

http://www.health.wa.gov.au/circularsnew/Information_Management.cfm

Activity Based Funding (Western Australia)

<https://ww2.health.wa.gov.au/Our-performance/Activity-based-funding-and-management>

Health Support Services

TOPAS, HCARE and webPAS Client Management System Support

Web page: <https://ww2.health.wa.gov.au/About-us/Health-Support-Services>

NATIONAL

Independent Hospital Pricing Authority (IHPA)

Online ordering at <http://ar-drg.laneprint.com.au/>

- ICD-10-AM (Australian Modification) 10th Edition books
- Australian Refined Diagnosis Related Groups definitions manuals

Information on Activity Based Funding may be obtained from:

Web page: <http://www.iHPA.gov.au>

National Hospital Cost Data Collection DRG cost weights and price weights are available from IHPA

<https://www.iHPA.gov.au/what-we-do/nhcdc>

Australian Consortium for Classification Development

Web page: <https://www.accd.net.au/>

Australian Institute of Health and Welfare

- METeOR (Metadata Online Repository)
- National Health Data Dictionary (NHDD)
- Australian Hospital Statistics

These and other publications/resources may be accessed from:

Web page: <http://www.aihw.gov.au>

Australian Health Practitioner Regulation Agency

Clinician Medical Board Registration Numbers (MBRNs), Podiatrist registration numbers and Dental Clinician registration numbers are maintained by the Australian Health Practitioner Regulation Agency.

Web page: <http://www.ahpra.gov.au>





3.0 HOSPITAL RESPONSIBILITIES



HOSPITAL RESPONSIBILITIES

This section provides instructions and guidelines for the submission of data for Health Service Providers (HSPs), Contracted Health Entities (CHEs) and Private Hospitals. This includes reference to relevant operational directives, policy and information about data validations.

HEALTH SERVICE PROVIDERS & CONTRACTED HEALTH ENTITIES

INFORMATION MANAGEMENT POLICY FRAMEWORK

The Information Management Policy Framework specifies the information management requirements that all HSPs and CHEs must comply with in order to ensure effective and consistent management of health, personal and business information across the WA health system.

The Director General (DG) of the Department of Health is the System Manager responsible for the overall management, strategic direction and stewardship of the WA health system. The DG will use policy frameworks to ensure a consistent approach to a range of matters undertaken by HSPs. Policy frameworks must be complied with and implemented as part of ongoing operations.

The purpose of the policy framework is to ensure:

- a consistent approach is adopted for collecting and managing information across the WA health system
- best practices for information management and protects the privacy of individuals
- health and personal information is appropriately managed throughout its lifecycle
- proper and secure handling of business related information necessary for its services and functions.

Please find the link below to the Information Management Policy Framework

http://www.health.wa.gov.au/CircularsNew/Information_Management.cfm

OPERATIONAL DIRECTIVES

All Operational Directives (ODs) produced by the Purchasing and System Performance (PSP) Division of WA Health System will be migrated across to the Information Management Policy Framework referred to above. At time of publishing, the *Clinical Coding Policy MP 0056/17* and the *Hospital Morbidity Data Reporting Cycle and Edit Protocol Policy MP 0059/17* are located within the Information Management Policy Framework. Please refer to the instructions to all HSPs and CHEs concerning definitions, reporting time frames and instructions for submitting data to the HMDS.

HOSPITAL SYSTEMS REPORTING SCHEDULES

HEALTH SERVICE PROVIDERS & CONTRACTED HEALTH ENTITIES

HSPs and CHEs are required to follow the data and edit submission schedule as outlined in current policy. Please see the schedule set out in the *Hospital Morbidity Data Reporting Cycle and Edit Protocol Policy MP 0059/17* found in the Information Management Policy Framework.

http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13366

All records will be subjected to data quality screening once received by the HMDC. Hospitals have 10 working days from data submission due dates to address and correct any data quality errors or issues.

It is pivotal to hospital reimbursement and activity reporting that all data quality errors or issues are addressed in a timely manner. Any data quality errors or issues remaining in error uncorrected will remain in error and be excluded from any reporting and as a consequence, affect the downstream uses of this data.

PRIVATE HOSPITALS

In accordance with the *Private Hospitals and Health Services Act 1927*, private hospitals are required to provide inpatient data as per the Annexure A of their license. From January 2014, this requirement included sites registering for MyFT secure data transfer application. Private hospitals are required to send their data according to the data and edit submission schedule outlined in the licensing documentation issued annually by the Licensing and Regulatory Unit (LARU).

Guidelines for private hospitals are reviewed and updated as required and additional guideline documents may be issued to cover not only private hospitals but also kindred health care institutions.

Enquiries regarding policy or these guidelines may be addressed to the Director General of Health via:

Manager
Licensing and Accreditation Regulatory Unit
Department of Health WA
189 Royal Street
EAST PERTH WA 6004

VALIDATION OF SUBMITTED RECORDS

A data quality validation is an edit that compares data against a business rule. They are designed to validate the accuracy of a submitted record. Data elements reported to HMDC are validated against expected values to identify any potential errors for correction.

Inpatient information received from hospitals is used for:

- Key Performance Indicators (KPI)
- Activity Based Funding
- Clinical Indicators for the Office of Safety and Quality in Healthcare (OSQH)
- Health service monitoring, evaluation and planning
- Reporting to the Federal Government
- Research

- Responding to parliamentary questions and Ministerials

It is important that the quality and accuracy of the information received is of a high standard. Validation of cases submitted to HMDC from the hospitals is performed by the Data Quality Team (DQT) to maintain the quality of the information. Commented edits on unexpected values for a data item are returned to the hospitals for review. An edit is returned to the hospital as either a fatal or warning edit and both are equally important and expected to be reviewed and corrected where applicable.

TYPES OF DATA QUALITY EDITS

There are two types of data quality edits inherent in the HMDS edit reporting protocol. They are:

FATAL DATA QUALITY EDITS

These edits are triggered when one or more 'critical' errors have been identified in the submitted episode of care. Generally, fatal edits occur when there is something erroneous, inconsistent or illogical within the episode of care that could potentially impact or impair the assignment of an AR-DRG. (However, this is not exclusive criteria for edits).

Where a fatal edit is triggered the error values in question must be updated, otherwise the episode of care is considered invalid and will not flow through to the HMDC and consequently will not be reported or funded.

WARNING DATA QUALITY EDITS

These edits are triggered when one or more 'non-critical' errors have been identified in the submitted episode of care. Generally, warning edits occur when there is something erroneous, inconsistent, illogical or simply unusual within the episode of care that could compromise the data integrity of the episode of care and data reporting in general.

Warning edits can be divided into two broad types:

Non-critical: These edits indicate that there are erroneous or missing values within the episode of care and correction is required, but the reporting hospital needs to assess the episode of care more closely to identify which data element needs correction.

Warning: These edits indicate that there is an unusual value within the episode of care that may or may not be erroneous. Warning edits require review of the unusual information and health units should respond to these edits by verifying the unusual values or correcting values where they are identified as an actual error.

ADDITIONAL DATA QUALITY VALIDATIONS / INTERNAL DATA CHECKING

HSPs and CHEs should have in place regular data checking processes that look for data quality issues in their own data entry systems. This is very important as it prevents errors from occurring as early as possible and assists with the ongoing education of admission and data entry personnel. Doing basic checks of data against known validations is a good place to start. For example, checking demographic details are being correctly entered into residential address fields i.e. suburbs and postcodes match Australia Post published standards, suburb spelling is correct and there are no PO Box addresses or postcodes being reported in residential addresses.

There are various methods of data validation that result in the discovery of data anomalies and may relate to non-current financial year's data. The DQT often find that audit processes and ad hoc data requests will bring to light errors that are not uncovered via the usual edit protocol processes. As the responsibility of HSPs and CHEs is to ensure optimal data accuracy and adherence to policy and business rules, the DQT have an obligation to review all anomalies and determine the way in which they can and/or should be corrected.

Policy timeframes for data submission and edit protocols refer to the current financial years. As the inpatient data collection is a fluid database being updated and changed over time, there are no time limits or cut offs as to when data is no longer correctable. The DQT try where possible to limit requests for correction of very old data. Where there are large numbers of cases involved and there are clear mismatches and errors, to ensure consistency of reporting and data accuracy over time, the DQT may request that data is corrected by HSPs and CHEs going back 2 or 3 financial years.

If there are HSPs or CHEs who are notified outside the normal edit protocol process to correct data anomalies within a timeframe, and they remain uncorrected, the DQT will manually place all cases in error to appear on edit reports to be included in HSP key performance indicators. This may include cases that have been instructed via audit to be updated.

IMPORTANT

For HSPs, please note:

- If the value of a data element for an episode of care in edit is not updated then the episode of care **is not to be resent / reconfirmed.**
- If the value of a data element is changed or corrected for an episode of care in edit, the episode of care **should be resent / reconfirmed.**

MULTIPLE EDITS FOR SAME PATIENT

It is possible that a single episode of care can trigger multiple edits, either related or unrelated to each other. Where this occurs the system user should address each edit in turn and make the necessary corrections and resend the episode of care to HMDC.

HMDS EDIT UPDATES

If you identify that a particular HMDS edit is incorrect or you believe it is the source of numerous queries, please contact the Manager, Data Quality on (08) 9222 2472 to discuss.



4.0 CODING STANDARDS



CODING STANDARDS

In July 2013, the Australian Consortium for Classification Development (ACCD) acquired responsibility for managing and updating ICD-10-AM, Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS) in Australia under contract from the Independent Hospital Pricing Authority (IHPA). This section provides information on the responsibilities of clinical coders and useful resources and contacts for clinical coding in Western Australia.

DEMOGRAPHIC STANDARDS

The AIHW is progressively developing definitions to standardise the collection of data items throughout Australia to enable accurate analysis and comparison of information across all States and Territories. These definitions are regularly updated and published in the NHDD. Definitions used in this manual are consistent with those of the NHDD, available on [METeOR](#).

Some non-NHDD variables (for example client status) have been developed to reduce the number of items and questions to be asked of patients, but still allow extraction of the NHDD formats.

CLINICAL CODING STANDARDS

Clinical coders are responsible for translating the narrative descriptions of diagnoses and procedures into valid ICD-10-AM and ACHI codes. The standards for translation and application of these codes are defined in:

- ICD-10-AM/ACHI/ACS
- ACCD Coding Rules on the ACCD Classification Information Portal: www.accd.net.au/Clip/Default.aspx
- WA Coding Standards (*Appendix 1 of Clinical Coding Policy MP 0056/17*) <http://www.health.wa.gov.au/circularsnew/pdfs/13364.pdf>
- WA Coding Rules on the WA Clinical Coding Authority website: https://ww2.health.wa.gov.au/Articles/A_E/Clinical-Coding-Authority

The Australian Coding Standards are in place to ensure sound and consistent coding practice with ICD-10-AM and ACHI.

The WA Clinical Coding Authority at the Department of Health together with advice from the WA Clinical Coding Advisory Group has developed a number of specific standards for WA coders. These standards take precedence over the ACS, and are located in the WA Coding Standards.

The WA Clinical Coding Authority is to be consulted when the interpretation of a coding standard is required or where the classification system has no code available for a given diagnosis or procedure. The ICD-10-AM, ACHI and ACS Tenth Edition, produced by the ACCD, are to be used to code all separations from 1st July 2017 and ICD-10-AM, ACHI and ACS Eleventh Edition are to be used to code all separations from 1st July 2019.





5.0 HMDS DATA PROCESSING



HMDS DATA PROCESSING

This section provides an overview on the submission and processing of data received by both public and private hospitals, with additional information regarding tcheck validation software for private hospitals.

OVERVIEW

The hospital morbidity data is first loaded onto the HMDS staging area, a location on the database where batches of cases or individual cases enter the System Queue. The system process manager constantly scans the active queue before individual cases from each of the batches are taken off the queue for processing.

Cases that have been processed correctly enter the HMDS database as final validated data, which can be used for reporting and analysis purposes by the Department of Health, HSPs, CHEs and other nominated users. (The level of access is subject to confidentiality restrictions).

HOSPITAL DATA FEEDER SYSTEMS

A list of all the reporting hospitals and the software systems they use is listed in the WA Establishment List found in *Part B: HMDS Reference Documents* of this manual. The major feeder systems and their methods of transmitting data and edits are documented below. Please note that at the time of publishing this manual, the crossover to one Patient Management System (PAS) for Health Service Providers across the state has just been completed.

WEBPAS

Data from webPAS are sent via File Transfer Protocol (FTP) directly to the HMDS database, using a multi-line interface file very similar to the one described in Interface File Specifications found in *Part B: HMDS Reference Documents*. Cases in error are reported back to each hospital via the web or by email. The extracts are to be provided daily for each site. The daily extracts should contain cases submitted (new or resent) by sites since the previous daily extract.

Hospitals on the webPAS system transfer their demographic and clinical edit corrections electronically via an update function. Updating electronic records at the hospital level automatically ensures that the correction is made on the HMDS database without manual intervention.

OTHER HEALTH INFORMATION SYSTEMS (INCLUDING IN-HOUSE SYSTEMS)

Hospitals other than those on webPAS (public sector version), transfer their data, in encrypted format, to the HMDS via MyFT. The extracts are to be supplied monthly, and must contain all cases for each month.



A computer program known as 'tcheck' is made available to these hospitals to run edit checks on their data files prior to submission. Since the release of tcheck version 1.6, all private hospitals have been required to run their data through tcheck before submitting to the DQT. The report from the current version of tcheck will need to be submitted with the data. Any data that contains genuine errors in tcheck will not be loaded into production and will be returned to site for correction and re-extraction. All data are loaded into the user testing environment and reviewed for errors prior to loading into production.

Edits are sent to private hospitals via email. DQT staff will manually enter required modifications onto the central system once the appropriate corrections are confirmed and authorised by the private hospitals.

For sites that supply information in this way, data for any given month is only available from the HMDS for reporting and analysis once a file of sufficient quality for loading into HMDS production has been submitted by the site.

HMDS PROCESSING SCHEDULE - PER FEEDER SYSTEM

Hospital System	Transmission methods	Extraction	HMDS Processing	Edits Returned to Hospitals	Corrected / Confirmed Edits Returned to HMDS
webPAS	Secure FTP	Daily AM	Daily AM	Via web	Corrected: re-extracted Confirmed: Email
Other health information systems	MyFT	Monthly	Weekly	Email	Email



6.0 DATA ELEMENT DEFINITIONS



DATA ELEMENTS

This section provides specific information about every data element captured in the HMDS, including definitions, permitted values, applicable business rules and practical data collection information.

As data is analysed across Australia, it is important that the same definitions used for terms such as hospital, patient, admission and neonate. In most instances, the terms used in this manual are consistent with those used in the National Health Data Dictionary (NHDD), available on [METeOR](#) or those defined in the *Admission, Readmission, Discharge and Transfer Policy MP0058/17* found in the Information Management Policy Framework. METeOR is an AIHW website which contains national metadata standards for health, housing and community services statistics and information.

This section provides definitions for each data element reportable to HMDS and is divided into two sections:

- Non-Clinical Data Element Definitions
- Clinical Data Element Definitions

The Non-Clinical Data Element Definitions incorporates all data elements that are deemed to be non-clinical and would generally be captured through normal administrative processes. For example, patient demographics, admission details and separation details.

The Clinical Data Element Definitions incorporate all data elements that would normally be captured through morbidity coding processes. Clinical data elements directly correspond to the morbidity and treatment aspects that occur within an admission. For example, diagnoses, procedures, external cause and morphology details.

Within both sections, the data element definitions are listed alphabetically.

DATA DEFINITION FORMAT

A standardised format has been applied to each data element. This format ensures that relevant information is presented consistently and efficiently to the reader. The following provides a definitional overview of the format:



DATA ELEMENT TITLE

Data element name:	<i>Specifies the official name of the data element in line with the HMDS. The term data element may also be referred to as 'field' or 'data item'.</i>
System specific names:	<i>webPAS: Specifies the name of the equivalent data element as displayed in key hospital patient administration systems. Where the termed "Derived" is utilised, this means that the data element may not be displayed on user screens but is derived or auto-calculated by the system.</i>
Definition:	<i>Specifies the definition of the data element. Where possible, HMDS endeavours to align data element definitions with the National Health Data Dictionary (NHDD).</i>
Collection requirement:	<i>Specifies whether the item must be provided for every case or only applies under special circumstances. The types of collection requirements for HMDS include: Mandatory - must be collected Conditional i.e. must be collected where certain conditions are met Not mandatory - collection is optional</i>
METeOR reference:	<i>Specifies the six-digit data element number of the equivalent data element in the NHDD. This field is hyperlinked for ease of reference.</i>
Format:	<i>Specifies the format of the data element in relation to how it must be submitted to HMDS.</i>
Maximum length:	<i>Specifies the maximum length of the field in relation to how it must be submitted to HMDS.</i>
Permitted values:	<i>Specifies the permitted values to be entered. The term 'permitted values' may also be known as 'data domain'. Where there is a large number of Permitted Values, the reader is referred to the Appendices.</i>

GUIDE FOR USE

- *Specifies general guidelines and business rules applicable to the collection of the data element as well as providing further clarification on key data collection issues.*
- *May also provide explanation on why the data element is collected and criteria for collection.*

VALUE DEFINITIONS

1 - Value Definition Title

Provides a specific description of each value listed under the Permitted values. Not all data elements will have a list of permitted values.

EXAMPLES

Provides practical examples of how to capture the data element. Generally, the examples will cover a broad range of scenarios, incorporating pertinent guidelines or business rules under the Guide for Use.



HA22 FORM (HOSPITAL INPATIENT SUMMARY FORM)

Historically the HA22 form was used to manually submit data to the HMDC before the introduction of the electronic transfer of data. This form has been retained in the HMDS reference manual as it may be used as a temporary backup during system downtime and lists all the current data elements required for reporting. Please refer to Hospital Inpatient Summary Form - HA22 July 2018 in *Part B: HMDS Reference Documents*.

DERIVED DATA ELEMENTS

There are other data elements used by HMDC that are derived from the reportable data elements:

- Admission Age (in years): Calculated by year of [Admission Date] minus year of [Date of Birth]. If month/day of [Admission Date] is earlier than month/day of [Date of Birth], it is subtracted by 1.
- Event ID: Generated automatically for each case by HMDC for reference purposes.
- Length of Stay: Calculated by [Separation Date] minus [Admission Date] minus [Total Leave Days].
- DRG: Generated by DRG Grouper software. The current version for 2018/19 is AR-DRG 9.0. If DRG values are supplied by the reporting hospitals, AR-DRG 8.0 values are also accepted. Please note: This is not a mandatory reporting field, however, if supplied with data submissions by the facility, the Major Diagnostic Category must also be supplied via the grouping process.
- Major Diagnostic Category (MDC): Generated by DRG Grouper software. The current version for 2018/19 is AR-DRG 9.0. If MDC values are supplied by the reporting hospitals, AR-DRG 8.0 values are also accepted. Please note that this is not a mandatory reporting field, however, if supplied with data submissions by the facility, the DRG must also be supplied via the grouping process.



NON-CLINICAL DATA ELEMENT DEFINITIONS



ACCOMMODATION OCCUPIED

Data element name:	Accommodation Occupied
System specific names:	webPAS: Room Type (CAT RT)
Definition:	The type of room occupied by the patient at discharge.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	N (Numeric code)
Maximum length:	1
Permitted values:	1 - Single room 2 - Shared room

VALUE DEFINITIONS

1 - Single room

The patient occupies a room with a single bed and the room is not intended for occupancy by more than one person. This includes a mother rooming with her newborn. The room must be surrounded by walls with a door and may contain an ensuite.

2 - Shared room

The patient occupies a room where the intended occupancy of the room is for more than one person.

EXAMPLES

Example 1:	A patient occupies a bed in a four-bed ward.	
	Accommodation Occupied	<input type="text" value="2"/>
Example 2:	A mother and her newborn baby occupy a single room intended for one person only.	
	Accommodation Occupied	<input type="text" value="1"/>
Example 3:	A renal dialysis patient occupies a chair in a walled off area.	
	Accommodation Occupied	<input type="text" value="1"/>
Example 4:	A same-day gastroenterology patient occupies a curtained off bed in an area with five other beds.	
	Accommodation Occupied	<input type="text" value="2"/>



ACCOUNT / ADMISSION NUMBER

Data element name: Account/Admission Number

System specific names: webPAS: Account Number

Definition: The unique identifier of a hospital episode of care that may be used for billing.

Collection requirement: Mandatory

METeOR reference: Not applicable

Format: Alphanumeric

Maximum length: 12

Permitted values: Alphanumeric combination up to 12 characters

GUIDE FOR USE

The Account/Admission Number can be alphanumeric or numeric up to a maximum of 12 characters and must be a unique number for every episode of care.

Boarders (if admitting) and neonates must have their own unique Account/Admission Numbers.

EXAMPLES

Example 1: A patient was admitted to hospital and assigned 9203148 as an Account Number.

Account / Admission Number

9	2	0	3	1	4	8					
---	---	---	---	---	---	---	--	--	--	--	--

Example 2: A patient was admitted to hospital and assigned AB945793 as the Account Number.

Account / Admission Number

A	B	9	4	5	7	9	3				
---	---	---	---	---	---	---	---	--	--	--	--



ADMISSION DATE

Data element name: Admission Date

System specific names: webPAS: Admission Date

Definition: The date on which an admitted patient commences an episode of care that can be formal or statistical.

Collection requirement: Mandatory

METeOR reference: [269967](#)

Format: DDMMYYYY

Maximum length: 8

Permitted values: Date (Numeric)

GUIDE FOR USE

Enter the full date of admission, including leading zeros where necessary.

FORMAL ADMISSION

A formal admission is an administrative process that initiates a record of the patient's treatment and accommodation within a hospital.

The Admission Date for a formal admission will be the date the hospital commenced treatment and accommodation of the patient.

STATISTICAL ADMISSION

A statistical admission is an administrative process that occurs within an episode of care and captures the commencement of a particular type of care (Care Type).

The Admission Date for a statistical admission will be the date the patient commenced a particular Care Type.

EXAMPLES

Example 1: A patient was admitted on the 8th January 2017.

Admission Date

0	8	0	1	2	0	1	7
---	---	---	---	---	---	---	---

Example 2: A patient was statistically admitted (e.g. change in care type from acute care to rehabilitation) on the 1st February 2017.

Admission Date

0	1	0	2	2	0	1	5
---	---	---	---	---	---	---	---



ADMISSION STATUS

Data element name:	Admission Status
System specific names:	webPAS: Admission Status (CAT P)
Definition:	The urgency of the patient's admission to hospital and whether the admission occurred on an emergency or elective basis.
Collection requirement:	Mandatory
METeOR reference:	686084
Format:	N (Numeric code)
Maximum length:	1
Permitted values:	3 - Elective - waitlist 4 - Elective - not waitlist 6 - Emergency - Emergency Department admission 7 - Emergency - Direct admission

GUIDE FOR USE

All admissions must have an admission status assigned to indicate if the admission occurred on an emergency or elective basis. This data element may also be referred to as Urgency Status.

Firstly identify whether the admission qualifies as Elective or Emergency as follows, then apply if the admission is waitlisted, admitted via the Emergency Department or a direct admission to a valid ward or unit within the health facility.

EMERGENCY ADMISSION

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.

An emergency admission occurs if one or more of the following clinical conditions are applicable such that the patient required admission within 24 hours.

Such a patient would be:

- 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



- 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, 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.

Emergency care includes patients suffering from an acute illness or injury that requires urgent assessment and treatment. These patients are usually admitted via the Emergency Department or may be a direct admission to an Intensive Care Unit, Burns Unit or other specialty area. An admission from a private medical practice directly to hospital, which has not been placed on a formal booking list or waitlist, is an emergency admission.

Patients admitted as emergency admissions cannot be considered as being admitted from the waitlist.

Some obstetric cases may also qualify as emergency admissions. For example, patients who deliver at least one month prior to term or are admitted before the expected date of delivery for treatment of an acute illness or injury, may be regarded as emergency admissions.

ELECTIVE ADMISSION

If an admission meets the definition of elective, 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, will be assigned an admission status of elective. 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, will be assigned an admission status of elective.

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.

As admission status is a mandatory data collection field, a status does need to 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.

VALUE DEFINITIONS

3 - Elective - waitlist

The category should be used for admission of a patient for care which, in the opinion of the treating medical practitioner, is necessary however the admission can be delayed for at least 24 hours.

A patient waitlisted for care may or may not have a scheduled admission date assigned. Patients on the waiting list are assigned a clinical urgency status to prioritise the urgency for which they require elective hospital care.

Elective Waitlist patients may include cases under investigation for a non-urgent illness, or planned non-urgent procedures (e.g. an admission for sterilisation or cholecystectomy procedures).

4 - Elective - not waitlist

An elective admission is an admission of a patient for care or treatment which, in the opinion of the treating medical practitioner, is necessary and an admission that can be delayed for at least 24 hours.

These patients are not entered on the waitlist but may be entered on booking lists that have a scheduled date of admission assigned.

'Elective - not waitlist' patients may include non-urgent obstetric cases, repeat admissions for renal dialysis, chemotherapy, check cystoscopy, follow-up endoscopies or scheduled admissions booked from an outpatient attendance for the following day. Newborn babies



In the birth episode or babies born before arrival at hospital are always 'elective - not waitlist' admissions.

6 - Emergency - Emergency Department admission

This category applies to patients admitted via the hospital's own Emergency Department and have been seen by an Emergency Department medical practitioner for assessment and a decision to admit has been made within the Emergency Department.

7 - Emergency - Direct admission

This category applies to patients directly admitted to hospital **without** admission via the hospital's own Emergency Department. The nature of the booking is an emergency situation requiring urgent assessment or treatment that cannot be delayed more than 24 hours. This includes patients admitted directly to a hospital ward or unit referred by a medical practitioner from an external establishment or from the hospital's Outpatient Clinic or on site doctor's private consulting rooms. Note: A patient referred for admission by an Emergency Department medical practitioner from *another hospital* and admitted directly to the receiving hospital ward or unit, will have an admission status of 'Emergency-Direct admission'.

EXAMPLES

Example 1: A patient admitted for treatment of abdominal pain through the hospital's Emergency Department and deemed to require treatment within 24 hours.

Admission Status Emergency - Emergency Department admission

Example 2: A patient admitted with a term pregnancy for caesarean section. Admission Status should be Elective - not waitlist.

Admission Status Elective - not waitlist

Example 3: A patient who is admitted for ligation of varicose veins with the procedure scheduled on the hospital waiting list.

Admission Status Elective – waitlist

Example 4: A critically ill patient admitted directly to the intensive care unit at RPH transferred from Armadale-Kelmscott Hospital Emergency Department.

Admission Status Emergency - Direct Admission

Example 5: A patient is seen in an Outpatient Clinic and medical practitioner decides they require day surgery that is booked in for the following day.

Admission Status Elective - not waitlist

Example 6: A patient is seen in Hospital A's Emergency Department (ED) and the ED Clinician refers them to Hospital B for admission. The patient is transported via ambulance to Hospital B's ED where they are assessed by Hospital B (within the Emergency Department) ED Clinician before being admitted to Hospital B ward/bed.

Admission Status Emergency - Emergency Department admission



ADMISSION TIME

Data element name: Admission Time

System specific names: webPAS: Admission Time

Definition: The time at which an admitted patient commences an episode of care that can be formal or statistical. It is required to identify the time of commencement of the episode.

Collection requirement: Mandatory

METeOR reference: [682944](#)

Format: HHMM

Maximum length: 4

Permitted values: NNNN (Numeric)

GUIDE FOR USE

The admission time is when the patient commences the episode of care e.g. the commencement time of the admission or the time of birth in the case of a newborn. The admission time should be completed in using the 24-hour clock.

Where a patient is assessed in an Emergency Department and the decision to admit is made, the admission commencement time should be the time the patient leaves the Emergency Department for admission to the inpatient ward.

EXAMPLES

Example 1: A patient was transferred in from another hospital as a direct admission at midnight.

Admission Time

0	0	0	0
---	---	---	---

Example 2: A patient was statistically admitted (e.g. change in care type from acute care to rehabilitation) at 5.25pm.

Admission Time

1	7	2	5
---	---	---	---



ADMITTED FROM

Data element name:	Admitted From
System specific names:	webPAS: Hospital
Definition:	The establishment or facility from which the patient is admitted from.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	NNNN (Numeric Code)
Maximum length:	4
Permitted values:	See Admitted from / Discharged To Establishment Code lists in <i>Part B: HMDS Reference Documents</i> .

GUIDE FOR USE

The reference table for this data element consists of a combination of formal reporting establishments (such as acute care hospitals) and organisations or facilities that may or may not be a health service.

This data element is captured on admission and identifies the specific Establishment or Facility from which the patient has come from via a 4 digit numeric code.

All newborn babies, or babies born before arrival at hospital, must be admitted from 0900 - Home.

New establishments with no current establishment number should be assigned 4099 - *Unlisted Other Health Care Accommodation*. This is used to allow a patient to be admitted or discharged until HMDS has created a valid establishment number and will raise an edit when used.

As the code is temporary, private hospitals or CHEs will need to advise the DQT of the new facility and correct establishment number once allocated. For HSPs the case will need to be resent / reconfirmed once the new establishment number has been updated. It is the hospital's responsibility to advise the DQT that creation of a new establishment code number is required.

For contracted activity, please see guidelines under *Client Status and Contract/Funding Establishment*.



EXAMPLES

Example 1: Patient admitted following a transfer from Beverley Hospital.

Admitted From

0	4	0	1
---	---	---	---

Example 2: Patient is driven to hospital from their home for a booked admission.

Admitted From

0	9	0	0
---	---	---	---

Example 3: Patient is admitted via ambulance from a newly established Day Hospital. The establishment code is currently unlisted on the HMDS. Admitted From should be 4099 - Unlisted Other Health Care Facility (for temporary use only).

Admitted From

4	0	9	9
---	---	---	---

Example 4: Care Type for a patient changed from acute to rehabilitation requiring a statistical separation and readmission. Admitted From should be reclassified to this Hospital.

Admitted From

0	9	4	4
---	---	---	---

Example 5: Patient was admitted from Casuarina Prison via the outpatient department following an outpatient appointment.

Admitted From

2	1	0	7
---	---	---	---

Example 6: Patient who has been an inpatient at hospital A (0616) for 6 days is transferred to hospital B to receive haemodialysis for 5 hours. Hospital A is funding the haemodialysis treatment to be delivered by hospital B under a contractual arrangement. On completion of haemodialysis, the patient is returned to hospital A to continue their previous admission.

Hospital A- (Funding Hospital)

Admitted From:

0	9	9	9
---	---	---	---

Hospital B – (Contracted Hospital)

Admitted From:

0	6	1	6
---	---	---	---



CARE TYPE

Data element name: Care Type

System specific names: webPAS: Care Type

Definition: The overall nature of 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).

Collection requirement: Mandatory

METeOR reference: [584408](#)

Format: NN (Numeric code)

Maximum length: 2

Permitted values:

- 21 - Acute Care
- 22 - Rehabilitation Care
- 23 - Palliative Care
- 24 - Psychogeriatric Care
- 25 - Maintenance Care
- 26 - Newborn
- 27 - Organ &/or Tissue Procurement
- 28 - Boarder
- 29 - Geriatric Evaluation and Management
- 32 - Mental Health Care

GUIDE FOR USE

Care type refers to a phase of treatment and is meant to reflect the clinical intent and purpose of the treatment being delivered. The treating medical practitioner is responsible for determining the Care Type and should decide which category of care is required during a hospital stay. More than one Care Type may apply during a hospital stay, each associated with a separate episode of care. However, only one care type may be reported to HMDC on the one day.

STATISTICAL TYPE CHANGES

When the Care Type changes, the patient should be statistically discharged and then statistically re-admitted. A statistical type change can only occur when there is an authorised change in Care Type by the appropriate responsible medical practitioner documented in the patient's medical record.

Statistical type changes should **not occur** for a change in Ward, Funding Source or Client Status.



Changes to Care Type are to be made by a statistical discharge and a statistical re-admission as follows:

The patient will be statistically discharged by assigning:

Mode of Separation:	(5) Statistical type change
Discharged to:	(944) Statistical admission / type change
The patient will be re-admitted with a new account / admission number on the same date (after the previous discharge time) as follows by assigning:	
Source of Referral-Location:	(4) Hospital
Source of Referral-Professional	(7) Statistical admission / type change
Admitted from	(944) Statistical admission / type change

Each Care Type including admissions with only one care type during an admission will have a unique account / admission number. Episodes with more than one care type allocated, will have an Episode of Care Link Field number. The Episode of Care Link Field enables episodes of care within a hospital stay to be rolled up into one admission.

Please refer to the *Admission, Readmission, Discharge and Transfer Policy* for further Care Type information and care type exclusions.

VALID REPORTABLE CARE TYPE VALUES

21 - Acute Care

22 - Rehabilitation Care

23 - Palliative Care

24 - Psychogeriatric Care

25 - Maintenance Care

26 - Newborn

27 - Organ Procurement

28 - Boarder

29 - Geriatric Evaluation and Management

32 - Mental Health Care

Note: The Mental Health Care type can be applied to all applicable patients either receiving treatment in a designated psychiatric ward or in a general ward from 1st July 2016. Decision to allocate this care type must be based on meeting the criteria for admission and the definition of Mental Health Care Type as defined in the *Admission, Readmission, Discharge and Transfer Policy (ARDT Policy) - Care Types MP0058/17* and is to be supported by documentation by the medical practitioner responsible.



Patients who are transferred for ECT treatment in a general ward as per a documented mental health treatment plan created or informed by a specialist mental health clinician, should be admitted with a Mental Health Care Type. Additionally, a mental health legal status needs to be reported for an ECT admission because the primary clinical purpose or treatment goal is related to the patient's mental health disorder. As long as the patient's treatment is being delivered under a plan of treatment managed or informed by a clinician with specialised expertise in mental health, it meets the criteria for mental health care type.

POSSIBLE CARE TYPE AND CLIENT STATUS COMBINATIONS

Care Type	Client Status							
	Fund. Hosp	QNB	UNQNB	BRD	NHTP	Contract Service	Admitted Client	Organ Proc.
Acute	✓					✓	✓	
Rehabilitation	✓					✓	✓	
Palliative	✓					✓	✓	
Psycho-geriatric	✓					✓	✓	
Maintenance	✓				✓	✓	✓	
Newborn	✓	✓	✓			✓		
Organ Proc.								✓
Boarder	✓			✓		✓		
GEM	✓					✓	✓	
Mental Health Care	✓					✓	✓	

Key:

QNB: Qualified newborn.

UNQNB: Unqualified newborn.

BRD: Boarder

NHTP: Nursing Home Type Patient

GEM: Geriatric Evaluation & Management

Organ Proc: Organ Procurement

EXAMPLES

Example 1: A patient was admitted to a hospice for palliative care of bony metastases and carcinoma of the lung.

Care Type (Palliation)

23

Client Status (Admitted Client)

6

Example 2: A young patient is admitted with Multiple Sclerosis with a treatment goal to improve functioning and meets the admission criteria for a Rehabilitation admission.

Care Type (Rehabilitation)

22

Client Status (Admitted Client)

6

Example 3: A patient with Alzheimer's disease was admitted under a Psychogeriatric team for behaviour modification.

Care Type (Psychogeriatric Care)

24

Client Status (Admitted Client)

6

Example 4: A patient is admitted to the geriatric assessment unit due to multiple falls and the family is having difficulty in managing them at home.

Care Type (Geriatric Evaluation)

29

Client Status (Admitted Client)

6



CLIENT IDENTIFIER - UNIT MEDICAL RECORD NUMBER

Data element name: Client Identifier or Unit Medical Record Number

System specific names: webPAS: Client Identifier

Definition: Person identifier unique within an establishment

Collection requirement: Mandatory

METeOR reference: [290046](#)

Format: Alphanumeric

Maximum length: 10

Permitted values: Alphanumeric combination up to 10 characters

GUIDE FOR USE

The Client Identifier can be alphanumeric or numeric up to a maximum of 10 characters. The year number should not form any part of the Client Identifier.

Alternate names for the Client Identifier include Unit Medical Record Number (UMRN) or Unit Record Number (URN).

The same Client Identifier is retained by the hospital for the patient for all admissions within a particular hospital.

Boarders should be admitted under their own Client Identifier.

Organ Procurements should be registered under their own Client Identifier.

EXAMPLES

Example1: UMRN 271864 is entered as

Client Identifier

2	7	1	8	6	4				
---	---	---	---	---	---	--	--	--	--



CLIENT STATUS

Data element name: Client Status

System specific names: webPAS: Patient Type

Definition: A category assigned to an episode of care to further define the type of hospital service being provided to the patient. This data element should be collected in conjunction with Care Type.

Collection requirement: Mandatory

METeOR reference: N/A

Format: NN (Numeric code)

Maximum length: 2

Permitted values:

- 0 - Funding Hospital
- 1 - Qualified Newborn
- 2 - Unqualified Newborn
- 3 - Boarder
- 4 - Nursing Home Type
- 5 - Contracted Service
- 6 - Admitted Client
- 7 - Organ &/or Tissue Procurement

GUIDE FOR USE

Client Status is used to categorise patients.

See the table under data item Care Type for possible combinations of Care Type with Client Status.

VALUE DEFINITIONS

0 - Funding Hospital

When patient treatment is contracted out to another establishment, the hospital funding the service (the funding hospital) should record the Client Status as 0 - Funding Hospital. The Ward (Location) should be recorded with a prefix of ZZ.

Record the establishment number of the contracted service provider (i.e. the service provider performing the service on behalf of the Funding Hospital) in the Contracted/Funding Establishment field.



Client status	(0) Funding Hospital
Ward	ZZxxx (dummy ward)
Contracted / Funding Establishment	XXXX (Contracted Service Provider establishment number, see <i>Admitted From / Discharged To Establishment Lists in the Part B HMDS Reference Documents</i>)
Admitted From	Code applicable e.g. admitted from home 0900
Discharged To	Code applicable e.g. admitted from home 0900

1 - Qualified Newborn

A newborn is deemed to be qualified if he or she is 9 days of age or less and meets at least one of the following criteria:

- a) Is the second or subsequent live born infant of a multiple birth; or
- b) Is admitted to an intensive care facility overnight in a hospital, being a facility approved by the Commonwealth Minister, for the purpose of the provision of special care and is receiving care that would require admission to the intensive care facility; and/or
- c) Is admitted to, or remains in hospital without their mother.

All newborns are reported as qualified once they have accumulated one day of qualified care during their admission. Newborns do not automatically accumulate qualified days after achieving one qualified day of care and the days of qualified care rules should be followed for calculating days of qualified care.

Refer to data element *Days of Qualified Newborn Care* for further information.

Please note that for criteria 1 c) to apply, the mother of the newborn cannot be admitted to the same hospital as the newborn. For example, a mother admitted to the ICU whilst the newborn is admitted to a ward nursery within the same facility does not satisfy the criteria to change newborn status to Qualified.

2 - Unqualified Newborn

A newborn is deemed unqualified if they do not meet at least one of the above criteria listed under 1 - Qualified Newborn. All Newborns who fail to accumulate one qualified day during the admission are reported as unqualified.

3 - Boarder

A 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.



4 - Nursing Home Type Patient

Legislative Definition of a Nursing Home Type Patient (NHTP):

Under the Commonwealth (Cth) *Health Insurance Act 1973* (the Act), a Nursing Home Type Patient (NHTP), in relation to a hospital, means a patient in the hospital who has been provided with accommodation and nursing care, as an end in itself, for a continuous period exceeding 35 days (with a break of no more than 7 consecutive days). Under the terms of the Australian Health Care Agreements (2003 - 2008), any patient who has been in hospital for more than 35 continuous days and no longer requires acute or sub-acute care may be deemed to be a Nursing Home Type Patient.

The designation of care type (e.g. acute, subacute, maintenance care) is the responsibility of the medical practitioner responsible for care.

Qualifying Period:

The 35-day qualifying period may accrue in a single hospital or two or more hospitals, but not in nursing homes. Hospitals in which the qualifying period is accrued may be public or private. Transferring between hospitals has no effect on the qualifying period.

The qualifying period is broken only if the patient leaves a hospital, and does not enter another hospital for at least seven days. In this case, the patient will commence a new 35-day qualifying period from day one of the next admission to a hospital. Periods of seven days or less do not break the continuity of the qualifying admission.

Long Stay Patients:

Patients, who remain in hospital for more than 35 days, in order to receive ongoing acute or sub-acute care, remain classifiable as Other Admitted Patients (not NHTP). They are not deemed NHTP until such time as the medical practitioner authorises a change in care type to Maintenance (non-acute) Care.

NHTP patients can be re-classified to acute/subacute care if the medical practitioner responsible deems it appropriate and may occur in situations such as where a patient develops a secondary condition requiring medical attention.

It is expected that Nursing Home Type patients will not actually remain in hospital but will be transferred to a nursing home, or allocated a nursing home type bed for their ongoing care.

5 - Contracted Service

The provision of a service by one hospital on behalf of another institution, either public or private, is known as a Contracted Service. The funding/purchasing hospital is the originating hospital that pays for the service to be performed. The activity or care provided should be reported by both the hospital performing the activity (the contracted service provider) and by the funding/purchasing hospital.



Lease or partial contracts between hospitals, such as providing theatre time but not staff or equipment to another organisation are considered to be a contracted service under this definition. Other special services where designated institutions are funded to provide entire services for the State (e.g. hyperbaric chamber treatment at Fremantle Hospital) are not a contracted service and should not be reported using the contract/funding data items.

The hospital providing the service (contracted service provider) should record the Client Status as (5) Contracted Service and enter the establishment number of the funding/purchasing hospital in the Contracted/Funding Establishment field.

When the Contracted/Funding Establishment field is recorded, it is also necessary to record where the patient came from, using the Admitted From field. For example, if the patient came directly from home, then Admitted From = (0900) Home; or a patient transferred from RPH then Admitted From = (0101) RPH. If the patient is a current inpatient, 0999 should be used in the Admitted From and Discharged To fields if they return for treatment (*see example below*).

It is important to record this field accurately because only one hospital will receive reimbursement for the service provided. However, both hospitals should code the procedure(s) performed or service(s) provided. It is up to each party in the contract arrangement to inform each other of the correct patient information to report. Where patient admission information is received by both the contracting hospital and the funding hospital and this does not align, the cases will be put into error. Both parties to the contract then need to make contact with each other to establish the correct information and communicate that to each other and to the DQT.

Example:

A current Royal Perth inpatient is to be admitted for haemodialysis at Cannington Dialysis under contract to Royal Perth Hospital (RPH). The activity occurs at Cannington Dialysis. Royal Perth Hospital creates a non-activity funding episode for the patient receiving haemodialysis at Cannington Dialysis, which is a dummy record.

Field	Cannington Dialysis	Royal Perth Hospital
Type of record	Contracted service	Funding
Establishment Number	0654 (Cannington Dialysis)	0101 (RPH)
Admitted From	0900 (Home)	0999
Discharged To	0900 (Home)	0999
Client Status	5 (Contracted Service)	0 (Funding Hospital)
Contracted/Funding Establishment	0101 (RPH)	0654 (Cannington Dialysis)
Ward/Location	CANNINGTON	ZZxxxx

6 - Admitted Client

An admitted client is a person for whom a hospital accepts responsibility for treatment and/or care. It includes a person in respect of whom the hospital admission procedures



are completed and for whom the hospital charges a fee for accommodation and/or therapeutic or diagnostic services during the period of care.

Admitted patients include:

- Patients for whom a medical practitioner considers that an admission is necessary due to a medical condition or other circumstance related to the patient.
- Patients who are receiving Psycho-geriatric care.
- Respite care patients, i.e. patients with chronic conditions who are usually managed at home but due to factors in the home environment (physical, social or psychological) require hospital admission. The care given is for maintenance treatment only within an acute hospital setting (not applicable in nursing home/aged care accommodation).
- Patients who are treated in psychiatric units who have a stable but severe level of functional impairment and inability to function independently without extensive care and support and for whom the principal function is provision of care over an indefinite period (Psycho-geriatric patients).
- Patients in acute care facilities who have been seen by an ACAT and are awaiting placement in a nursing home, who remain in hospital for 35 days or less.

Admitted Patients **do not include:**

- Same day patients whose procedures are cancelled – please refer to the *ARDT Reference Manual* within the *ARDT policy MP 0058/17* <http://www.health.wa.gov.au/circularsnew/attachments/1242.pdf>
- Same day patients having procedures that do not require a hospital admission – please refer to the *ARDT Reference Manual* within the *ARDT policy MP 0058/17* <http://www.health.wa.gov.au/circularsnew/attachments/1242.pdf>
- Non-admitted patients who receive their entire care during an outpatient or other non-admitted service event.
- Boarders
- Patients who are dead on arrival
- Posthumous organ donors
- Aged care and flexible care residents (if admitted, they are not reportable to HMDC)
- Mothers who elect to deliver at home and their newborn(s) born at home (excluding newborns requiring inpatient admission post-delivery)
- Patients who receive care in their home (except where classifiable as Hospital in the Home [HITH]).

7 – Organ &/or Tissue Procurement



Posthumous organ and/or tissue procurement is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead. These patients are not admitted to the hospital but are registered by the hospital. The Care Type for this field should be Organ &/or Tissue Procurement.

This status of organ &/or tissue procurement may follow an acute episode in which the patient dies or be the initial period following brain death in another institution, in which the patient is ventilated and organ &/or tissue procurement procedures are carried out.

Criteria for organ &/or tissue procurement:

- The official time of death should be the time of discharge.
- The count of hours in ICU and/or the duration of mechanical ventilation recorded must cease at the time of death.
- The diagnoses and procedures undertaken during organ procurement are to be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards.

EXAMPLES

Example 1: A patient was admitted to Hospital X for Endoscopy under a pre-existing arrangement between Hospital X and Royal Perth Hospital. The contract required Hospital X to provide Endoscopy services for RPH.

Client Status (Contracted service)	5
Contracting/Funding Establishment	0101

Example 2: A patient was admitted for an appendectomy to be performed in the hospital of admission.

Client Status (Admitted Client)	6
---------------------------------	---

Example 3: A newborn baby was transferred from KEMH to Bunbury Regional Hospital aged three days and admitted with his mother for routine perinatal care.

Client Status (Unqualified newborn)	2
-------------------------------------	---

Note: The baby is not a boarder.

Example 4: A newborn baby aged 4 days admitted to hospital without his mother for treatment of tachypnoea.

Client Status (Qualified newborn)	1
-----------------------------------	---

Example 5: A newborn baby aged 10 days admitted for treatment of feeding problems.

Client Status (Admitted client)	6
---------------------------------	---



Example 6: A baby delivered stillborn at 28 weeks gestation.

Do not report baby's record to HMDS. This information is already captured on the mother's record
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Example 7: A patient admitted to an acute hospital for respite care while the normal carer was on holidays.

Client Status (Admitted client)	6
Care Type (Maintenance)	25

Example 8: A Royal Perth Hospital patient who was admitted to SJOG Subiaco hospital to have coronary artery bypass graft procedure as part of a contracted service arrangement between SJOG and RPH.

Client Status (for Royal Perth Hospital)	0
Ward/Location (for Royal Perth Hospital)	ZZ
Contracted/Funding Establishment (for RPH)	0616
Client Status (for SJOG hospital)	5
Contracted/Funding Establishment (for SJOG)	0101

Example 9: A patient was pronounced brain dead and consent was given for organ donation. The patient was discharged as deceased at this time and the organ procurement recorded in the registration that followed, with a client status of organ &/or tissue procurement.

Client Status (Organ Procurement)	7
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CLINICIAN ON ADMISSION

Data element name:	Clinician on Admission
System specific names:	webPAS: Attending Doctor
Definition:	The hospital medical practitioner who authorises the patient to be admitted to hospital as represented by the MBRN.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	Alphanumeric code
Maximum length:	13
Permitted values:	Valid Medical Board Registration Number as per AHPRA link listed below.

GUIDE FOR USE

The MBRN of the clinician on admission should be reported to HMDS using the Australian Health Practitioner Regulation Agency (AHPRA) website for providing the medical practitioner's current registration number:

<http://www.ahpra.gov.au/Registration/Registers%20of%20Practitioners.aspx>

The medical practitioners' registration number must be reported as 13 characters in length. Please ensure that you incorporate all leading zeros where applicable.

The Dental and Podiatrists' registration number is in the same 13 character alphanumeric format. The registration number for Dentists and Surgical Podiatrists should be reported to HMDS. Current registration numbers can be obtained from the above website.

Please note that the clinician on admission must have admitting rights at your hospital to be entered into this field.

For **BOARDERS** only, the number used for doctor on admission should be recorded as 000000.

EXAMPLES

Example 1: Dr Clarke admitted a patient to hospital and his registration number is MED0000010094.

Clinician on Admission

M	E	D	0	0	0	0	0	1	0	0	9	4
---	---	---	---	---	---	---	---	---	---	---	---	---



Example 2: Dentist Mr. White admitted a patient to hospital and his registration number is DEN0000002914.

Clinician on Admission

D	E	N	0	0	0	0	0	0	2	9	1	4
---	---	---	---	---	---	---	---	---	---	---	---	---

Example 3: Surgical Podiatrist Mr. Gold admitted a patient to hospital and his registration number is POD0000001935.

Clinician on Admission

P	O	D	0	0	0	0	0	0	1	9	3	5
---	---	---	---	---	---	---	---	---	---	---	---	---

Example 4: A boarder registered with the hospital while sick relative was treated.

Clinician on Admission

0	0	0	0	0	0
---	---	---	---	---	---

Example 5: A baby 6 days of age is admitted while their mother received treatment (the baby has the same number as the mother).

Clinician on Admission (for mother's record)	M	E	D	0	0	0	0	2	5	6	0	7	0
Clinician on Admission (for baby's record)	M	E	D	0	0	0	0	2	5	6	0	7	0



CLINICIAN ON SEPARATION

Data element name:	Clinician on Separation
System specific names:	webPAS: Attending Doctor
Definition:	The medical practitioner in the hospital who authorises the patient to be discharged from hospital.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	Alphanumeric code
Maximum length:	13
Permitted values:	Valid Medical Board Registration Number as per AHPRA link listed below.

GUIDE FOR USE

This field requires the Medical Board Registration Number (MBRN) of the medical practitioner authorising the patient's discharge from hospital.

Each doctor is assigned a MBRN as per the Australian Health Practitioner Regulation Agency (AHPRA).

To identify a particular medical practitioner's current MBRN you can reference the AHPRA website and perform a search using the medical practitioner's name:

<http://www.ahpra.gov.au/Registration/Registers%20of%20Practitioners.aspx>

Clinician on Separation field is a 13 character alphanumeric field and requires all leading zeros to be included, except when reporting boarders.

Please note that the clinician on separation must have admitting rights at your hospital to be entered into this field.

For boarders, the number used for clinician on separation should be "000000".

The Dental and Podiatrists' registration number is in the same 13 character alphanumeric format and should be reported.

EXAMPLES

Example 1: Dr Clarke was the medical practitioner on separation and his registration number is MED0000010094.



Clinician on Separation

M	E	D	0	0	0	0	0	1	0	0	9	4
---	---	---	---	---	---	---	---	---	---	---	---	---

Example 2: Dentist Mr. White admitted a patient to hospital and his registration number is DEN000000014. He was also the clinician on separation.

Clinician on Separation

D	E	N	0	0	0	0	0	0	0	0	1	4
---	---	---	---	---	---	---	---	---	---	---	---	---

Example 3: Surgical Podiatrist Mr. Gold admitted a patient to hospital and his registration number is POD0000001935. He was also the clinician on separation.

Clinician on Separation

P	O	D	0	0	0	0	0	0	1	9	3	5
---	---	---	---	---	---	---	---	---	---	---	---	---

Example 4: A boarder baby was registered with the hospital while his mother was treated.

Boarder

0	0	0	0	0	0
---	---	---	---	---	---



CONTRACTED / FUNDING ESTABLISHMENT

Data element name:	Contracted / Funding Establishment
System specific names:	webPAS: N/A
Definition:	The establishment number of the Contract Service Provider or Funding Hospital where a contractual treatment/care service occurs with an admitted episode of care.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	NNNN (Numeric code)
Maximum length:	4
Permitted values:	<i>See Admitted from / Discharged to Establishment List in Part B: HMDS Reference Documents.</i>

GUIDE FOR USE

An episode of care for an admitted patient whose treatment and/or care is provided under an arrangement between a hospital that purchases hospital care (the funding hospital) and a provider of an admitted service (the contracted service provider).

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 combinations of hospitals. For example, public to public or public to private.

All services provided by the Contracted Service Provider hospitals should be recorded and reported by the both the Funding Hospital and the Contracted Service Provider hospital. There are some circumstances where this will not be applicable, particularly where a provider does not report their activity to the HMDC. **Sites must notify the HMDC Data Managers of any arrangements where this is the case prior to finalisation of any contract.**

The Contracted Service Provider 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.

The Funding Hospital should record the Contracted Service Provider establishment number in the Contracted/Funding Establishment field, indicating that the patient received the treatment from that specified provider.



The Contracted Service Provider should record the Funding Hospital establishment number in the Contracted / Funding Establishment field, indicating that they have provided the service on contract on behalf of the specified Funding Hospital.

The establishment number recorded in the Contracting / Funding Establishment field should never be the same as the reporting establishment's number.

If the patient requires a contracted service whilst a current inpatient in the same establishment, use the code 0999 as the establishment number in the 'Admitted From' and 'Discharged To' fields. The code 0999 is to be used as a replacement for your own establishment when recording a funding admission within your own establishment.

A funding establishment admission must match the details of the contracted establishment episode in terms of admission and separation dates and the clinical coding of the treatment provided at the contracting establishment. The only exception to this is the medical practitioner's medical board registration number details.

**** Please note:** If you are unable to register the actual medical practitioner details providing the services at the contracting hospital into your system, it is permissible to use a generic medical board registration number as long as it is registered with the HMDC **prior** to reporting. *Please refer to the contacts page in this reference manual to contact HMDC to discuss.*



COUNTRY / STATE OF BIRTH

Data element name:	Country / State of Birth
System specific names:	webPAS: Country of Birth (CAT C)
Definition:	The Country/State of Birth identifies the Australian State or Country in which a patient was born.
Collection requirement:	Mandatory
METeOR reference:	659454
Format:	NNNN (Numeric code)
Maximum length:	4
Permitted values:	See Country of Birth Code list in <i>Part B: HMDS Reference Documents</i>

GUIDE FOR USE

The country of birth code embodies an important concept in the study of disease patterns between different ethnic population groups in Australia.

It also allows health care authorities to monitor the health status of migrants and assists in the provision of health services for diverse population groups.

If the patient is born overseas indicate country of birth, e.g. Italy, France, England, Scotland, and Wales.

If the patient is born within Australia, when known, indicate the State of birth, e.g. Western Australia, Tasmania etc.

If the patient is born in an Australian Territory other than the Australian Capital Territory (ACT) or the Northern Territory (NT), (e.g. Christmas Island, Cocos (Keeling) Islands, please enter code (0909) Other Territories (Ninth State).

If the patient is born on a ship or aircraft, indicate country of citizenship.

Only where all this information is not available, should you enter the code (0003) Not Stated.

EXAMPLES

Example 1: Patient born in Western Australia was admitted to hospital.

Country/State of Birth

0	9	0	5
---	---	---	---



Example 2: Patient born in Australia (not otherwise specified) was admitted to hospital.

Country/State of Birth

1	1	0	0
---	---	---	---

Example 3: Patient born in Tokyo was admitted to hospital. Country/State of Birth should be Japan.

Country/State of Birth

6	2	0	1
---	---	---	---

Example 4: Patient born at sea while parents were on a cruise was admitted to hospital, but is eligible for citizenship in Poland.

Country/State of Birth

3	3	0	7
---	---	---	---

Example 5: Patient born in New South Wales was admitted to hospital.

Country/State of Birth

0	9	0	1
---	---	---	---

Example 6: Patient born on Christmas Island was admitted to hospital.

Country/State of Birth

0	9	0	9
---	---	---	---

Example 7: Patient admitted but Country of Birth details Not Stated.

Country/State of Birth

0	0	0	3
---	---	---	---



DATE OF BIRTH

Data element name: Date of Birth

System specific names: webPAS: Date of Birth

Definition: The date of birth of the person expressed as DDMMYYYY.

Collection requirement: Mandatory

METeOR reference: [287007](#)

Format: DDMMYYYY

Maximum length: 8

Permitted values: Date (Numeric)

GUIDE FOR USE

Date of Birth enables derivation of age, at admission, for use in demographic analysis, assists in the unique identification of clients if other identifying information is missing or in question, and may be required for the derivation of other metadata items (e.g. the DRG for admitted patients).

The Date of Birth should always be given in day, month and full year (DDMMYYYY).

The day range is 01-31 (depending on the month), the month range is 01-12 and the century range is 18, 19 or 20.

Age is not to be sent on electronic files as it is a calculated field and that is performed by the HMDC.

It is important to be as accurate as possible when completing the birth date. It is recognised that some patients do not know the exact date of their birth. When the exact date of birth is unknown, please estimate the person's age and record the date of birth as follows:

AGE 76 YEARS DATE OF BIRTH 01/07/1942

AGE 31 YEARS DATE OF BIRTH 01/07/1987



EXAMPLES

Example 1: Date of Birth is 12th June 1960

Date of Birth

1	2	0	6	1	9	6	0
---	---	---	---	---	---	---	---

Example 2: Estimated age of 14 years old

Date of Birth

0	1	0	7	2	0	0	3
---	---	---	---	---	---	---	---

Example 3: A female patient is admitted to hospital in labour at 10.30pm on the 13th September 2017 and the baby is delivered at midnight 14th September 2017

Date of Birth for infant

1	4	0	9	2	0	1	7
---	---	---	---	---	---	---	---



DAYS OF HOSPITAL IN THE HOME CARE

Data element name:	Days of Hospital in the Home Care
System specific names:	webPAS: Not applicable (auto-calculated on extract)
Definition:	The number of hospital in the home days occurring within an episode of care for an admitted patient.
Collection requirement:	Conditional (required if Hospital in the Home days accrued, blank if none)
METeOR reference:	686115
Format:	NNN
Maximum length:	3
Permitted values:	Numeric count

GUIDE FOR USE

Hospital in the Home care (HITH) is the provision of overnight acute or mental health inpatient care in the patient's home or usual place of residence by hospital clinical staff. HITH care is considered a replacement for admitted hospital care and without HITH being available, patients would require to be seen in hospital daily. A HITH admission may occur as a continuation of a current inpatient admission or may be a stand-alone HITH admission. As HITH is a substitute for inpatient care, it is expected that patients are seen at least every second day by hospital clinical staff and clinical documentation is recorded for every visit. A HITH patient must be put on leave for every day they are not seen for treatment and these days are to be reported as leave days.

If the patient is attending the hospital for scheduled specialist medical review or other diagnostic investigation or treatment not appropriate for the home setting, for example an X-ray, HITH days may be reported for this contact.

It is accepted patients may be on leave over the weekend and receiving care during weekdays. Where patients are on leave for more than two consecutive days consideration should be given to whether the patient continues to require admitted care.

Where patients are not receiving/intended to receive this level of care, consideration should be given to whether the patient's treatment is more appropriately classified and reported as non-admitted care.

To qualify for a reported HITH day, a patient must have an in-person interaction with HITH staff in their home, which must contain therapeutic/clinical content and result in a dated



entry in the patient's medical record. If satellite/secondary medical records are maintained for HITH this should be cross referenced in the main hospital medical record.

Service days that consist of only telephone calls or delivery of items, cannot be reported as HITH days.

If scheduled care is cancelled, or the patient is not home when HITH staff visit, a leave day shall be reported for the patient.

Episodes with a HITH length of stay greater than 25 days should be reviewed to ensure the patient is still requiring admitted care.

HITH episodes with a length of stay of 1 day will be flagged as potential invalid admissions and require review.

If HITH patients require non-admitted care within the same hospital, e.g. attending an outpatient clinic, ED, or allied health service:

- Non-admitted care provided to an admitted patient is included as part of the admitted care episode. It may be recorded as non-admitted activity but will not be reported as activity (service event) for ABF purposes.

HITH patients attending ED may be transferred into an ED virtual ward. Current inpatients attending ED are to be assigned a visit type of admitted in the EDIS. Do not discharge the patient from HITH for this purpose.

If HITH patients should require a same day procedure, within the same hospital, a ward/bed transfer is recorded but no care type change, discharge or leave is required.

If HITH patients require admitted or non-admitted care at another hospital, and it is expected they will return within seven days, the patient is to be placed on leave and when the patient returns continue with the HITH admission. The date of discharge from HITH is to be recorded as the last day the patient received treatment.

HITH patients are recorded on leave for days not receiving clinical care.

Calculating the number of HITH days:

- The day the patient is admitted is counted as a HITH day if the patient was at home at the end of the day (overnight).
- The date of change between hospital and home accommodation is counted if the patient was at home at the end of the day (overnight).
- The date of separation is not counted, even if the patient was at home at the end of the day (overnight).
- Days of HITH cannot be greater than Length of Stay and cannot include any leave days.



EXAMPLES

Example 1: Patient admitted to Fremantle Hospital for 15 days. The last 5 days of the admission episode were within the HITH ward and care was delivered on each of these days in the patient's home by the clinical team.

DAYS OF HITH CARE

5

Example 2: Patient admitted to the HITH program and visited each day over 4 consecutive days delivering treatment for a long standing non-healing abscess.

DAYS OF HITH CARE

4



DAYS OF PSYCHIATRIC CARE

Data element name:	Days of Psychiatric Care
System specific names:	webPAS: Psychiatric days (<i>Derived</i>)
Definition:	The sum of the number of days or part days of stay that the person received care as an admitted patient within a designated psychiatric unit, minus the sum of leave days occurring during the stay within the designated unit.
Collection requirement:	Conditional (Required if mental health patient admitted to designated unit; blank otherwise)
METeOR reference:	552375
Format:	NNNN
Maximum length:	4
Permitted values:	Day count (Numeric)

GUIDE FOR USE

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 disorders.

To calculate days of psychiatric care, subtract the admission date to the designated psychiatric unit from the discharge date from the designated psychiatric unit, less any leave days during this period and less any days not in a designated psychiatric bed. Total psychiatric days must be less than or equal to the Length of Stay.

It is important to note that the counting of the days commences on admission to the designated psychiatric bed and ends when the patient is either discharged or transferred from the bed. It is possible that psychiatric care days may include one or more different periods during an admission. In these cases, the total number of psychiatric care days for the admission should be reported, excluding days not spent in a designated psychiatric unit.

If the patient is transferred to another part of the hospital for acute surgical or medical care, the days spent in the general ward should not be counted as psychiatric days, regardless of whether psychiatric care is continued or not.

Patients being admitted as boarders do not require this field to be completed.



Days of psychiatric care cannot be blank if a patient is admitted to a *designated psychiatric unit*.

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.

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.

Psychiatric hospitals

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 and Ageing under the Health Insurance Act 1973 (now licensed/approved by each State/Territory health authority), catering primarily for patients with psychiatric or behavioural disorders are included in this category.

Total psychiatric care days in stand-alone psychiatric hospitals are calculated by counting those days the patient received specialist psychiatric care. Leave days should be excluded.

EXAMPLES

Example 1: A patient was admitted to the psychiatric unit at Hospital A and discharged 36 days later after having 4 days on leave during the total period.

TOTAL PSYCHIATRIC CARE DAYS

0	0	3	2
---	---	---	---

Example 2: A patient was admitted to Hospital B for a hysterectomy but on the 4th day was noted to be severely depressed and was then transferred to the psychiatric unit. Total length of stay was 15 days.

TOTAL PSYCHIATRIC CARE DAYS

0	0	1	1
---	---	---	---

Example 3: A patient is admitted to a Medical Ward with depression and back pain. A psychiatrist reviews him but care continues under the admitting physician. The principal diagnosis is depression.

TOTAL PSYCHIATRIC CARE DAYS

			0
--	--	--	---



Example 4: *This example shows incorrectly reported data*

A patient is admitted to Fremantle Hospital. The Ward on discharge is not a designated psychiatric unit. However, the Days of Psychiatric Care equal the Length of Stay.

(This will raise a warning edit. If the ward on discharge was not a designated psychiatric unit, then the Days of Psychiatric Care would usually be less than the Length of Stay).

TOTAL PSYCHIATRIC CARE DAYS		1	0
LENGTH OF STAY		1	0

Example 5: *This example shows incorrectly reported data*

A patient is admitted to Abbotsford Private Hospital. The Days of Psychiatric Care are less than the Length of Stay.

(This will raise a warning edit. If the hospital is a designated psychiatric hospital, the Days of Psychiatric Care should equal the Length of Stay.)

TOTAL PSYCHIATRIC CARE DAYS			8
LENGTH OF STAY		1	0



DAYS OF QUALIFIED NEWBORN CARE

Data element name:	Days of Qualified Newborn Care
System specific names:	webPAS: <i>Derived</i>
Definition:	The number of qualified newborn days occurring within a newborn episode of care.
Collection requirement:	Conditional (leave blank if not newborn)
METeOR reference:	270033
Format:	NNN
Maximum length:	3
Permitted values:	Day count (Numeric)

GUIDE FOR USE

A newborn patient day is qualified if the infant is 9 days of age or less and meets at least one of the following criteria at midnight:

- Is the second or subsequent live born infant of a multiple birth.
- 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 and is receiving care that would require admission to the intensive care facility.
- Is admitted to, or remains in hospital without their mother.

A newborn patient day is unqualified if the infant does not meet any of the above criteria.

If at day 10 with date of birth counted as 0, a newborn patient is still receiving acute care, then every day they are receiving acute care after day 9 is counted as a qualified day.

Newborns 10 days of age or greater who no longer require an admitted patient level of clinical care should be statistically discharged, and then statistically re-admitted as boarders for the remainder of their admission or discharged.

The rules for calculating the number of qualified newborn days are outlined below.



MULTIDAY

The number of qualified days is calculated with reference to the admission date, separation date, and any date of change to qualification status:

- 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.

SAME DAY

The normal rules for calculation of patient days apply (in relation to leave and same day patients) i.e. a qualified patient should be allocated one qualified day if admitted and separated on the same day.

The length of stay for a newborn episode of care is equal to the sum of the qualified and unqualified days.

EXAMPLES

Example 1: A second twin is born in hospital and is discharged after 7 days. The baby remains qualified for the entire period.

Days of Qualified Newborn Care

0	0	7
---	---	---

Example 2: A premature baby is born in hospital and immediately admitted to the neonatal intensive care unit where they remain for 120 days.

Days of Qualified Newborn Care

1	2	0
---	---	---

Example 3: A newborn baby is admitted from another hospital aged 3 days and remains in hospital until aged 11 days while being treated with feeding problems. The mother comes to visit on a daily basis.

Days of Qualified Newborn Care

0	0	8
---	---	---

Example 4: A baby in the birth episode is classified as unqualified at the beginning of the episode but develops respiratory distress and 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) for 3 days. The baby then returns to the care of its mother for the remainder of the episode.

Note: the baby will have a Qualified Client Status and a Newborn Care Type. Only the actual days the requirement for qualified care are met, are reported as days of qualified care.



Days of Qualified Newborn Care

0	0	3
---	---	---

Example 5: A newborn baby is admitted from another hospital aged 5 days and remains in hospital for 3 days. The mother is registered as a Boarder for this period. Note: The boarder mother, like all boarders, is a registered non-admitted patient. The baby meets the criterion of “admitted to hospital without its mother” for the full 3 days. Therefore, the baby is a qualified newborn:

Days of Qualified Newborn Care

0	0	3
---	---	---

Example 6: A second twin is born in the early hours of the morning and later on the same day is transferred to another acute hospital for further monitoring and specialised treatment.

Days of Qualified Newborn Care

0	0	1
---	---	---



DISCHARGED TO

Data element name: Discharged To

System specific names: webPAS: Hospital

Definition: The Establishment or Facility to which the patient was discharged or transferred to when they left hospital.

Collection requirement: Mandatory

METeOR reference: Not applicable

Format: NNNN (Numeric code)

Maximum length: 4

Permitted values: *See Admitted From / Discharged To Establishment List in Part B: HMDS Reference Documents*

GUIDE FOR USE

- The reference table for this data element consists of a combination of formal reporting Establishments (such as acute care hospitals) and organisations or facilities that may or may not be a health service.
- This data element is captured on discharge and identifies the specific Establishment or Facility the patient is going to.
- The codes are not limited to hospitals only for the Discharged To field. This field also indicates some special codes for deceased patients, reclassified patients (i.e. care type changes), funding/contracting hospital and other locations or programs.

EXAMPLES

Example 1: The Discharged To field for contracted services at the funding hospital is to be completed as follows (if the patient is already an inpatient at the funding hospital at the time of transfer):

MODE OF SEPARATION	Other/home	9
DISCHARGED TO	Funding hospital	0999

Example 2: The patient is discharged to a hospital in another country:

MODE OF SEPARATION	Acute Hospital	1
DISCHARGED TO	Referred to Other hospital in another country	0986

Example 3: The patient is discharged to the police lockup:

MODE OF SEPARATION	Other/home	9
DISCHARGED TO	Referred to Police/Law Enforcement	0584



DVA CARD COLOUR

Data element name:	DVA (Veterans) Card Colour
System specific names:	webPAS: Veterans Card Colour
Definition:	An indicator of treatment entitlements assigned by the Department of Veterans' Affairs to eligible veterans. The Veteran Card Colour can be determined by sighting the patient's Department of Veterans' Affairs entitlement card.
Collection requirement:	Conditional (required if DVA; blank otherwise)
METeOR reference:	339127
Format:	N (Numeric code)
Maximum length:	1
Permitted values:	1 – Gold 2 – White

GUIDE FOR USE

The Hospital Services Arrangement (HSA) between the Department of Veterans' Affairs (DVA) and Western Australia ensures that persons entitled under the Veterans' Entitlements Act 1986 (Cth) and the Military Rehabilitation and Compensation Act 2004 (Cth), receive a comprehensive range of admitted patient hospital services.

Under the terms of the HSA, WA Health is required to provide DVA with information on entitled persons who are using admitted patient services. This information includes details of their service utilisation.

All patients must be asked whether they are entitled persons for that episode of care. Identification of entitled persons requires collection of the following data items:

- Funding Source (the value for entitled persons should be DVA)
- DVA File Number
- Veterans Card Colour

It is essential to identify all entitled persons at the point of service provision and their level of entitlement. Level of entitlement is indicated by the Veteran Card Colour.

Entitled patients who choose to use WA publicly funded hospital services and be treated as Repatriation private patients under the HSA are entitled to a choice in:

- Publicly funded hospital with a minimum of shared ward accommodation; and



- Doctor (provided the doctor has admitting rights for private patients at the chosen hospital).

This does not remove the patient’s right to elect to be treated as a public patient under the Australian Health Care Agreements. However, by electing to be a public patient, patients will not be entitled to choice of hospital or doctor.

Repatriation private patient status is not equivalent to having a private health insurance.

The above identifiers must be collected on admission, and recorded electronically on the relevant electronic data collection systems.

EXAMPLES

Example 1: A DVA patient was admitted with a gold card

Funding Source	2	7	(DVA)
Veterans Card Colour	1		(Gold)
DVA File Number	WX12345		

Example 2: A DVA patient was admitted with a white card

Funding Source	2	7	(DVA)
Veterans Card Colour	2		(White)
DVA File Number	WX6789A		



DVA FILE NUMBER

Data element name:	Department of Veterans' Affairs File Number
System specific names:	webPAS: DVA Number
Definition:	A unique personal identifier issued to a veteran by the Department of Veterans' Affairs.
Collection requirement:	Conditional (required if DVA; blank otherwise)
METeOR reference:	339127
Format:	Alphanumeric code
Maximum length:	9
Permitted values:	Alphanumeric

GUIDE FOR USE

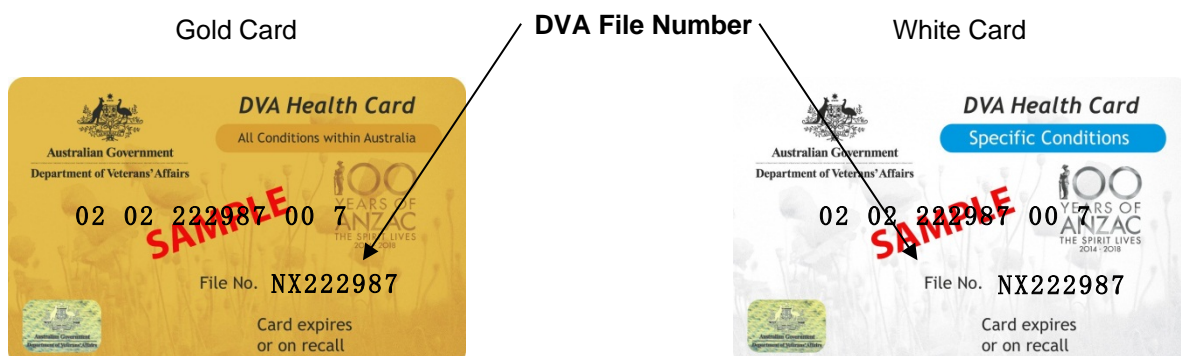
The DVA File Number is the number located below the person's name on the Repatriation Health Card that is issued by the DVA to eligible Veteran beneficiaries.

This data item is required to identify Veteran beneficiaries at point of service provision for admitted and non-admitted patients.

There should be NO spaces between the alpha and numeric values. The Alpha characters in the first position refer to the Australian States' initials. Therefore, the only valid characters in the first position of this field are N, Q, S, T, V and W. Veterans from the ACT and the Northern Territory have the initials N and S respectively.

The DVA File Number to be recorded is the one below the person's name on the GOLD and WHITE cards as shown below.

Note: The DVA File Number is NX222987 not 02 02 222987 00 7



Patients who choose to give up their entitlement for treatment under the Veterans' Entitlements Act 1986 (Cth) must have their card colour and DVA File Number recorded, regardless of the type of Funding Source indicated.

In some instances a patient may have a letter of authority to provide a particular inpatient service and may not have a DVA card. It is imperative that the patient contact DVA and ask them to provide details such as their DVA file number and the card colour they are considered to be.

EXAMPLES

Example 1: A patient was admitted to Royal Perth Hospital for treatment of a leg ulcer. The DVA has assumed responsibility for funding this patient's treatment.

Funding Source (Department of Veteran Affairs)								2	7
Veterans Card Colour									1
DVA File Number	W	X	3	9	6	1	4	6	

Example 2: A patient was admitted to Fremantle Hospital for treatment of a Chronic Obstructive Airways Disease. The patient is admitted as a public patient even though they have DVA entitlements.

Funding Source (Department of Veteran Affairs)								2	1
Veterans Card Colour									1
DVA File Number	W	X	3	9	6	1	4	6	



EMPLOYMENT STATUS

Data element name:	Employment Status
System specific names:	webPAS: Employment Status (CAT P2)
Definition:	The self-reported employment status of a patient, immediately prior to admission.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	NN (Numeric code)
Maximum length:	2
Permitted values:	1 - Child not at School 2 - Student 3 - Employed 4 - Unemployed 5 - Home Duties 6 - Retired 7 - Pensioner 8 - Other

GUIDE FOR USE

1 - Child not at School

Includes children attending kindergarten, playgroup, pre-primary and with an age under 4 years old or has their 5th birthday in the second half of the year (i.e. birth date is after 1 July).

2 - Student

Includes children attending school. Also applies to individuals who start full-time or have part-time study commitments equivalent to 20 hours per week or more. If less than 20 hours study and does not fit into any other category record Status as '8-Other'.

3 - Employed

Applies to individuals who have full-time or part-time employment either as an employee, employer, self-employed or volunteer.

4 - Unemployed



Applies to all individuals who are unemployed regardless of whether they are actively seeking employment or receiving unemployment benefits.

5 - Home Duties

Applies to individuals whose sole role is performing home duties i.e. they do not have any other occupation.

6 - Retired

Applies to a person who is retired from work but is not receiving an aged pension e.g. self-funded retiree.

7 - Pensioner

Applies to a person who has retired from work and is receiving an aged pension; or a person who is unable to work and receives other type of pension such as an invalid pension.

8 - Other

Includes a child with a disability who is not attending school between the age of 6 and 15. Once the child reaches 16 years of age, they should be entered as employed, unemployed or pensioner (invalid pensioner). Boarders and neonates must have their own unique Account/Admission Numbers.

EXAMPLES

Example 1: A 45 year old retired carpenter:

Employment Status (Retired)

Example 2: A 4-year-old child attending mandatory school:

Employment Status (Student)

Example 3: A 14-year-old child, not attending school and not employed:

Employment Status (Unemployed)

Example 4: A 14-year-old child, attending school:

Employment Status (Student)

Example 5: A 36 year old attending full time study at Curtin University, but working one evening a week at Pizza Hut:



Employment Status (Student)

Example 6: 13-year-old adolescent with a disability, not attending school and not employed:

Employment Status (Other)

Example 7: An 18 year old person with a disability, not employed and on an invalid pension:

Employment Status (Pensioner)

Example 8: A 20 year old person enlisted in the Defence Forces:

Employment Status (Employed)



EPIISODE OF CARE LINK FIELD

Data element name:	Episode of Care Link Field
System specific names:	webPAS: Account Number
Definition:	The account number from the first episode of care in a formal admission.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	Alphanumeric
Maximum length:	12
Permitted values:	Must be the same as the Account Number if there are no care type changes within the admission.

GUIDE FOR USE

The Episode of Care Link Field can be alphanumeric or numeric up to a maximum of 12 characters. This field contains the Account/Admission Number from the first episode of care in a formal admission.

The Episode of Care Link field must be populated for every admission and for any admissions with subsequent statistical admissions occurring due to care type changes within the one episode. The episode of care link field for the first admission will contain the admission/account number from that admission. The episode of care link field for each subsequent admission should contain the admission/account number from the first admission in the chain of care type changes.

****Please note:** Every separation must have the Episode of Care Link Field populated, not only statistical discharges and readmissions.

EXAMPLES

Example 1: A patient was admitted for acute care, with Account/Admission Number 09203148, so the Episode of Care Link Number is also 09203148.

Account / Admission Number	0	9	2	0	3	1	4	8				
Episode of Care Link Field	0	9	2	0	3	1	4	8				

Example 2: The patient's care type changed to rehabilitation care after a few days and so they were assigned a new Account/Admission Number 12349685. However, their Episode of Care Link Number stays as 09203148.

Account / Admission Number	1	2	3	4	9	6	8	5				
Episode of Care Link Field	0	9	2	0	3	1	4	8				



ESTABLISHMENT CODE

Data element name:	Establishment (Hospital/Health Service)
System specific names:	webPAS: N/A
Definition:	A unique four-digit number that is assigned globally by HMDS to each establishment as an identifier for the facility. A code may represent a valid inpatient reporting establishment or a non-reporting facility.
Collection requirement:	Mandatory
METeOR reference:	269973
Format:	NNNN (Numeric code)
Maximum length:	4
Permitted values:	<i>See Part B: HMDS Reporting Establishment List in HMDS Reference Documents compiled from the Health Services (Health Service Providers) Order 2016 and mandated in policy MP 0059/17</i>

GUIDE FOR USE

A list of valid hospital and health service establishments is provided in *Part B: HMDS Reference Documents*.

The establishments listed and indicated with a Y in the 'Report to HMDS' column, are hospitals or health services that are considered valid reporting establishments for the purposes of required reporting of admitted activity data to the HMDS. Only facilities indicated with a Y in the 'Report to HMDS' column on this list, are valid HMDS reporting establishments. [*Please see facilities listed under the Health Services (Health Service Providers) Order 2016*]

Each organisation must only have one Establishment Code assigned.

Establishment Allocation

Establishment Codes are assigned by the Inpatient Data Collections (IDC). If your Establishment is new and you require allocation in order to report data to HMDS, please contact IDC to arrange allocation of a unique code.

Updated establishment lists are uploaded to the Morbidity intranet periodically for HSPs to access throughout the year. CHEs and other Private Hospitals are sent updated copies of the Establishment Lists via MyFT as and when required.



Difference between Establishments and Admitted From / Discharged To data elements

Within the HMDS, the Admitted From and Discharged to data elements include Establishment Codes within their respective reference tables.

The Admitted From and Discharged To data elements are designed to capture the particular facility that the patient came from (on admission) or is being referred to (on discharge). These facilities can be valid reporting establishments or they can be non-reporting facilities such as prisons, residential aged care facilities, hostels or community health services.

EXAMPLES

Example 1: A patient was admitted to Bentley Hospital.

Establishment

0	2	5	5
---	---	---	---

Example 2: A patient was admitted to St John of God Health Care Murdoch.

Establishment

0	6	4	0
---	---	---	---



FIRST AND SECOND FORENAMES

Data element name:	First and second forenames
System specific names:	webPAS: 1 st Given name and 2 nd Given name
Definition:	The person's identifying name(s) within the family group or by which the person is socially identified, as represented by text. A patient may have more than one given name. All given names should be recorded.
Collection requirement:	First forename is mandatory Second forename is not mandatory
METeOR reference:	613440
Format:	Alpha
Maximum length:	First Forename - 30 Second Forename – 30
Permitted values:	Not applicable

GUIDE FOR USE

First and second name fields is a 30 character alphabetical field in which dots, dashes, apostrophes and hyphens are allowed.

First and second names should be recorded as follows:

- When the forename of a baby aged less than 29 days is unknown, BABY is valid. Babies of multiple births should be reported in the sequence of their birth.
- If the forename of a person over 28 days old is unknown - "UNKNOWN" should be recorded.
- Do not include the patient's alias name in the First Forename field.
- The use of brackets () for alias names is not accepted.
- Alias names should be recorded in the Alias field in the hospital's CPI or PMI.
- Some patients only have one name by which they are known. Record this name in the Surname field and enter "NO GIVEN NAME" in the First Forename field. **Do not report** any characters other than Alphas in the First Forename field e.g. (dots '.')



EXAMPLES

Example 1: Edwin J Roberts was admitted to hospital.

First Forename	EDWIN
Second Forename	J

Example 2: A patient was admitted to hospital in a coma and her forename was not known.

First Forename	UNKNOWN
Second Forename	

Example 3: A baby was born in hospital and was the second triplet of a multiple birth. The baby had not yet been named. The Mother's name was Karen.

First Forename	TR TWO KAREN
Second Forename	

Example 4: A baby was born in hospital and was named Peggy Sue Jones.

First Forename	PEGGY
Second Forename	SUE

Example 5: A newborn was admitted to hospital, the forename was not known and the mother's UMRN was not known.

First Forename	BABY OF CATHERINE
Second Forename	

Example 6: Than Phoon, who is also known as Tony, was admitted to hospital. Do not enter Tony as the first name. If your computer system has a function or field for storing the alias name (e.g. TOPAS) use the latter.

First Forename	THAN
Second Forename	TONY



FUNDING SOURCE

Data element name:	Funding Source
System specific names:	webPAS: Claim Type (CAT CL)
Definition:	The principal source of funds for an admitted patient episode.
Collection requirement:	Mandatory
METeOR reference:	679815
Format:	NN (Numeric code)
Maximum length:	2
Permitted values:	21 - Australian Health Care Agreement 22 - Private Health Insurance 23 - Self-Funded 24 - Worker's Compensation 25 - Motor Vehicle Third Party Personal Claim 26 - Other Compensation 27 - Department of Veterans' Affairs 28 - Department of Defence 29 - Correctional Facility 30 - Reciprocal Health Care Agreement 31 - Ineligible 32 - Other 33 - Ambulatory Surgery Initiative 34 - Detainee

GUIDE FOR USE

Funding Source must be captured for all patients as soon as practicable following admission to hospital. The patient must elect in writing to be treated as either public or private.

Funding Source is independent of the patient's Insurance Status. For example, a patient with private health insurance can have a Funding Source election of either public or private.

All qualified and unqualified newborns must have the same Funding Source as their mother.



VALUE DEFINITIONS

21 - Australian Health Care Agreements

Australian Health Care Agreements (AHCA) should be recorded as the Funding Source for:

- Medicare eligible admitted patients who elect 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. Please record these patients with a funding source of Reciprocal Health Care Agreement.

22 - Private Health Insurance

Applies to a patient who is eligible for treatment under the Australian Health Care Agreements and elects in writing to be treated as an admitted private patient by a medical practitioner of his/her own choice and is covered for hospital care by a private health insurance fund.

Excludes overseas visitors for whom travel insurance is the major funding source.

23 - Self Funded

Applies to a patient who is eligible for treatment under the Australian Health Care Agreements and elects in writing to be treated as an admitted private patient by a medical practitioner of his/her own choice, and is responsible for paying all hospital charges during the admission episode.

Professional charges raised by any medical or dental practitioner treating him or her and the charges for any other services agreed between the Commonwealth Minister and the State Minister is the responsibility of the patient. This includes patients who have given expressed or implied consent to another person to make the financial election on their behalf.

24 - Worker's Compensation

Applies to patients who are entitled to claim damages under the Workers' Compensation and Injury Management Act 1981. Include persons injured at their place of work where their employer's workers compensation insurance will pay for hospital and medical charges incurred during the hospital admission.



25 - Motor Vehicle Third Party Personal Claim

Applies to patients involved in a motor vehicle accident (MVA) and whose personal injury claims for hospital and medical charges are covered by Motor Vehicle Third Party Insurance.

The insuring party may be the Insurance Commission of Western Australia or equivalent agencies from other Australian States (e.g. Eastern States MVIT).

From July 2004, the Insurance Commission of WA will meet the costs of Emergency medical treatment for patients treated in an Emergency Department and/or admitted into an Intensive Care Unit, as a result of personal injury arising from a MVA involving a Western Australian registered vehicle irrespective of liability considerations.

Vehicles not covered include:

- Unregistered farm utility used solely for on farm use
- Dune buggy/trail bike used for off-road recreational purposes
- Non-West Australian, or Commonwealth registered vehicles that are the only vehicles involved in the accident

Refer to the Insurance Commission of Western Australia (ICWA) website for further information. [Insurance Commission of Western Australia](#)

26 - Other Compensation

Applies to a patient who is entitled to claim compensation under public liability, common law or medical negligence.

Includes compensation from a sporting club / association or other party where the latter are responsible for payment of the hospital account.

Foreign shipping company employees have their hospital and medical charges covered by the employing shipping company.

Excludes patients covered under Workers Compensation, Motor Vehicle Third Party Personal claims, and Department of Defence, Department of Veterans' Affairs and Travel Insurance claims.

27 - Department of Veterans' Affairs

Applies to a patient eligible for Veterans' Affairs beneficiary and whose hospital and medical charges are covered by the Department of Veterans' Affairs (DVA). These include payment by DVA for public hospital treatment of DVA gold cardholders for all conditions or payment of public hospital treatment of DVA white cardholders for specific war/conflict-related conditions.



28 - Department of Defence

Applies to a patient who is a member of the Australian Defence Forces. Defence personnel injured at work are covered under this classification, not Worker's Compensation.

Please note that members of overseas defence forces should be coded to 31 - Ineligible unless they are involved in joint armed forces exercises and are covered under a special health cover agreement with the Department of Defence.

29 - Correctional Facility

To be used for prisoners and other patients admitted to a hospital where the Department of Justice should be responsible for the payment of the hospital and medical charges.

These patients are currently treated as a public patient although the funding source is Correctional Facility.

Immigration detainees do not come under this funding source; they should be assigned to category 34 - Detainee.

30 - Reciprocal Health Care Agreement

Australia has Reciprocal Health Care Agreements (RHCA) with:

Belgium	New Zealand
Finland	Norway
Italy	Sweden
Ireland	Slovenia
Malta	United Kingdom
Netherlands	

RHCAs provide for free accommodation and treatment as public hospital services, but do not cover treatment as a private patient in any kind of hospital.

RHCAs with Belgium, Finland, Italy, Malta, the Netherlands, Norway, Sweden, Slovenia 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.

RHCAs 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 (i.e. visiting a general practitioner).

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

Excludes overseas visitors who elect to be treated as private patients.



31 - Ineligible

Applies to patients who are not covered under the Australian Health Care Agreement, and are not considered exempt from fees for service.

Ineligible patients include:

- Overseas visitors whose countries of origin do not have Reciprocal Health Care Agreements with Australia. (Generally, all fees for service would be covered by travel insurance for these patients).
- Foreign Defence Force personnel (unless there is a special arrangement with the Australian Defence Force to provide health care cover for these patients while involved in a joint exercise).
- Any other ineligible patients who are not covered by any of the other funding source categories listed.

The Insurance Commission of Western Australia may cover overseas visitors involved in traffic accidents.

Please Note: Eligibility for Medicare relates to the patient's Country of Birth and current residency. A patient may be eligible for Medicare due to being born in Australia and residing there, but may choose to not register with Medicare. This does **not** deem the patient 'ineligible'. The patient may choose to self-fund their care and should be reported with a self-funded funding source and provided with an invoice for payment.

32 - Other

Applies to patients who do not satisfy the requirements of any other funding source categories. Includes:

- Overseas patients receiving humanitarian treatment - those not covered by Commonwealth funding.
- Overseas students covered by private health insurance; these patients have special fee arrangements.

33 - Ambulatory Surgery Initiative

Applies to patients who are admitted to the Ambulatory Surgery Initiative (ASI). ASI has been undertaken at some public hospitals to cater for day surgery cases that can be done as ambulatory care.

34 - Detainee

Applies to patients who are, on admission, deemed as ineligible immigrants detained in an Immigration Detention Centre. Identification of Detainee patients facilitates fiscal reimbursement by the Commonwealth for any health services provided to detainees.



EXAMPLES

Example 1: A patient is admitted with a work-related injury, where the company is responsible for payment.

Funding Source for Hospital Patient

2	4
---	---

 (Worker's Compensation)

Example 2: A patient is admitted for treatment of an injury sustained in a motor vehicle accident, where the Insurance Commission of WA is responsible for payment.

Funding Source for Hospital Patient

2	5
---	---

 (Motor Vehicle Third Party Personal Claim)

Example 3: A patient is admitted after falling and injuring her back in the local supermarket. She is making a public liability insurance claim.

Funding Source for Hospital Patient

2	6
---	---

 (Other Compensation)

Example 4: A patient with a Repatriation Health Gold Card is admitted to a public hospital for treatment of chronic airways limitation.

Funding Source for Hospital Patient

2	7
---	---

 (DVA)

Example 5: A patient from Netherlands is admitted to a public hospital following a Stroke.

Funding Source for Hospital Patient

3	0
---	---

 (RHCA)

Example 6: A Japanese tourist was admitted for treatment of abdominal pain.

Funding Source for Hospital Patient

3	1
---	---

 (Ineligible)

Example 7: An Overseas Student is admitted with appendicitis to Royal Perth Hospital.

Funding Source for Hospital Patient

3	2
---	---

 (Other)

Example 8: A patient is attending hospital under the Ambulatory Surgery Initiative.

Funding Source for Hospital Patient

3	3
---	---

 (Ambulatory Surgery Initiative)

Example 9: A patient detained in the Christmas Island Detention Centre is admitted to Royal Perth Hospital for treatment of Pneumonia.

Funding Source for Hospital Patient

3	4
---	---

 (Detainee)



HOURS IN INTENSIVE CARE UNIT

Data element name:	Hours in Intensive Care Unit
System specific names:	webPAS: Not Applicable (auto-calculated on extract)
Definition:	The number of hours spent in a designated intensive care bed during an episode of admitted care, rounded to the nearest hour.
Collection requirement:	Conditional (required if time spent in a designated intensive care bed; blank otherwise)
METeOR reference:	471553
Format:	NNNNN (Numeric)
Maximum length:	5
Permitted values:	0001-99999

GUIDE FOR USE

ICU hours cannot be greater than Length of Stay, and cannot include any periods of leave.

Report the hours in ICU for each episode of care type reported within an admission. For example, if a patient has been statistically discharged between Care Types and had more than one period of stay in a designated ICU bed, report hours in ICU for each Care Type change. Do not aggregate the hours in ICU for each Care Type and report the aggregate hours on the final discharge.

Round the cumulative hours in ICU, up or down to the nearest hour. If 0 - 29 minutes round down to 0 hours. If 30 - 59 minutes round up to 1 hour. For example, if a patient was in a designated ICU bed for 19 hours and 20 minutes, round down the total hours in ICU to 19 hours.

This data element includes hours spent in Level 3 or > intensive care unit only.

- Adult Intensive Care Unit, Level 3
- Paediatric Intensive Care Unit
- Neonatal Intensive Care Unit, Level 3

This data element **excludes** hours spent in:

- Critical Care Units
- High Dependency Units
- Level 2 Nurseries

Days in a Level 2 Nursery must be reported as qualified newborn days.



Types of Intensive Care Units

An ICU is a designated ward of the hospital that is especially 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.

There are five different types and levels of ICU:

1. Adult intensive care unit, Level 3
2. Paediatric intensive care unit
3. Neonatal intensive care unit, Level 3

These intensive care units are defined according to three main criteria as follows:

- a) The nature of the facility
- b) The care process
- c) The clinical standards and staffing requirements

Clinical standards and staffing requirements:

An intensive care unit must substantially conform to the appropriate guidelines of the Australian Council of Health Care Standards.

Adult Intensive Care Unit, Level 3

Nature of facility: A Level 3 adult ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period. It must be a tertiary centre for patients in need of intensive care services and have extensive back up laboratory and clinical service facilities to support this tertiary referral role.

Care process: A Level 3 adult ICU must be capable of providing mechanical ventilation, extracorporeal renal support services and invasive cardiovascular monitoring for an indefinite period. These types of service are illustrative of the nature of the care provided in a Level 3 adult intensive care unit but are not exhaustive of the possibilities.

Do not report hours in High Dependency Units (HDU) and Critical Care Units (CCU) as Hours of ICU care.

Paediatric Intensive Care Unit

Nature of facility: A paediatric ICU must be a separate and self-contained facility in the hospital capable of providing complex, multisystem life support for an indefinite period. It must be a tertiary referral centre for children needing intensive care services and have extensive back up laboratory and clinical service facilities to support this tertiary role.



Care process: A paediatric ICU 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. These types of service are illustrative of the nature of the care provided in a paediatric intensive care unit but are not exhaustive of the possibilities.

Neonatal Intensive Care Unit, Level 3

Nature of facility: A Level 3 neonatal ICU must be a separate and self-contained facility in the hospital capable of providing complex, multisystem life support for an indefinite period.

Care process: A Level 3 neonatal ICU must be capable of providing mechanical ventilation and invasive cardiovascular monitoring. These types of service are illustrative of the nature of the care provided in a Level 3 neonatal ICU but are not exhaustive of the possibilities.

The hospitals in WA who have neonatal ICU under this definition are King Edward Memorial Hospital and Princess Margaret Hospital.

EXAMPLES

Example 1: Admitted to ICU 12/04/2015 at 1300 hours. Discharged from ICU 12/04/2015 at 1720 hours. Total time in ICU = 4 hours and 20 minutes. Round down to 4 hours.

Reported as

Example 2: Admitted to ICU 15/07/2015 at 1315 hours. Discharged from ICU 19/07/2015 at 1600 hours. Total time in ICU = 98 hours and 45 minutes.

Round up to 99 hours.

Reported as

Example 3: Admitted to ICU 20/09/2015 at 2000 hours. Discharged from ICU 20/09/2015 at 2020 hours. Total time in ICU = 20 minutes. Round down to 0 hours.

No hours reported. Field left blank.

Example 4: Admitted to ICU 15/03/2015 at 0900 hours. Discharged from ICU 15/03/2015 at 1330 hours Total time in ICU = 4 hours and 30 minutes.

Round up to 5 hours.

Reported as



INDIGENOUS STATUS

Data element name:	Indigenous Status
System specific names:	webPAS: Aboriginality
Definition:	Whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin.
Collection requirement:	Mandatory
METeOR reference:	602543
Format:	N (Numeric code)
Maximum length:	1
Permitted values:	1 - Aboriginal but not Torres Strait Islander 2 - Torres Strait Islander but not Aboriginal 3 - Both Aboriginal and Torres Strait Islander 4 - Neither Aboriginal nor Torres Strait Islander

GUIDE FOR USE

Collection of indigenous status is extremely important in health data collections throughout Australia. Historically there have been significant data quality issues with the collection of this data item resulting in unreliable measures of indigenous inpatient activity. Of note, there may be a loading applied by the Independent Hospital Pricing Authority (IHPA) to account for additional costs of treatment of Aboriginal and Torres Strait Islander patients.

There are three components to this definition: descent, self-identification and community acceptance. All three should be satisfied for a person to be Aboriginal. However, it is not possible to collect proof of descent or community acceptance in the hospital setting. If a person identifies himself or herself as Aboriginal, then assign the most appropriate code (1-3).

The following question must be asked of ALL PATIENTS:

"Are you (or your family member) of Aboriginal or Torres Strait Islander origin?"

In circumstances where it is impossible to ask the patient directly, such as in the case of death or lack of consciousness, the question should be asked of a close relative or friend if available to do so.

If the Admission Clerk is unable to speak directly with the patient, the ward staff should ask the patient the above question, or ask a close relative or friend if the patient is not able to provide the information.



VALUE DEFINITIONS

1 - Aboriginal but not Torres Strait Islander

An Aboriginal is a person of Aboriginal descent who identifies as an Australian Aboriginal.

2 - Torres Strait Islander but not Aboriginal

A Torres Strait Islander is a person of Torres Strait Island descent who identifies as Torres Strait Islander.

3 - Both Aboriginal and Torres Strait Islander

A person who identifies as both an Australian Aboriginal and Torres Strait Islander.

4 – Neither Aboriginal nor Torres Strait Islander

A person who does not identify as either an Australian Aboriginal, Torres Strait Islander or both. Generally, a person who identifies under this category are considered "Non-Indigenous". Persons of other ethnicity such as Caucasian, Afro-American, Polynesian, Asian or Indian must be recorded as 4 – Neither Aboriginal nor Torres Strait Islander

EXAMPLES

Example 1: A patient of Afro-American ethnicity was admitted. The patient is not an Aboriginal nor Torres Strait Islander.

Indigenous Status

4

(Neither Aboriginal nor Torres Strait Islander)

Example 2: An Aboriginal patient was transferred from Kununurra, and gave his place of birth as Torres Strait. (Note: It is important to clarify whether the patient wants both heritages recorded. If so, the following code assignment should be made).

Indigenous Status

3

(Aboriginal and Torres Strait Islander)

Example 3: If the patient does not wish to have both heritages recorded then assign the heritage as provided by the patient (Aboriginal but not Torres Strait Islander).

Indigenous Status

1

(Aboriginal not Torres Strait Islander)



INFANT WEIGHT

Data element name: Infant Weight

System specific names: webPAS: Admission Weight

Definition: The first weight, in grams, of the live-born 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.

Collection requirement: Conditional (required if < 1 year of age)

METeOR reference: Not applicable

Format: NNNN (Numeric)

Maximum length: 4

Permitted values: 0001 to 9999 gms

GUIDE FOR USE

The weight of all patients less than 1 year of age must be reported to the HMDS, that is either the:

- First weight recorded after birth for a live born newborn during the hospital admission for the birth episode. (Note: The birth of stillborn babies is not reported to the HMDS)

OR

- The weight on admission (where the baby was born elsewhere or born during the mother's previous admission to hospital).
- Infant weight should be recorded for all infants if they are less than 1 year of age. For infant admission weights that are greater (>) than 9999 gms, please record as 9999 gms.
- For infants admitted as boarders, an infant weight does not need to be recorded. Some systems may require a weight to be recorded, in which case it is permissible to do so as per directives above.

EXAMPLES

Example 1: A 10-day old baby was readmitted for circumcision and his admission weight was 4130 grams.

Infant Weight

4	1	3	0
---	---	---	---



Example 2: A premature baby six months old with a low birth weight was transferred to another hospital to increase weight and condition, and on admission weighed 1820 grams.

Infant Weight

1	8	2	0
---	---	---	---

Example 3: An eleven month old baby was admitted with RSV positive bronchiolitis with an admission weight of 10,200 grams.

Infant Weight

9	9	9	9
---	---	---	---

*** It is imperative that infant weights 10,000 gms or greater be recorded as 9999 grams. This will ensure that DRG assignment is not adversely impacted.**



INSURANCE STATUS

Data element name:	Insurance Status
System specific names:	webPAS: Health fund
Definition:	Indicates whether patient has hospital insurance.
Collection requirement:	Mandatory
METeOR reference:	647326
Format:	N (Numeric code)
Maximum length:	1
Permitted values:	1 - Yes (Hospital Insurance) 2 - No (No Hospital Insurance)

GUIDE FOR USE

This data element indicates whether the patient has hospital insurance, not their method of payment for the episode of care.

If a patient does not have Hospital Insurance cover, they can still be admitted as a private patient, but the Funding Source must be 'Self-Funded' and the Insurance Status must be 'No'.

If a patient elects their Funding Source to be Private Health Insurance, the Insurance Status must be 'Yes'.

VALUE DEFINITIONS

1 - Yes (Hospital Insurance)...

A patient is deemed to have hospital insurance if they have:

- Registered insurance - hospital insurance with a health insurance fund registered under the National Health Act 1953 (Cth); or
- General insurance - hospital insurance with a general insurance company under a guaranteed renewable policy providing benefits similar to those available under registered insurance; or
- No hospital insurance or benefits coverage under the above.



2 - No (No Hospital Insurance)

No hospital insurance includes patients who are not covered by any benefits as outlined above.

A patient who has ancillary benefits only does not have hospital insurance. Ancillary benefits do not cover admission to hospital as a private patient.

Patients who have taken out hospital insurance, but are not covered for a particular procedure due to waiting period requirements of the health fund, are not considered to have Hospital Insurance for that admission.

EXAMPLES

Example 1: A patient was admitted to a public hospital as a private patient for treatment and the Health Insurance Fund accepted responsibility for payment.

INSURED

Example 2: A patient is admitted to a public hospital, and their private insurance covers ancillary benefits only.

DOES NOT HAVE HOSPITAL INSURANCE

Example 3: A patient is admitted to a public hospital and has no private insurance.

DOES NOT HAVE HOSPITAL INSURANCE

Example 4: A patient is admitted to a public hospital with private hospital insurance but has opted to be admitted as a public patient.

INSURED

Example 5: An overseas student is admitted to a public hospital with private hospital insurance as they have joined HBF to provide Health Insurance cover while they are studying in Australia.

INSURED

Example 6: A prisoner is admitted to a public hospital from Casuarina prison.

NO HOSPITAL INSURANCE

Example 7: A person is admitted from New Zealand, and does not have any private health insurance. However, New Zealand has a Reciprocal Health Care Agreement with Australia.

NO HOSPITAL INSURANCE



INTENDED LENGTH OF STAY

Data element name: Intended Length of Stay

System specific names: webPAS: Intended Stay (CAT VI)

Definition: The intention of the responsible medical practitioner 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.

Collection requirement: Mandatory

METeOR reference: [270399](#)

Format: N (Numeric code)

Maximum length: 1

Permitted values: 1 - Intended same-day stay
2 - Intended overnight stay

GUIDE FOR USE

- Intended length of stay should be assigned on admission and should not be revised regardless of the actual length of stay.
- Where the intended length of stay is not known on admission, the value for the intended overnight stay is assigned.

VALUE DEFINITIONS

1 - Intended same-day stay

Applies to any patient where the doctor on admission decides that the hospital stay will be for one day only. This means, the intention of the doctor at admission is to admit and discharge the patient on the same date.

A complication may occur or a late theatre listing may mean a risk in discharging the patient on the same day and the patient may actually need to stay in hospital overnight or for a longer period. However, because the intention at admission was to admit and discharge on the same day, the patient remains as an intended same day stay.

2 - Intended overnight stay

Applies to any patient where the doctor at admission decides that the hospital stay will be overnight. The actual number of days the patient stays in hospital will not affect this category.



EXAMPLES

Example 1: A patient was admitted to a day ward for uncomplicated cataract extraction, which the medical practitioner indicated would take four hours and the patient would be discharged later the same day.

Intended Length of Stay

Example 2: A patient admitted for cataract extraction was intended for discharge on the same day. Patient developed respiratory failure after surgery and was transferred to ICU for five days. Final discharge was nine days after admission.

Intended Length of Stay

Example 3: A patient admitted in the morning for treatment of concussion was discharged later that day, although it was planned to admit the patient overnight.

Intended Length of Stay

Example 4: A patient was admitted to hospital for monitoring of a cardiac condition that was thought to require an overnight stay. On ECG, it was found to be a harmless anomaly and the patient was discharged on the day of admission.

Intended Length of Stay



INTERPRETER SERVICE

Data element name:	Interpreter Service
System specific names:	webPAS: Interpreter
Definition:	Whether an interpreter service is required by or for the patient.
Collection requirement:	Mandatory
METeOR reference:	304294
Format:	N (Numeric code)
Maximum length:	1
Permitted values:	1 - Yes 2 - No

GUIDE FOR USE

The use of an interpreter service may be necessary for any language, including non-verbal languages, used by the patient for communication.

This information is required by the interpreter services to establish the use of these resources in the health sector.

This data item should only have a value of (1) Yes **if an official paid interpreter service is used.**

Family members or friends interpreting for the patient are not considered as providing an interpreter service for the purposes of completing this data item. However, if an interpreter service is required for a patient's relative because the patient cannot communicate for some reason, this field should be completed on the patient's admission. This may apply to patients who are unconscious; or newborn babies and small children whose relatives are not fluent in English and require an interpreter to communicate on the patient's behalf.

EXAMPLES

Example 1: A patient is admitted to hospital for treatment of a urinary tract infection and cannot speak English. An official paid interpreter service is used to communicate with the patient.

Interpreter Service

Example 2: A patient is admitted primary language is not English but the patient can speak English. Interpreter is not required.

Interpreter Service



LANGUAGE

Data element name:	Language
System specific names:	webPAS: Language
Definition:	The language (including sign language) most preferred by the person for communication.
Collection requirement:	Conditional (required if used interpreter; blank otherwise)
METeOR reference:	659407
Format:	NNNN (Numeric code)
Maximum length:	4
Permitted values:	See Language Codes

GUIDE FOR USE

This data item should only be completed if an official paid interpreter service is used.

Family members or friends interpreting for the patient are not considered as providing an interpreter service for the purposes of completing this data item.

The language can include sign language.

EXAMPLES

Example 1: An interpreter service was used for a patient who spoke Greek only.

Language

2	2	0	1
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Example 2: A patient with Sensorineural Deafness using Sign language required an interpreter from the Deaf Society.

Language

9	7	9	9
---	---	---	---

Example 3: A patient's family member (who is not an official paid interpreter) interpreted for a patient who spoke only Croatian.

Language

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Example 4: An Indonesian patient was admitted for cataract surgery but no interpreter service was required as the patient spoke adequate English.

Language

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LEAVE DAYS (TOTAL)

Data element name:	Leave Days (Total)
System specific names:	webPAS: <i>Derived</i>
Definition:	Sum of the length of leave (date returned from leave minus date went on leave) for all periods within the hospital stay.
Collection requirement:	Conditional (required if leave taken; blank otherwise)
METeOR reference:	270251
Format:	NNNN
Maximum length:	4
Permitted values:	Day count (Numeric)

GUIDE FOR USE

Sum of the length of leave (date returned from leave minus date went on leave) for all periods within period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type. This will be the same number of days recorded for accounting purposes.

The following rules apply in the calculation of leave days:

- The day the patient goes on leave is counted as a leave day (as long as leave spans overnight).
- The day the patient is on leave is counted as a leave day (as long as it is not on the day of admission or separation and the leave spans overnight).
- The day the patient returns from leave is counted as a patient day (as long as it is not on the day of separation).
- 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 (as long as the leave spans overnight).
- 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.

A leave day is counted if the patient is on leave from the hospital overnight.



The maximum number of consecutive leave days allowable is 7 days. If a patient is on leave for greater than 7 days, the patient should be discharged and readmitted on returning from leave.

For involuntary mental health inpatients, the maximum consecutive leave days are 21. Patients not returning after 21 days should be discharged and readmitted if they return from leave.

For HITH patients, the days that the patient was not receiving care or treatment must be reported as leave days. If scheduled care is cancelled or the patient is not at home when HITH staff visit, a leave day must be reported for the patient. Note: HITH patients should be receiving care and visited every second day. (See section 6.3 of the ARDT Policy MP0058/17)

Patients not returning from leave

Patients who are permitted leave with the intention of returning to resume care and do not return from their leave, must be contacted to ascertain if they are returning to hospital. If the patient does not return they must be discharged. The discharge date is recorded as the date the patient went on leave.

For Involuntary Mental Health inpatients, please consult the Mental Health Act with regard to stipulations and conditions set down for Involuntary inpatients granted leave of absence.

There are occasions when the days on leave will equal the length of stay resulting in a length of stay calculation of zero days. As the patient would have spent some time in hospital, perhaps not overnight, the HMDS will round up the day to a 1-day length of stay. This is similar to the approach used in the calculation of length of stay for same day patient admissions.

EXAMPLES

Example 1: A patient goes on overnight leave on the second day in hospital, returns to hospital for 3 days, goes on overnight leave for one day, returns to hospital for 1 day and is discharged the next day.

TOTAL LEAVE DAYS

0	0	2
---	---	---

Example 2: A patient goes on leave from 0900 hrs and returns that evening at 2000 hrs. (This leave period should not be reported to HMDS, as the patient was not on leave overnight.)

TOTAL LEAVE DAYS

0	0	0
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Example 3: A patient goes on leave on the evening of the 20th July and returns on the 22nd July. The patient has been on leave from the hospital for two nights.

TOTAL LEAVE DAYS

0	0	2
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Example 4: A patient is transferred to HITH post-surgery and visited by HITH team Tuesday to Friday with no visits scheduled over the weekend. The patient was put on leave Saturday and Sunday, returned from leave Monday and had their last visit that day. The patient was discharged from HITH on Tuesday.

TOTAL LEAVE DAYS

0	0	2
---	---	---

Example 5: A patient is discharged with a Mode of Separation of Statistical Discharge while on leave and leave days are blank.

TOTAL LEAVE DAYS

0	0	0
---	---	---



LEAVE PERIODS (NUMBER OF)

Data element name:	Leave Periods (number of)
System specific names:	webPAS: <i>Derived</i>
Definition:	Number of leave periods in a hospital stay (excluding same day leave periods for admitted patients).
Collection requirement:	Conditional (required if any leave was taken; blank otherwise). Where leave periods exceed 100, the maximum reportable value is 99.
METeOR reference:	270058
Format:	NN
Maximum length:	2
Permitted values:	Leave period count (Numeric up to 99)

GUIDE FOR USE

Leave period is a temporary absence from hospital overnight, with medical approval for a period no greater than seven consecutive days (excluding Involuntary psychiatric inpatients).

This data element now takes into account the Mental Health Act 2014 for psychiatric inpatients and differentiates the period of consecutive leave allowable for Involuntary inpatients. Under the Mental Health Act 2014, an Involuntary patient is allowed a leave of absence period of 21 consecutive days.

If the period of leave is greater than seven days (or 21 days for Involuntary psychiatric inpatients) or the patient fails to return from leave, the patient is to be discharged. Please refer to *Transfers and Leave* in the [ARDT Policy Reference Manual](#).

There must be at least one overnight leave day on different occasions to report as separate periods of leave (see example below).

If a patient is on leave for part of a day and was not on leave overnight this **should not** be reported to HMDS as a Leave Day or a Leave Period.

If the leave period exceeds 7 days (or 21 days for Involuntary psychiatric inpatients) and the patient does not return, the patient should be discharged and readmitted if or when they return. The discharge date is recorded and backdated to the date the patient went on leave.



EXAMPLES

Example 1: A patient was admitted to hospital on 1st January 2004 and discharged on 8th January 2004. The patient went on leave overnight from the 6th January 2004 to the 7th January 2004.

LEAVE PERIODS	0	1
LEAVE DAYS	0	1

Example 2: A patient was admitted to hospital for 3 months and during the episode of care the patient went on leave for two days on four weekends.

LEAVE PERIODS	0	4
LEAVE DAYS	0	8

Example 3: A patient was admitted to hospital for seven days and went on leave for six hours on one day.

LEAVE PERIODS	0	0
LEAVE DAYS	0	0

Example 4: Patient was admitted to hospital for 14 days and put on leave with the intention of returning to continue treatment within 7 days. As the patient did not return from leave during this time they were contacted and advised they would not be returning. The patient was discharged on the date they were recorded as going on leave.

LEAVE PERIODS	0	0
LEAVE DAYS	0	0



MARITAL STATUS

Data element name: Marital Status

System specific names: webPAS: Marital Status (CAT M)

Definition: The marital status is a person's current relationship status in terms of a couple relationship; or for those in a couple relationship, the existence of a current or previous registered marriage.

Collection requirement: Mandatory

METeOR reference: [291045](#)

Format: N (Numeric code)

Maximum length: 1

Permitted values:

- 1 – Never married
- 2 – Widow/Widower
- 3 – Divorced
- 4 – Separated
- 5 – Married
- 6 – Unknown

GUIDE FOR USE

The category “5-Married” applies to registered unions and de facto relationships, including same sex couples.

Where a patient’s marital status has not been specified and the patient is a minor (16 years of age or less), assign “1-Never Married” as a default.

EXAMPLES

Example 1: An 18-year-old pregnant woman in a de facto relationship is admitted to have her baby.

Marital Status

Example 2: Five-year-old child is admitted to hospital. Marital status is Never Married

Marital Status



MEDICARE CARD NUMBER / MEDICARE PERSON NUMBER

Data element name:	Medicare Card Number	Medicare Person Number
System specific names:	webPAS: Medicare Number	webPAS: N/A
Definition:	Person identifier that appears on a Medicare card that is allocated by Medicare Australia to eligible persons under the Medicare scheme.	The individual person or reference number given to each person listed on the Medicare Card. The number is listed to the right of the Medicare Number.
Collection requirement:	Medicare Card Number is not mandatory	Conditional: The individual person number is required if the 10 digit Medicare number is provided
METeOR reference:	270101	
Format:	NNNNNNNNNN	N
Maximum length:	10	1
Permitted values:	Must be a valid current Medicare Number issued by the Health Insurance Commission.	Must be a valid current Medicare Person Number issued by the Health Insurance Commission.

GUIDE FOR USE

The Medicare Card Number should be collected from the *physical sighting* of the Medicare Card. Collecting full Medicare Card details involves recording both the Medicare Card Number (10 digits) and the Medicare Person Number (1 digit).

Full Medicare Card details are used to define eligibility for specific services and not as a patient identifier. As persons can be listed on more than one Medicare Card, the full Medicare number is not a unique identifier and should **not** be used for this purpose.



The picture to the left shows a typical Medicare card and the various information on the face of the card.



1. Medicare number: This is the 10 digit number on top of the card
2. Individual reference number: This is the 1 digit number to the left of the person's name
3. Valid to: Ensure the date is entered as per your Patient Administration System requirements.

EXAMPLES

Example 1: Child X appears on two different Medicare Cards held in the names of both their mother and father who are living apart. Each Medicare Card has a separate Medicare Card Number and thus the child will have two valid Medicare Numbers.

The card presented by the parent attending with the child is recorded for that attendance. NB: For this reason it is good practice to request the **physical sighting** of the Medicare Card at each attendance.

Medicare Number	6	0	1	3	0	0	0	0	0	0	
Medicare Person Number	2										



MENTAL HEALTH LEGAL STATUS

Data element name: Mental Health Legal Status (MHLS)

System specific names: webPAS: Mental Health Legal Status

Definition: Whether a person is treated on an involuntary basis under the relevant state or territory mental health legislation, at any time during an episode of admitted patient during a reporting period, as represented by a code.

Collection requirement: Conditional (required if mental health patient; blank otherwise)

METeOR reference: [534063](#)

Format: N (Numeric code)

Maximum length: 1

Permitted values:
1 - Involuntary
2 - Voluntary

GUIDE FOR USE

A MHLS should be reported for a patient who is treated on an involuntary or voluntary basis under the Mental Health Act 2014, at any time during an episode of admitted patient care.

MHLS item is required to monitor trends in the use of compulsory treatment provisions under State and Territory mental health legislation by Western Australian hospitals and community health care facilities.

If a patient is admitted for psychiatric examination and thereafter deemed not requiring admission, the Mental Health Act 2014 considers the legal status of this patient as *'detained'*. Until such times as there is a means to collect a legal status of *'detained'* in all patient management systems, the only reportable legal status options remain as Voluntary or Involuntary. Therefore, if these patients are admitted, a Mental Health Legal Status of voluntary is required for reporting purposes.

Multiple MHLS within an Episode of Care

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 as involuntary and subsequently changed to voluntary; or
- Admitted as voluntary but transferred to involuntary during the hospital stay.



Where this occurs, the involuntary status overrules and the hospital should report the MHLS as involuntary to HMDC.

VALID VALUES

1 - Involuntary

If a person is not willing to provide consent or is unable to give consent for treatment, and in the opinion of those with the authority to do so (as set out in the Mental Health Act 2014) they can be admitted or treated as an involuntary patient in an authorised hospital, they are defined as an involuntary patient.

Use this category if the patient is deemed involuntary for all or part of the episode of care. The care of involuntary patients can only be provided in an authorised psychiatric facility. Authorised hospitals can receive, assess, admit or detain involuntary patients for psychiatric treatment.

2 - Voluntary

Patients who require mental assessment and/or treatment can receive care in any health or mental health facility if they are willing to provide their consent for treatment. These patients are defined as voluntary patients.

EXAMPLES

Example 1: A patient was admitted to Fremantle Hospital on an involuntary basis for five days treatment for acute schizophrenia. After the fifth day, he then agreed to remain in hospital as a voluntary patient for extensive treatment. Reported to HMDS as Involuntary.

INVOLUNTARY PATIENT

1

Example 2: A patient is admitted voluntarily to Abbotsford Private Hospital for treatment of severe depression.

VOLUNTARY PATIENT

2

Example 3: A patient is admitted to Bentley Hospital as a Voluntary patient but decides, after five days, to sign a Discharge Against Advice form, and leave the hospital. Medical staff decide that this is not in the patient's best interest and have an Legal Order Form signed declaring that the patient be admitted and treated as an Involuntary Patient.

INVOLUNTARY PATIENT

1

Example 4: A patient on a Community Treatment Order is admitted to a surgical ward in the hospital with acute appendicitis.

DO NOT RECORD THE MENTAL HEALTH LEGAL STATUS



MODE OF SEPARATION

Data element name:	Mode of Separation
System specific names:	webPAS: Discharge Destination (CAT DD)
Definition:	Status at separation of person (discharge/transfer/death) and place to which person is released (where applicable).
Collection requirement:	Mandatory
METeOR reference:	270094
Format:	NN (Numeric code)
Maximum length:	2
Permitted values:	1 - Discharge/transfer to an acute hospital 2 - Discharge/transfer to a residential aged care service 3 - Discharge/transfer to a psychiatric hospital 4 - Discharge/transfer to other health care accommodation 5 - Statistical discharge Type Change 6 - Left against medical advice/discharge at own risk 7 - Discharge from Leave 8 - Deceased 9 - Other/Home

GUIDE FOR USE

See Admitted From/Discharged To lists in Part B: HMDS Reference Documents for corresponding Mode of Separation values.

VALUE DEFINITIONS

1 - Discharge/transfer to (an) other acute hospital

Refers to the separation of a patient to another acute care facility. This includes designated psychiatric units that are part of an acute hospital (e.g. Alma Street Centre, Bentley Lodge, Osborne Lodge, etc.)

2 - Discharge/transfer to a residential aged care service

Refers to the relocation of a patient at separation to a recognised Residential Aged Care Service (nursing home or aged care hostel).



3 - Discharge/transfer to (an) other psychiatric hospital

Refers to the relocation of a patient at separation to a hospital providing only psychiatric services (e.g. Graylands Hospital, Selby Authorised Lodge, Perth Clinic and Abbotsford Private Hospital).

4 - Discharge/transfer to other health care accommodation

Refers to a separation to health care accommodation other than an aged care hostel, nursing home or hospital. This includes hostels providing non-acute care to psychiatric patients. Includes mothercraft hospitals.

5 - Statistical discharge type change

Refers to a statistical discharge in which the patient's care type changes. For example, a patient classified as a boarder falls ill while in hospital and changes from a Boarder to an Admitted Client Status patient. The Care Type also alters from Boarder to Acute Care. The Discharged To is then recorded as (0944) Reclassified this hospital for the episode where the Client Status changes.

6 - Left against medical advice/discharge at own risk

Refers to patients taking their own discharge against medical advice, or without advising staff of their intentions (i.e. absconding).

7 - Discharge from Leave

Refers to a patient who is on leave from the hospital, and chooses not to return or does not return for some other reason.

8 - Deceased

Refers to the death of the patient as recorded by a doctor, and hence their discharge.

9 - Other/Home

Includes institutions such as prisons, detention centres, non-health care hostels, psychiatric outpatient facilities and group homes providing primarily welfare services, orphanages and refuge accommodation.

This is also used to record the Mode of Separation for a contracting/funding case at the funding hospital where the discharge establishment is (0999) Funding Hospital.

Discharge Home refers to the formal separation of the patient from hospital to the patient's place of usual residence (e.g. friend or family home), unless the place of usual residence is a nursing home or hostel.



EXAMPLES

Example 1: A patient was discharged home.

MODE OF SEPARATION	OTHER/HOME	9
DISCHARGED TO	HOME	0900

Example 2: A patient was transferred to St. John of God Hospital in Subiaco.

MODE OF SEPARATION	TRANSFER TO ACUTE HOSPITAL	1
DISCHARGED TO	ST JOHN OF GOD, SUBIACO	0616

Example 3: A patient was reclassified from boarder to admitted patient.

MODE OF SEPARATION	STATISTICAL TYPE CHANGE	5
DISCHARGED TO	RECLASSIFIED THIS HOSPITAL	0944

Example 4: A patient died during this admission to hospital.

MODE OF SEPARATION	DECEASED	8
DISCHARGED TO	DECEASED	0912

Example 5: A patient with an intellectual disability who was discharged to Brighton Hostel. Brighton Hostel was not the patient's usual place of residence.

MODE OF SEPARATION	OTHER HEALTH CARE ACCOMMODATION	4
DISCHARGED TO	BRIGHTON HOSTEL	0989



MOTHER'S IDENTIFIER - UNIT MEDICAL RECORD NUMBER

Data element name: Mother's Identifier or Mother's Unit Medical Record Number

System specific names: webPAS: Link MR

Definition: The Client Identifier or Unit Medical Number of the patient's mother.

Collection requirement: Conditional (required if newborn; blank otherwise)

METeOR reference: Related to [290046](#)

Format: Alphanumeric

Maximum length: 10

Permitted values: Alphanumeric combination up to 10 characters

GUIDE FOR USE

The Mother's Identifier is her UMRN or URN as described under the data element Client Identifier.

The field is to be collected only for a birth admission and is added to the baby's record. It does not require completion in any other circumstance.

This field is only completed on the baby's birth admission details to provide a link between mother and baby during the birth episode. It should not be entered for any subsequent admissions of the baby.

EXAMPLES

Example 1: Newborn baby admitted onto the patient administration system after a normal delivery

Baby's UMRN C7271864 is entered as:

Client Identifier	C	7	2	7	1	8	6	4		
-------------------	---	---	---	---	---	---	---	---	--	--

Mother's Identifier UMRN B2059564 is entered as:

Client Identifier	B	2	0	5	9	5	6	4		
-------------------	---	---	---	---	---	---	---	---	--	--



POSTCODE OF ADDRESS

Data element name: Postcode

System specific names: webPAS: Postcode

Definition: The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a party (person or organisation), as defined by Australia Post.

Collection requirement: Mandatory

METeOR reference: [611398](#)

Format: NNNNNN

Maximum length: 6

Permitted values: Australia Post postal codes

GUIDE FOR USE

A postcode list is maintained by HMDS with entries that are valid on the current list of postcodes from Australia Post. See Australia Post (<http://www.auspost.com.au/>) for current listings.

Where the address is unknown or there is no fixed permanent address, the following postcodes should be used depending on the patient's State/Territory of residence:

Postcode	Suburb	State/Territory Code	State/Territory Description
0899	UNKNOWN	7	Northern Territory
2999	UNKNOWN	1	New South Wales
2999	UNKNOWN (ACT)	8	ACT
3999	UNKNOWN	2	Victoria
4999	UNKNOWN	3	Queensland
5999	UNKNOWN	4	South Australia
6999	UNKNOWN	5	Western Australia
7999	UNKNOWN	6	Tasmania
9999	UNKNOWN	0	Not Applicable

When both the address and State/Territory are unknown you should assign the **9999** Postcode with a State/Territory value of (0) Not Applicable.



When the patient has no fixed permanent address (NFPA) (e.g. no permanent address) but the State/Territory they live in is known, enter NFPA in the Residential Address field then select the State/Territory and Postcode combination as listed in the table above. If the patient temporarily resides in a known suburb, then record the NFPA in the Residential Address field and then the suburb and correct corresponding postcode. **DO NOT** record the suburb and postcode of the hospital.

If the patient advises they have no fixed permanent address and provide no temporary suburb or postcode details, but they reside in Western Australia, please record as follows:

Residential Address	NFPA			
Suburb	NFPA			
Postcode (for W.A.)	6	9	9	9
State/Territory	5			

Overseas visitors should have their Country recorded in the Suburb field and the postcode recorded as 8888. The country must be as stated in *Part B: HMDS 2018 Reference Documents - Overseas Suburbs* listing.

Interstate visitors should have the postcode of their usual place of residence recorded.

The postcodes for Australian Territories are as per Australia Post. Only relevant post codes as listed by Australia Post will be accepted. **DO NOT submit Post Office box postcodes with residential addresses** as these will be placed into edit for correction.

EXAMPLES

Example 1: A patient was admitted to Fiona Stanley Hospital via the emergency department in an unconscious state. The patient after initial treatment was transferred out to another hospital and their address details remained unknown.

Suburb	UNKNOWN			
Postcode	6	9	9	9
State/Territory	5			

Example 2: A patient from Japan was admitted to hospital.

Suburb	JAPAN			
Postcode	8	8	8	8
State/Territory	0			

Example 3: A patient was admitted to hospital and indicated she had no fixed permanent address but was temporarily living in Broome W.A.

Residential Address	NFPA			
Suburb	BROOME			
Postcode	6	7	2	5



State/Territory

5	
---	--

Example 4: A patient from Chiswick NSW was admitted to RPH.

Suburb

CHISWICK			
2	0	6	9
1			

Postcode

State/Territory

Example 5: A patient is admitted from Christmas Island, Western Australia

Suburb

CHRISTMAS ISLAND			
6	7	9	8
5			

Postcode

State/Territory



READMISSION STATUS

Data element name:	Readmission Status
System specific names:	webPAS: Readmission Status (CAT KO)
Definition:	Indicates whether the patient's readmission to hospital for the same illness or injury within 28 days was deemed planned or unplanned.
Collection requirement:	Conditional (required if readmitted within 28 days with related condition; blank otherwise)
METeOR reference:	Not applicable
Format:	N (Numeric code)
Maximum length:	1
Permitted values:	1 – Planned Readmission 2 – Unplanned Readmission

GUIDE FOR USE

This Australian Council of Health Care Standards (ACHS) key performance indicator measures the number of cases that are readmitted to the same hospital within 28 days relating to the previous illness or injury for which they were treated.

The data item should only be coded if a patient is readmitted to the same establishment within 28 days of the previous admission and one of the following is true:

- A patient is admitted for further treatment of the same condition for which the patient was previously hospitalised; or
- A patient is admitted for treatment of a condition related to the one for which the patient was previously hospitalised; or
- A patient is admitted for complication of the condition for which the patient was previously hospitalised (this may include mechanical complications).

Day stay patients are included in this indicator if they meet the above criteria.

It is the medical practitioner who is responsible for determining whether re-admissions are unexpected, and therefore unplanned.

This field should not be filled in if the patient is readmitted to the same hospital within 28 days for a condition unrelated to the previous condition treated.



This code is collected on the second admission.

VALUE DEFINITIONS

1 - Planned Readmission

A planned readmission is when the patient is readmitted at either a specified or unspecified time following discharge, and on the advice of the treating medical officer. This may include staged procedures or ongoing treatment such as recurring cases of chemotherapy and dialysis.

2 - Unplanned Readmission

Unplanned readmission is an unexpected admission of a patient within 28 days of discharge to the same establishment. There is no intention of the treating medical officer to readmit for treatment of the same or related condition as the previous admission.

Patients with progressive or chronic conditions may return to the hospital within 28 days of discharge. Although these admissions are not planned, they are not unexpected and therefore should not be classified as unplanned readmissions.

A patient may be scheduled to attend the same health service on one day for more than one booked procedure (for example, a day procedure on the same day as scheduled dialysis) however, only one admitted episode is to be reported.

EXAMPLES

Example 1: A patient was readmitted to hospital with a wound infection, following previous surgery performed twenty-seven days ago.

Readmission Status (Unplanned readmission)

Example 2: Patient with advanced metastatic carcinoma readmitted for vomiting following chemotherapy the previous week.

Readmission Status (Unplanned readmission)

Example 3: Patient with a long history of chronic back pain readmitted within 28 days. The admission was not planned but it was also not unexpected.

Readmission Status (Do not code)

Example 4: A young patient with a cleft palate, requiring stage 2 of their surgery, who is admitted for the second stage 15 days after their first surgery.

Readmission Status (Planned readmission)



RESIDENTIAL ADDRESS

Data element name:	Residential Address
System specific names:	webPAS: Address
Definition:	The address provided for the patient's place of usual residence.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	Alphanumeric
Maximum length:	50
Permitted values:	Not applicable

GUIDE FOR USE

The house number, street name and street type should be on the first of two address lines to be sent. Suburb is to be recorded on another line.

Estate names must not be entered in the suburb field.

Suburb names are generally not abbreviated, unless otherwise specified by Australia Post (<http://auspost.com.au/>).

The HMDS validates the suburbs and postcodes against the list provided by Australia Post (<http://auspost.com.au/>). It is strongly recommended that all reporting establishments and information system providers update their look-up tables according to the latest version of the Australia Post postcode/suburb list.

Non-residential addresses for accounts or billing purposes (e.g. PO Boxes) **are not acceptable as residential addresses**. Every effort should be made to collect the patient's actual residential address. Under Activity Based Funding arrangements, the patient physical address may play an important role in funding calculations.



Overseas Patients

If the patient is an overseas visitor, their permanent residential address overseas should be recorded, not their local temporary address. The country of residence should be entered into the suburb line for overseas residential addresses. In these cases, suburbs are not required. Please note overseas residential addresses should have the postcode of 8888. Please see *Overseas Suburbs* listings in *Part B: HMDS Reference Documents*.

Interstate Patients

If the patient is an interstate visitor, their permanent interstate residential address should be recorded.

Seamen

A seaman who is a citizen of another country should have his/her permanent residential address recorded. However if this is unknown, the address of the shipping company that employs him is acceptable.

Patients with no fixed permanent address

If a patient has no fixed permanent address, typing NFPA in the address field can indicate this. No Fixed Permanent Address (NFPA) means a person does not have an address in a State of Australia or other Country (See Postcode of Address section).

In these circumstances, hospitals are strongly encouraged to report 'NFPA' (instead of 'No fixed address or other variants) in the address field, to reduce the chance of typos. If the hospital needs to include additional information to assist with locating the patient, this should follow the term 'NFPA', i.e., NFPA should always appear at the start of the address line. e.g., NFPA COOGEE BEACH CARAVAN PARK; NFPA MURRAY STREET MALL. Correct capture of this information is important for analysis of inpatient activity for patients who do not have a permanent home. Entering NFPA at the start of address information will allow consistent analysis of this information in instances where a real suburb is reported.

Unknown residential address

If a patient presents to a hospital in Western Australia and they are unconscious or is a disaster patient (an acknowledged disaster situation), then the following should be recorded. Please do not use Unknown if the patient or next of kin / family can provide residential address information.

Patients subsidised by International Health Care Funds

These patients should have their permanent residential address recorded, and not the address of the fund. Please refer to the correct Country name to use in the suburb field in *Part B: HMDS 2018 Reference Documents – Overseas Suburbs*.

Prisoners

Prisoners have as their residential address, the prison address, not their home address.



Residential Aged Care Patients

Patients whose usual place of residence is a Residential Aged Care Service (e.g. nursing home or aged care hostel) should have the nursing home or hostel's address as their residential address.

EXAMPLES

Example 1: The patients address is 8 Fourth Avenue, Mount Lawley, Western Australia

Residential Address	8 Fourth Avenue
Suburb	MOUNT LAWLEY

Example 2: A patient with no fixed permanent address and is a resident of Australia

Residential Address	NFPA
Suburb	UNKNOWN

Example 3: An overseas visitor whose permanent address is 14 Apian Way, Roma, Italy

Residential Address	14 Apian Way, Roma
Suburb	ITALY

Example 4: A merchant seaman (use only if residential address is unknown)

Residential Address	C/- AP Shipping Line
Suburb	FREMANTLE

Example 5: A prisoner at Casuarina Prison

Residential Address	Casuarina Prison
Suburb	CASUARINA

Example 6: A resident of Kingsley Nursing Home

Residential Address	Kingsley Nursing Home, 41 Renegade Way
Suburb	EDEN HILL



SEPARATION DATE

Data element name: Separation Date

System specific names: webPAS: Separation Date

Definition: The date on which an admitted patient completes an episode of care. The patient can be formally or statistically discharged from hospital. If a patient dies in hospital, the separation date is the date of death.

Collection requirement: Mandatory

METeOR reference: [270025](#)

Format: DDMMYYYY

Maximum length: 8

Permitted values: Date (Numeric)

GUIDE FOR USE

Enter the full date of separation, including leading zeros where necessary.

If an admitted patient is on leave but does not return after 7 days the patient is then formally discharged on the 7th day, and the preceding days are counted as leave days.

Formal Separation/Discharge

A formal separation/discharge is an administrative process that ceases a record of the patient's treatment and accommodation within a hospital.

The Separation Date for a formal separation/discharge will be the date the hospital completed treatment and accommodation of the patient.

Statistical Separation/Discharge

A statistical separation/discharge is an administrative process that occurs within an episode of care and captures the end date the patient received a particular type of care (Care Type).

The Separation Date for a statistical admission will be the date the patient completed a particular Care Type.



EXAMPLES

Example 1: A patient was discharged from hospital on 1st July 2017.

Separation Date

0	1	0	7	2	0	1	7
---	---	---	---	---	---	---	---

Example 2: A patient was transferred from hospital on 20th February 2017.

Separation Date

2	0	0	2	2	0	1	7
---	---	---	---	---	---	---	---

Example 3: A patient died on 23^d March 2017.

Separation Date

2	3	0	3	2	0	1	7
---	---	---	---	---	---	---	---



SEPARATION TIME

Data element name: Separation Time

System specific names: webPAS: Separation Time

Definition: Separation time is the time at which the admitted patient completes an episode of care.

Collection requirement: Mandatory

METeOR reference: [682919](#)

Format: HHMM

Maximum length: 4

Permitted values: Time (Numeric)

GUIDE FOR USE

The Separation Time is required to identify the time of completion of the care type or hospital stay. It mandatory for both formal and statistical discharges from hospital.

Separation Time must be captured in 24 hour clock.

Where a patient is deceased during the admission or is transferred to another health unit, the Separation Time should reflect the actual time the patient died or the actual time the patient was transferred.

EXAMPLES

Example 1: A patient was transferred to another hospital at 2 pm.

Separation Time

1	4	0	0
---	---	---	---

Example 2: A patient died at midnight.

Separation Time

0	0	0	0
---	---	---	---

Example 3: A patient was discharged at 9.15am.

Separation Time

0	9	1	5
---	---	---	---



SEX

Data element name:	Sex
System specific names:	webPAS: Gender
Definition:	Sex is the biological distinction between male and female.
Collection requirement:	Mandatory
METeOR reference:	635126
Format:	N (Numeric)
Maximum length:	1
Permitted values:	1 - Male 2 - Female 3 - Indeterminate

GUIDE FOR USE

The term 'Sex' is a biological concept that describes, in part, a person's physical features, including genitalia, other sexual reproductive anatomy, chromosomes, hormones and secondary physical features emerging from puberty.

'Gender' is a social concept that describes the way in which a person identifies or expresses their masculine or feminine traits and the way they are recognised within a community. A person's gender identity may not always be exclusively male or female and may not always correspond with their sex assigned at birth.

The NHDD advises that the correct terminology for this data element is Sex.

Information collection for trans or gender diverse people should be treated in the same manner. To avoid problems with edits, transsexuals undergoing a sex change operation should have their current (biological) sex at time of hospital admission recorded as the Sex for that admission episode.

Intersex (also referred to as indeterminate) refers to a person born with genetic, hormonal or physical sex characteristics that are not typically male or female. Intersex people have a diversity of bodies and identities. For some intersex people these traits are apparent at birth while for others they become apparent or emerge later in life, often at puberty. This includes babies diagnosed with gynandrous, hermaphroditism, ovotestis, pseudohermaphroditism (male) (female), and pure gonadal dysgenesis. These persons may have either male and female sex organs or structural aberrations of the sex chromosomes.



EXAMPLES

Example 1: A female patient admitted to hospital.

Sex Female

Example 2: A patient was admitted to hospital that had previously undergone a sex change operation from male to female.

Sex Female

Example 3: A patient was admitted to hospital that is undergoing sex reassignment from male to female and reassignment is not yet complete.

Sex Male

Example 4: An examination of a newborn baby fails to determine the sex

Sex Indeterminate



SOURCE OF REFERRAL - LOCATION

Data element name:	Source of Referral - Location
System specific names:	webPAS: Admission Source (CAT S)
Definition:	The type of establishment (physical accommodation) from which the patient has been referred or transferred for admission to hospital.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	NN (Numeric code)
Maximum length:	2
Permitted values:	1 - Home 2 - Residential Aged Care Service 3 - Other Health Care Accommodation 4 - Acute Hospital 5 - Psychiatric Hospital 6 - Prison 7 - Other

GUIDE FOR USE

Each establishment has only one source of referral location that is valid for that establishment.

The Source of Referral-Location is linked to the list of establishments. Every establishment has a valid Source of Referral-Location code (SORL). See *Part B HMDS Reference Documents*.

VALUE DEFINITIONS

1 - Home

Refers to the patient's place of usual residential accommodation but does not include institutional care in acute or psychiatric hospitals or prisons.

From 1 July 2003, if a patient is a permanent resident of a Residential Aged Care Service or Other Health Care Accommodation (e.g. nursing home or hostel) which is considered their usual place of residence, the appropriate admitting establishment should be entered in the Admitted From field, and the Source of Referral-Location entered as Residential Aged Care Service or Other Health Care Accommodation, as appropriate.



2 - Residential Aged Care Service

Refers to establishments that provide long-term care and residential facilities primarily to aged people but also to chronically ill, frail, disabled or senile persons. They must be approved by the Commonwealth Department of Health and Ageing and/or licensed by the State, or controlled by government departments. Includes nursing homes (high-care) and aged care hostels (low-care).

3 - Other Health Care Accommodation

Refers to residential health care services that provide board, lodging or accommodation and minimal supervision for the distressed or disabled who cannot live independently but do not need nursing care in a hospital or nursing home. Excludes aged care hostels but include psychiatric residential facilities and hostels for people with disabilities who don't need regular nursing care.

4 - Acute Hospital

Refers to acute care establishments that provide, at least, minimal medical, surgical or obstetric services for inpatient treatment and ambulatory care, and comprehensive qualified nursing service as well as other professional health services. They must be licensed by the State or controlled by government departments.

The Commonwealth approves acute care establishments for the purposes of basic table health insurance benefits.

Acute care establishments include:

- Freestanding day surgery centres providing investigation and treatment of acute conditions on a day-only basis and hospices for palliative care treatment.
- Designated psychiatric units that are part of an acute hospital, including psychiatric lodges, Alma Street Centre and Mills Street Centre and other designated psychiatric units within acute hospitals.

5 - Psychiatric Hospital

Psychiatric Hospitals are stand-alone establishments devoted primarily to the inpatient treatment and care of patients with psychiatric, mental or behavioural disorders. State health authorities license these establishments. The psychiatric hospitals in Western Australia are:

- Graylands Hospital
- Selby Authorised Lodge
- Perth Clinic
- The Marian Centre
- Abbotsford Private Hospital
- State Forensic Mental Health Service



6 - Prison

Prisons are residential institutions in which people are accommodated following punitive sentencing for a criminal offence or awaiting trial for a criminal offence. The State Department of Justice administers prisons.

7 - Other

Includes any physical location not defined above.

EXAMPLES

Example 1: A patient was admitted from St. Georges Nursing Home, which is their usual place of residence. Source of Referral-Location is Residential Aged Care Service.

Source of Referral-Location	2			
Admitted From	0	8	6	4

Example 2: A patient was admitted from Rangeview Prison. Source of Referral-Location is prison.

Source of Referral-Location	6			
Admitted From	2	1	1	7

Example 3: A baby, born before arrival at hospital, was admitted. Source of Referral-Location should be home.

Source of Referral-Location	1			
Admitted From	0	9	0	0

Example 4: A patient was transferred from Bunbury Hospital. Source of Referral-Location should be Acute Hospital.

Source of Referral-Location	4			
Admitted From	0	2	0	8

Example 5: A patient was statistically readmitted. Source of Referral-Location should be Acute Hospital.

Source of Referral-Location	4			
Admitted From	0	9	4	4



SOURCE OF REFERRAL - PROFESSIONAL

Data element name: Source of Referral - Professional

System specific names: webPAS: Referred by (CAT SH)

Definition: The appropriate health professional/medical practitioner who directly refers the patient to hospital for admission.

Collection requirement: Mandatory

METeOR reference: Not applicable

Format: NN (Numeric code)

Maximum length: 2

Permitted values:

- 1 - General practitioner
- 2 - Specialist medical practitioner
- 3 - Outpatient department medical practitioner
- 4 - Emergency department medical practitioner
- 5 - Hospital medical practitioner (re-admission)
- 6 - Community health medical practitioner
- 7 - Statistical admission/type change
- 8 - Other

GUIDE FOR USE

The code assignment for medical practitioners who fall into two or more categories will depend on where the referral was made from. For example, if the referral came from a specialist working in an outpatients department, the value for Outpatients Department Medical Practitioner should be assigned.

VALUE DEFINITIONS

1 - General practitioner

The primary medical care officer working in general practice.

2 - Specialist medical practitioner

The medical officer whose principal area of clinical practice is one special area of medicine.



3 - Outpatient department medical practitioner

The medical officer who referred the patient to hospital from an outpatient clinic within a hospital.

4 - Emergency department medical practitioner

The medical officer who referred the patient to hospital from an emergency department at another hospital OR the patient was not referred to hospital by a health professional and the emergency department medical practitioner made the decision to admit the patient.

5 - Hospital medical practitioner (re-admission)

The medical officer who decided to re-admit the patient following a previous admission for a second stage procedure or recurring care such as renal dialysis.

6 - Community health medical practitioner

The medical officer practicing in a community health area such as the Aboriginal Medical Service or Royal Flying Doctor Service.

7 - Statistical admission/type change

Refers to those patients whose episode of care changes during a hospital admission creating an additional episode of care.

8 - Other

Includes referral from other professionals not listed above.

EXAMPLES

Example 1: A patient was referred to hospital and admitted by the general practitioner.

Source of Referral-Professional 1

Example 2: A patient was referred to the hospital by an emergency department medical practitioner at another hospital.

Source of Referral-Professional 4

Example 3: A patient was taken to hospital by ambulance following an accident and the emergency department medical practitioner decided to admit the patient.

Source of Referral-Professional 4

Example 4: The care type for a patient undergoing treatment for a fractured hip changes from acute to rehabilitation. Source of Referral-Professional should be Statistical admission/type change.



Source of Referral-Professional

7

Example 5: Dr Jones, who is a cardiologist in a hospital Outpatients Department, admits a patient for cardiac catheterisation.

Source of Referral-Professional

3

Example 6: Dr Smith (General Practitioner) referred a patient to the Fremantle Hospital Emergency Department for further investigation and management. The Emergency Department medical practitioner at Fremantle Hospital decided the patient required admission for treatment of his emphysema.

Source of Referral-Professional

1



SOURCE OF REFERRAL - TRANSPORT

Data element name:	Source of Referral - Transport
System specific names:	webPAS: Mode of Transport (CAT SI)
Definition:	The type of transport a patient uses to go to hospital prior to admission.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	NN (Numeric code)
Maximum length:	2
Permitted values:	1 - Private/public transport 2 - Hospital transport 3 - Ambulance - emergency 4 - Royal Flying Doctor Service 5 - Helicopter (evacuation) 6 – Other

GUIDE FOR USE

This field provides vital information in regard to Ambulance and Royal Flying Doctor Service usage.

If a patient is transported by Royal Flying Doctor Service to an airport and then taken to hospital by ambulance, the Royal Flying Doctor Service should be coded as it takes priority over other forms of transport.

VALUE DEFINITIONS

1 - Private/public transport

Refers to any vehicle such as a car, bus or taxi used by the patient to go to hospital. Also includes patients who walk to the hospital for care.

2 - Hospital transport

Refers to booked hospital transport. Includes booking an ambulance or other hospital vehicles to transfer patients between hospitals or from a nursing home or other health establishment to hospital. Voluntary transport service that is booked from a hospital to transport patients from home to the hospital is also included.



3 - Ambulance - emergency

Refers to unbooked ambulance transport. This includes ambulance transport from accidents or for treatment of serious sudden disorders. The Western Australian Neonatal Transfer Service (Flying Squad) is included in this category.

4 - Royal Flying Doctor Service

Refers to direct transport to hospital by the Royal Flying Doctor Service and includes transfers between hospital and other health establishments.

5 - Helicopter (evacuation)

Refers to direct admission to hospital by helicopter or air ambulance.

6 - Other

Refers to transport methods such as police car or other means not covered under the categories above.

EXAMPLES

Example 1: A patient travelled to hospital from a nursing home by ambulance that was previously booked. Source of Referral-Transport should be Hospital transport.

Source of Referral-Transport 2

Example 2: A patient evacuated to Royal Perth Hospital by emergency helicopter.

Source of Referral-Transport 5

Example 3: Royal Flying Doctor Service evacuated a patient from Broome to Derby airport. He was then transferred from the airport to Derby Regional Hospital by ambulance.

Source of Referral-Transport 4

Example 4: A patient, injured in a road traffic accident, transported to Sir Charles Gairdner Hospital by ambulance.

Source of Referral-Transport 3

Example 5: A patient travelled to hospital by taxi. Source of Referral-Transport should be Private/public transport.

Source of Referral-Transport 1





Example 6: A patient travelled to hospital by commercial airline and then taxi.

Source of Referral-Transport 1

Example 7: A newborn transported from Armadale Hospital to King Edward Memorial Hospital by the Western Australian Neonatal Transfer Service (Flying Squad). Source of Referral-Transport should be Ambulance-emergency.

Source of Referral-Transport 3



SPECIALTY OF CLINICIAN ON ADMISSION

Data element name: Specialty of Clinician on Admission

System specific names: webPAS: Unit (CAT DT)

Definition: The area of clinical expertise held by the admitting medical practitioner.

Collection requirement: Mandatory

METeOR reference: Not applicable

Format: NNN (Numeric code)

Maximum length: 3

Permitted values: See *Medical Practitioner Specialty Codes* listed in *Part B HMDS Reference Documents*.

GUIDE FOR USE

These specialty type codes are gazetted under the Medical Practitioners Regulations 2008 as part of the Medical Practitioners Act 2008. The specialty reported to the HMDS must reflect the specialty held by the clinician as applicable for the admission.

Hospitals may have a list of specialty codes for their own use, but these must be mapped to the list provided in *Medical Practitioner Specialities, Part B: HMDS Reference Documents*. This mapping must be done at the hospital level.

Hospitals must notify the HMDS of any new specialty abbreviations to obtain the correct mapping.

If the Medical Practitioner Specialty Code is 02 - 07, please ensure that the nominated code is prefixed with a 0 i.e. "02", "03", "04" etc.

EXAMPLES

Example 1: Patient admitted under the care of a General Medicine physician.

Specialty of Clinician on Admission 12

Example 2: Newborn baby admitted under the care of a General Practitioner.

Specialty of Clinician on Admission 84

Example 3: Newborn baby admitted under the care of a Paediatrician as she developed respiratory distress syndrome.

Specialty of Clinician on Admission 21



SURNAME

Data element name: Surname

System specific names: webPAS: Surname

Definition: The part of a name a person usually has in common with other members of his/her family, as distinguished from his/her given names, as represented by text.

Collection requirement: Mandatory

METeOR reference: [613331](#)

Format: Alpha

Maximum length: 50

Permitted values: Alpha characters (dots, apostrophes and hyphens permitted)

GUIDE FOR USE

Surname is a 50 character alphabetical field. Surname should be recorded as follows:

- Alias or assumed names should not be included if the legal Surname is known.
- Do not use brackets () for alias names in the Surname.
- Where hospitals have the facility to record an alias, this field must be used.
- Where the surname is unknown or there is no surname, the name the person is identified by should be recorded in the Surname field and the First Forename field left blank.
- Numeric values are not permitted.

EXAMPLES

Example 1: Edwin Roberts was admitted to hospital.

Surname

ROBERTS

Example 2: A patient was admitted to hospital in a coma and her name was not known.

Surname

UNKNOWN

Example 3: Dallas D'Silva is admitted from the Waiting List.

Surname

D'SILVA

Example 4: A patient is identified by a first name of Anastasia and has no surname.

Surname

ANASTASIA



SPECIALTY OF CLINICIAN ON SEPARATION

Data element name:	Specialty of Clinician on Separation
System specific names:	webPAS: Unit (CAT DT)
Definition:	The clinical specialty of the medical practitioner treating the patient immediately prior to discharge.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	NNN (Numeric code)
Maximum length:	3
Permitted values:	See <i>Medical Practitioner Specialty Codes</i> list in <i>Part B: HMDS Reference Documents</i>

GUIDE FOR USE

These specialty type codes are gazetted under the Medical Practitioners Regulations 2008 as part of the Medical Practitioners Act 2008. The specialty reported to the HMDS must reflect the specialty held by the clinician as applicable for the separation.

The specialty of clinician on discharge may be different to the speciality of clinician on admission, if two or more clinicians are involved.

All hospitals should code from the Medical Practitioner Specialties listed in Appendix 4. Hospitals may have a list of specialty codes for their own use, but these should be mapped to the list provided in Appendix 4. This mapping must be done at the hospital level.

Hospitals must notify the HMDS of any new specialty abbreviations to obtain the correct mapping.

If the Medical Practitioner Specialty Code is 02 - 07, please ensure that the nominated code is prefixed with a 0 i.e. "02", "03", "04" etc.

EXAMPLES

Example 1: Patient discharged from the care of a Gynaecologist.
SPECIALTY OF CLINICIAN ON SEPARATION

Example 2: Newborn baby discharged under the care of a General Practitioner.
SPECIALTY OF CLINICIAN ON SEPARATION

Example 3: Newborn baby discharged under the care of a Paediatrician.
SPECIALTY OF CLINICIAN ON SEPARATION



STATE / TERRITORY

Data element name:	State/Territory
System specific names:	webPAS: State/Territory
Definition:	The Australian state or territory where the patient's residential address is located.
Collection requirement:	Mandatory
METeOR reference:	286919
Format:	N (Numeric code)
Maximum length:	1
Permitted values:	0 - Not applicable (includes overseas resident and unknown) 1 - New South Wales 2 - Victoria 3 - Queensland 4 - South Australia 5 - Western Australia 6 - Tasmania 7 - Northern Territory 8 - Australian Capital Territory

GUIDE FOR USE

The order of permitted values is the standard for the Australian Bureau of Statistics (ABS).

EXAMPLES

Example 1: A patient was admitted whose Residential Address was in the Northern Territory.

STATE/TERRITORY



UNPLANNED RETURN TO THEATRE

Data element name:	Unplanned Return to Theatre
System specific names:	webPAS: 'Return to Theatre (CAT Y6)
Definition:	Indicates when the patient unexpectedly returns to theatre for further surgery.
Collection requirement:	Conditional (required if returned to theatre for further surgery within admission; blank otherwise)
METeOR reference:	578317
Format:	N (Numeric)
Maximum length:	1
Permitted values:	1 - Yes (unplanned return to theatre) 2 - No (planned return to theatre)

GUIDE FOR USE

This field should be completed if there is more than one attendance in theatre during this admission.

Provision of the Unplanned Return to Theatre status is the responsibility of the medical practitioner responsible for care.

EXAMPLES

Example 1: A patient admitted for excisional debridement and SSG of a chronic leg ulcer attends theatre firstly for the excisional debridement, and harvesting of skin. The patient then returns to theatre 5 days later for laying of the skin graft.

Unplanned Return to Theatre (No)

Example 2: A patient booked for an abdominal hysterectomy, needs to return to theatre the following day to control a postoperative haemorrhage.

Unplanned Return to Theatre (Yes)

Example 3: A patient, 5 days post appendicectomy, is noted to have developed a suture line abscess, and the doctor removes some sutures and irrigates the wound on the ward.

Unplanned Return to Theatre (Do not code)



WARD / LOCATION

Data element name:	Ward/Location
System specific names:	webPAS: Ward
Definition:	The ward or unit within the hospital where the patient was being treated immediately prior to discharge.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	Alphanumeric
Maximum length:	20
Permitted values:	Free text up to 20 characters

GUIDE FOR USE

Please note that the ward on discharge must be the physical ward that the patient was discharged from. Please do not record or report discharge lounges or virtual wards as the ward location on discharge.

EXAMPLES

Example 1: A patient was separated from the paediatric ward.

Ward / Location

Example 2: A record was inserted for a patient undergoing a contracted procedure in another hospital to show that this is the funding hospital.

Ward / Location

Example 3: A patient admitted to Wandoo ward and later transferred to Karri ward before being discharged home.

Ward / Location

Example 4: A patient is attending hospital under the Ambulatory Surgery Initiative and the Ward/Location field is recorded as ASW.

Ward / Location



CLINICAL DATA ELEMENT DEFINITIONS



ACTIVITY

Data element name:	Activity
System specific names:	webPAS: O
Definition:	The type of activity being undertaken by the person when injured.
Collection requirement:	Mandatory where applicable
METeOR reference:	641383
Format:	Alphanumeric codes
Maximum length:	10
Permitted values:	Refer to ICD-10-AM 10th Edition (effective from 1 July 2017)

GUIDE FOR USE

The Activity code 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.

The code values for this field are in the range U50-U73 as described below:

- Codes within U50-U71 for sporting activities enable the circumstances of sporting injuries to be better identified and thus aid prevention strategies.
- U72 *Leisure activity, not elsewhere classified* is provided to enable coding of other leisure activities not identified as sport.
- U73 *Other activity* includes codes for working for income according to industry type, which are of particular importance for occupational safety; for other types of work; for vital activities such as resting, sleeping and eating; and for other/unspecified activities.

Guidelines for coding Activity:

- Select the most specific code possible
- The Activity code should be sequenced after the Place of Occurrence code to which it relates
- All External Cause codes require an Activity code as set out in the WA Coding Standards (see Clinical Coding Policy MP 0056/17, Appendix 1)



- When multiple categories apply, assign the code appearing highest in the Tabular List
- The Activity code can be repeated with different External Cause codes
- This data item is to be used in conjunction with the External Cause code and Place of Occurrence
- Where there is an overlap between sport and work, the sport code takes precedence only when the person is injured in their role as a professional sportsperson (e.g. Perth Glory player injured while playing in a National Soccer League game, Jockey injured while riding a horse in the Melbourne Cup)
- Where the sporting activity is inherent in the job, but is not the task for which the person is paid, assign the appropriate code from U73.0 *Activity, while working for income* (e.g. a farmer riding his horse while rounding up the sheep)

EXAMPLES

Example 1: A nurse slipped and fell in hospital, while working.

External Cause	W01.0
Place of Occurrence	Y92.24
Activity	U73.07

Example 2: A child fell off a swing, in the playground at school, during recess.

External Cause	W09.4
Place of Occurrence	Y92.21
Activity	U72

Example 3: A grandmother was accidentally burnt, at home, while cooking dinner.

External Cause	X10.2
Place of Occurrence	Y92.09
Activity	U73.1

Example 4: A sixteen year old intentionally overdosed on antidepressants, while sitting in a car at the beachside.

External Cause	X61
Place of Occurrence	Y92.83
Activity	U73.8



ADDITIONAL DIAGNOSIS

Data element name: Additional Diagnosis

System specific names: webPAS: O

Definition: A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health care establishment, as represented by a code.

Collection requirement: Mandatory where applicable

METeOR reference: [588981](#)

Format: Alphanumeric codes

Maximum length: 10

Permitted values: Refer to ICD-10-AM 10th Edition (effective from 1 July 2017)

GUIDE FOR USE

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 analysis relating to severity of illness and for correct classification of patients into AR-DRGs.

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

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

Australian Coding Standard 0002 *Additional Diagnoses* (10th Edition) provides guidance on the appropriate allocation of Additional Diagnosis codes.



ADDITIONAL PROCEDURE

Data element name: Additional Procedure

System specific names: webPAS: P

Definition: A clinical intervention represented by a code that:

- is surgical in nature, and/or
- carries a procedural risk, and/or
- carries an anaesthetic risk, and/or
- requires specialised training, and/or
- requires special facilities or equipment only available in an acute care setting

Collection requirement: Conditional

METeOR reference: [641379](#)

Format: NNNN-NN (Numeric codes)

Maximum length: 10

Permitted values: Refer to ACHI 10th Edition (effective from 1 July 2017)

GUIDE FOR USE

All significant procedures undertaken from the time of admission to the time of discharge should be recorded. These include diagnostic and therapeutic procedures.

EXAMPLES

Example 1: A surgeon performing an abdominal hysterectomy removes the appendix while he is operating.

Principal Procedure	ABDOMINAL HYSTERECTOMY
Additional Procedure	APPENDICECTOMY

Example 2: A surgeon performing a cholecystectomy needs to divide dense abdominal adhesions before she can proceed.

Principal Procedure	CHOLECYSTECTOMY
Additional Procedure	LYSIS OF ADHESIONS



CLINICIAN PERFORMING PROCEDURE

Data element name:	Clinician performing procedure
System specific names:	webPAS: Clinician
Definition:	The medical practitioner responsible for performing or authorising the procedure.
Collection requirement:	Mandatory where applicable
METeOR reference:	Not applicable
Format:	AAANNNNNNNNNNN
Maximum length:	13
Permitted values:	Valid Medical Board Registration Number as per AHPRA

GUIDE FOR USE

This field requires the Medical Board Registration Number of the medical practitioner performing or authorising the patient's procedure.

Each medical practitioner is assigned a Medical Board Registration Number (MBRN) as per the Australian Health Practitioner Regulation Agency (AHPRA).

To identify a particular medical practitioner's current MBRN you can reference the AHPRA website and perform a search using the medical practitioner's name:

<http://www.ahpra.gov.au/Registration/Registers%20of%20Practitioners.aspx>

Clinician Performing Procedure field is a 13 character alphanumeric field and requires all leading zeros to be included.

Please note that the Clinician Performing Procedure must have admitting rights at your hospital to be entered into this field.

This number may be different to the Clinician on Admission or Clinician on Separation in some hospitals as the registrar who performs the procedures may not be the Clinician on Admission or the Clinician on Separation.

The Dental and Podiatrists' registration number is in the same 13 character alphanumeric format and should be reported.

When assigning a new 'doctor database number', it is important to link the number to the medical practitioner's relevant (i.e. doctor, dental or podiatry) MBRN.



Should the medical practitioner's MBRN (i.e. doctor, dental or podiatry) change, it is important that the 'doctor database' is updated to reflect this change.

EXAMPLES

Example 1: Dr Jones operated on a patient in hospital, and his Doctor MBRN is MED0000010094.

Clinician on Separation

M	E	D	0	0	0	0	0	1	0	0	9	4
---	---	---	---	---	---	---	---	---	---	---	---	---

Example 2: Dentist Mr. White operated on a patient in hospital and his Dental MBRN is DEN0000000014.

Clinician on Separation

D	E	N	0	0	0	0	0	0	0	0	1	4
---	---	---	---	---	---	---	---	---	---	---	---	---

Example 3: Surgical Podiatrist Mr. Gold operated on a patient in hospital, and his Podiatry MBRN is POD0000001935.

Clinician on Separation

P	O	D	0	0	0	0	0	0	1	9	3	5
---	---	---	---	---	---	---	---	---	---	---	---	---



CO-DIAGNOSIS (CODE ALSO)

Data element name:	Co-Diagnosis
System specific names:	webPAS: A
Definition:	ICD-10-AM diagnosis code that is used to record the disease associated with Principal Diagnosis in accordance with ICD-10-AM 10 th Edition aetiology and manifestation conventions.
Collection requirement:	Mandatory where applicable
METeOR reference:	Not applicable
Format:	Alphanumeric codes
Maximum length:	10
Permitted values:	Refer to ICD-10-AM 10th Edition (effective from 1 July 2017)

GUIDE FOR USE

Co-Diagnosis or Code Also (CA) is an event type that is assigned with an ICD-10-AM code to identify the relationship between the Principal Diagnosis code and the next sequenced code.

The field may be called Code Also or Co-Diagnosis.

Code Also (CA) is the second listed code under the Principal Diagnosis and is used to record the disease associated with the Principal Diagnosis in accordance with ICD-10-AM 10th Edition aetiology and manifestation conventions.

Although dagger and asterisk pairs are always listed with the aetiology code sequenced first in the ICD-10-AM Alphabetic Index, either code can be assigned as the Principal Diagnosis. When either a dagger or asterisk code is allocated as Principal Diagnosis, the Co-Diagnosis or Code Also (CA) field must contain the associated code i.e. if the asterisk code is Principal Diagnosis, the dagger code will be allocated as Code Also (CA). It is easy to recognise these codes in the ICD-10-AM Tabular List as the corresponding aetiology or manifestation code is enclosed in brackets after the code description.

These matched codes if appearing further down the sequence of codes, can also be reported as Additional Diagnoses.



EXAMPLES

Example 1: A patient is admitted for treatment of their glaucoma and is suffering from Lowe's syndrome.

Principal Diagnosis	<i>Glaucoma in endocrine, nutritional and metabolic diseases</i>	H42.0*
Co-Diagnosis (Code Also)	<i>Disorders of amino-acid transport (Lowe's syndrome)</i>	E72.0†



CONDITION ONSET FLAG

Data element name:	Condition Onset Flag
System specific names:	webPAS: Onset type
Definition:	A qualifier for each coded diagnosis (including external cause, activity and place of occurrence) to indicate the onset of the condition relative to the beginning of the episode of care, as represented by a code.
Collection requirement:	Mandatory
METeOR reference:	651997
Format:	N (Numeric code)
Maximum length:	1
Permitted values:	1 - Condition with onset during the episode of admitted patient care 2 - Condition not noted as arising during the episode of admitted patient care

GUIDE FOR USE

The Condition Onset Flag (COF) must be allocated to each Diagnosis code, External Cause code, Place of Occurrence code, Activity code and Morphology code to indicate:

- Condition with onset during the episode of admitted patient care
- Condition not noted as arising during the episode of admitted patient care

Reporting of the COF for each reported diagnosis code is mandatory for all separations from 1 July 2008.

The focus of the COF is to identify conditions arising during the episode of admitted patient care. An understanding of these conditions may inform prevention strategies particularly in relation to complications of medical care. It is used in the calculation of [Classification of Hospital Acquired Diagnoses \(CHADx\)](#) and [Hospital Acquired Complications](#) (developed by the Australian Commission for Safety and Quality in Health Care).

The COF does not differentiate between those conditions where onset was definitely before the episode commenced; and conditions where the point of onset is not clear due to lack of documentation or because the point of onset could not be clinically determined. The flag only indicates that the condition onset occurred during the episode of admitted patient care, and cannot be used to indicate whether a condition was considered preventable.



Clinical coders are responsible for assigning the COF in conjunction with 10th Edition Australian Coding Standard 0048 *Condition onset flag*.

As a general rule of thumb "COF 2 - Condition not noted as arising during the episode of admitted patient care" must be assigned to:

- Principal Diagnosis
- Z codes relating to outcome of delivery on the mother's record (Z37.x)
- Z codes relating to the outcome of delivery on the baby's record (Z38.x)

The exception to this is neonates in their admitted birth episode where the code sequenced as the Principal Diagnosis may be assigned COF 1 if appropriate.

The Condition Onset Flag does not influence the sequencing of Diagnosis codes. Therefore clinical coders must not re-sequence diagnosis codes so that the same Condition Onset Flags are grouped together. Clinical coders must sequence Diagnosis codes in accordance with Australian Coding Standards.

The Condition Onset Flag on External Cause, Place of Occurrence and Activity codes should match that of the corresponding injury or disease code.

If a single Diagnosis code describes more than one disease concept (e.g. diabetes with renal complications) and one of the disease concepts meets the criteria of COF 1 and is not represented by another code with COF 1 value, then assign COF 1 to the combination code.

If a condition requires more than one Diagnosis code to describe it, it is possible for each Diagnosis code to have a different COF.

The COF value assigned to Morphology codes should match that of the corresponding neoplasm code.

VALUE DEFINITIONS

1 - Condition with onset during episode of admitted patient care [COF 1]

A condition which arises during the episode of admitted patient care and would not have been present or suspected on admission. Examples of inclusions:

- a condition resulting from an unintentional event during surgical or medical care in the current episode of admitted patient care (eg accidental laceration during procedure, foreign body left in cavity, medication infusion error)
- an abnormal reaction to, or later complication of, surgical or medical care arising during the current episode of admitted patient care (eg post procedural shock, disruption of wound, catheter associated UTI (urinary tract infection))



- a condition newly arising during the episode of admitted patient care (eg pneumonia, rash, confusion, UTI, hypotension, electrolyte imbalance)
- a condition impacting on obstetric care arising after admission, including complications or unsuccessful interventions of labour and delivery or prenatal/postpartum management (eg labour and delivery complicated by fetal heart rate anomalies, postpartum haemorrhage)
- for neonates, this also includes the condition(s) in the birth episode arising during the birth event (ie the labour and delivery process) (eg respiratory distress, jaundice, feeding problems, neonatal aspiration, conditions associated with birth trauma, newborn affected by delivery or intrauterine procedures)
- disease status or administrative codes arising during the episode of admitted patient care (eg cancelled procedure, MRSA (Methicillin Resistant or Multi-Resistant Staphylococcus aureus))

2 - Condition not noted as arising during episode of admitted patient care [COF 2]

A condition previously existing or suspected on admission such as the presenting problem, a comorbidity or chronic disease. Examples of inclusions:

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



EXAMPLES

Example 1: Patient admitted with pneumonia 7 days into the admission develops a urinary tract infection.

Code type	Description	ICD-10-AM code	COF
PDx	Pneumonia	J18.9	2
ADX	Urinary tract infection	N39.0	1



DATE OF PROCEDURE

Data element name:	Date of Procedure
System specific names:	webPAS: Date
Definition:	The date on which a procedure commenced during an inpatient episode of care.
Collection requirement:	Mandatory where applicable
METeOR reference:	270298
Format:	DDMMYYYY
Maximum length:	8
Permitted values:	Date (Numeric)

GUIDE FOR USE

The procedure date is to be recorded for **all** procedures undertaken during an episode of care and must reflect the date upon which that procedure was performed.

Note: please do not assume that all procedures are performed during the same theatre visit- documentation must be checked to ensure correct procedure dates are collected and reported.

All procedures are to be coded in accordance with the current edition of ICD-10-AM.

EXAMPLES

Example 1: A patient was admitted for a Vaginal Hysterectomy that was performed on 20/02/2011.

	DAY		MONTH		YEAR			
Date of Procedure	2	0	0	2	2	0	1	1

Example 2: A patient was admitted in labour and had to have an emergency Caesarean section for foetal distress on 18th April 2012.

	DAY		MONTH		YEAR			
Date of Procedure	1	8	0	4	2	0	1	2



EXTERNAL CAUSE (OF INJURY)

Data element name:	External Cause
System specific names:	webPAS: O
Definition:	The environmental event, circumstance or condition as the cause of injury, poisoning and other adverse effect, as represented by a code.
Collection requirement:	Mandatory where applicable
METeOR reference:	641415
Format:	Alphanumeric code
Maximum length:	10
Permitted values:	Refer to ICD-10-AM 10th Edition (effective from 1 July 2017)

GUIDE FOR USE

This information is important because it is reported to the National Injury Surveillance Unit (NISU) for the examination of causes of injury and poisoning, and the setting of targets for reduction of these events.

Guidelines for coding External Causes:

- Select the most specific code possible
- Unlimited External Cause codes may be recorded
- The External Cause code should be sequenced after the diagnostic code to which it relates
- All External Cause codes require a Place of Occurrence and Activity code as set out in the WA Coding Standards (see Clinical Coding Policy MP 0056/17, Appendix 1)

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

An External Cause code should be sequenced following the related injury or poisoning code, or following the group of codes, if more than one injury or condition has resulted from this External Cause. Provision should be made to record more than one External Cause if appropriate.

External Cause codes in the range V00-Y89 must be accompanied by a Place of Occurrence code and Activity code.



HOURS OF CONTINUOUS VENTILATORY SUPPORT

Data element name:	Hours of Continuous Ventilatory Support
System specific names:	webPAS: Hours of mechanical ventilation
Definition:	The number of hours of administration of non-invasive ventilation.
Collection requirement:	Mandatory where applicable
METeOR reference:	359644
Format:	NNNNN (Numeric value)
Maximum length:	5
Permitted values:	Integer value (whole hours)

GUIDE FOR USE

Continuous Ventilatory Support (CVS) (previously known as Continuous Mechanical Ventilation (CMV)) is the provision of mechanical respiration to assist patients with respiratory failure via an invasive artificial airway (endotracheal tube or tracheostomy).

Non-invasive ventilation support such as Continuous Positive Airways Pressure (CPAP), Bi-Level Positive Airway Pressure (BIPAP) and Intermittent Positive Pressure Breathing (IPPB) should not be reported as CVS hours unless it forms part of the weaning from CVS or is administered by an invasive artificial airway.

Refer to 10th Edition Australian Coding Standard 1006 *Ventilatory support* for calculating the duration of CVS and guidelines for coding.

EXAMPLES

Example 1: A patient was treated on CVS for seven days.

7 DAYS	CVS HOURS	168
--------	-----------	-----

Example 2: A patient was treated on CVS for 48 hours.

48 HOURS	CVS HOURS	48
----------	-----------	----

Example 3: A patient went to theatre and was on mechanical ventilation for 12 hours. CVS hours is not coded as it is less than 24 hours, and is associated with the anaesthesia and considered an integral part of the surgical procedure.

CVS HOURS	0
-----------	---



NOT CODED

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Example 4: A patient received 14 hours of CVS and 3 hours of CPAP (non-invasive ventilatory support) as part of the weaning from CVS. The CPAP is included in the calculation of CVS hrs as it part of the weaning from CVS.

17 HOURS

CVS HOURS	17
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MORPHOLOGY

Data element name: Morphology

System specific names: webPAS: M

Definition: A 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).

Collection requirement: Mandatory where applicable

METeOR reference: [399491](#)

Format: Alphanumeric code

Maximum length: 6

Permitted values: Refer to ICD-10-AM 10th Edition (effective from 1 July 2017)

GUIDE FOR USE

This information is to be collected for all morbidity data for the national cancer registers.

The format of the codes is X9999/9. For example, the Morphology code for infiltrating ductal carcinoma of breast is M8500/3. Infiltrating ductal carcinoma of axillary tail of breast would be coded as follows:

INFILTRATING DUCTAL CARCINOMA OF AXILLARY TAIL OF
BREAST
INFILTRATING DUCTAL CARCINOMA

C	5	0	.	6		
---	---	---	---	---	--	--

M	8	5	0	0	/	3
---	---	---	---	---	---	---

If there is more than one neoplasm of the same type, the Morphology code should be sequenced directly after the last neoplasm diagnosis code to which it applies (see Examples).

Where there is more than one histological feature in a neoplasm, assign the highest Morphology and sequence directly after the neoplasm. For example, transitional cell epidermoid carcinoma has two morphology codes M8120/3 and M8070/3. The code to be assigned directly after the neoplasm code is M8120/3 as it is the code with the highest number.



Morphology codes can never be assigned as Principal Diagnosis or Co-Diagnosis.

Behaviour	Description	Diagnosis code
/0	Benign neoplasms	D10.0-D36.9
/1	Neoplasm of uncertain and unknown behaviour	D37.0-D48.9
/2	In situ neoplasms	D00.0-D09.9
/3	Malignant neoplasms, stated or presumed to be primary	C00.0-C76.8 C80.0-C96.9
/6	Malignant neoplasms, stated or presumed to be secondary	C77.0-C79.9
/9	Malignant neoplasms, uncertain whether primary or metastatic site	C00.0-C76.8 C80.0, C80.9

EXAMPLES

Example 1: A patient was admitted for excision of a meningioma of cerebral meninges.

MENINGIOMA OF CEREBRAL MENINGES
MENINGIOMA

D	3	2	.	0		
M	9	5	3	0	/	0



PLACE OF OCCURRENCE

Data element name: Place of Occurrence

System specific names: webPAS: O

Definition: The place where an injury, poisoning or accident occurred. This item is important for monitoring injuries, setting injury control targets, injury costing and research.

Collection requirement: Mandatory where applicable

METeOR reference: [641422](#)

Format: Alphanumeric code

Maximum length: 10

Permitted values: Refer to ICD-10-AM 10th Edition (effective from 1 July 2017)

GUIDE FOR USE

The code values for this item are:

- Y92.0x Home
- Y92.1x Residential institution
- Y92.2x School, other institution and public administrative area
- Y92.3x Sports and athletics area
- Y92.4x Street and highway
- Y92.5x Trade and service area
- Y92.6x Industrial and construction area
- Y92.7 Farm
- Y92.8x Other specified place of occurrence
- Y92.9 Unspecified place of occurrence

These codes are further subdivided (e.g. Y92.21 School) to provide greater specificity to the Place of Occurrence.



Place of Occurrence is mandatory if an External Cause code is present.

Guidelines for coding Place of Occurrence:

- Select the most specific code possible.
- The Place of Occurrence code should be sequenced after the External Cause code to which it relates.
- All External Cause codes require a Place of Occurrence as set out in the WA Coding Standards (see [Clinical Coding Policy MP 0056/17](#))
- When multiple categories apply, assign the code appearing highest on the list.
- The Place of Occurrence code can be repeated with different External Cause codes.



PRINCIPAL DIAGNOSIS

Data element name: Principal Diagnosis

System specific names: webPAS: D

Definition: The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care, an episode of residential care or an attendance at the health care establishment, as represented by a code.

Collection requirement: Mandatory

METeOR reference: [640978](#)

Format: Alphanumeric code

Maximum length: 10

Permitted values: Refer to ICD-10-AM 10th Edition (effective from 1 July 2017)

GUIDE FOR USE

Clinical coders should review 10th Edition Australian Coding Standard 0001 *Principal diagnosis* for information relating to the assignment of a Principal Diagnosis code.

Every patient episode must contain a Principal Diagnosis.



PRINCIPAL PROCEDURE

Data element name: Principal Procedure

System specific names: webPAS: P

Definition: The most significant clinical intervention, represented by a code, that was performed for treatment of the principal diagnosis and 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.

Collection requirement: Conditional

METeOR reference: [641379](#)

Format: NNNNN-NN (Numeric code)

Maximum length: 10

Permitted values: Refer toACHI 10th Edition (effective from 1 July 2017)

GUIDE FOR USE

See the 10th Edition Australian Coding Standards for further information relating to the coding of Principal and Additional Procedures.

The following points should be taken into account when selecting procedures to code but it should be noted that sequencing of procedures, including the Principal Procedure, would not affect AR-DRG grouping.

When no procedure was performed for treatment of the Principal Diagnosis, use the following hierarchy:

- Procedure performed for treatment of Additional Diagnoses
- Diagnostic/exploratory procedure related to the Principal Diagnosis
- Diagnostic/exploratory procedure related to the Additional Diagnoses

If an anaesthetic is used, the anaesthetic procedure code should follow the procedure code to which it relates and be coded as per Australian Coding Standard 0031 *Anaesthesia* (10th Edition).



EXAMPLES

Example 1: A patient injured in a traffic accident has surgery for a fractured tibia on day 15 after his major brain trauma has resolved. (The Principal Diagnosis is the most life threatening injury, even though the only surgery performed was for the Additional Diagnosis.)

Principal Diagnosis	BRAIN INJURY
Principal Procedure	ORIF TIBIA FRACTURE

Example 2: A woman is admitted for an open biopsy of a breast lump. Pathology confirms malignancy and she remains in hospital and undergoes a mastectomy.

Principal Diagnosis	BREAST MALIGNANCY
Principal Procedure	RADICAL MASTECTOMY
Additional Procedure	OPEN BIOPSY OF BREAST

Example 3: A woman with complications of pregnancy is admitted for Induction of Labour. She is taken to theatre for an emergency Caesarean section.

Principal Diagnosis	CAESAREAN SECTION
Principal Procedure	EMERGENCY LUSCS
Additional Procedure	INDUCTION OF LABOUR BY ARM

Example 4: A male patient is admitted with gynaecomastia, for a simple mastectomy. (This will raise a sex edit and will require confirmation from the hospital.)

Principal Diagnosis	GYNAECOMASTIA
Principal Procedure	SIMPLE MASTECTOMY





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