Enterprise Data & Information

ADMITTED PATIENT CARE

Data Elements 2023-2024

Date March 2024

Government of South Australia

SA Health

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CHANGE HISTORY

Document Version	Date	Updated By	Change Summary
1.0	16-Jun-2022	Mark Hall: Manager Information Assembly	New 2511, 2772, 2773, 2774, 2775, 2776, 2777, 2778, 2779, 2780, 4081, 4087, 4203, 4204 & 4426 Amended 1310, 2060, 2077, 2078, 2081, 2082, 2083, 2084, 2086, 2087, 2088, 2090, 2114, 2117, 2280, 2300, 2341, 2510, 2610, 2611, 2612, 2753, 2754, 4001, 4002, 4003, 4004, 4005, 4006, 4007, 4008, 4010, 4020, 4030, 4036, 4040, 4046, 4066, 4070, 4075, 4080, 4170, 4175, 4190, 4190A, 4210, 4220, 4225, 4230, 4240, 4250, 4260, 4280, 4290, 4300, 4310, 4320, 4340, 4370, 4380, 4382, 4382A, 4390, 4390A, 4395, 4400, 4410, 4410A, 4420, 4425, 4450, 4460, 4470, 4474, 4480, 4490, 4500, 4510, 4530, 4540, 4560, 4570, 4571, 4580, 4610, 4620, 4641, 4643, 4652, 4755, 4760, 4770, 4780, 4789, 4790, 4800, 4820, 4880, 4906, 4910, 4920, 4920A & 4960 Deactivated 2078, 2089, 2160 2161, 2162 & 4086
2.0	30-Sep-22	Mark Hall: Manager Information Assembly	Amended 4691, 4824, 4833, 4870 & 4898
3.0	06-Nov-22	Mark Hall: Manager Information Assembly	Updated Periods of Leave appendix Amended 2585, 4662, 4670, 4690, 4730 & 4950 Deactivated 4663 & 4680
4.0	18-Mar-23	Mark Hall: Manager Information Assembly	Updated Sub-acute references for Admission Type 2 (Long Stay Acute) Added new Source of Referral Code V – Virtual Care Services New 4660 data quality check Amended 2753, 4030 data quality checks

			Deactivated 2780 data quality check
5.0	16-Jun-23	Senior Quality Assurance Officer	Added new data items Gender, IHI – Person, IHI – Record Status, IHI – Number Status and EPAS Chart GUID Updated Code sets Type of Usual Accommodation, Mental Health Accommodation Prior, Legal Status and Referral for Further Care New 4992 data quality check Amended 2170, 4013, 4220, 4230, 4720, 4780 data quality checks Deactivated 2341 data quality check
6.0	12-Mar-24	Chloe Earls: Data Quality Assurance Officer	New 4041 data quality check Amended 4013,4780

APPROVALS

This document is approved on the basis that it meets the following acceptance criteria.

Document Endorsement

This document requires the following endorsement:

Version	Date	Name	Endorsed Yes/No?	Signature
1.0	5th September 2022	Anthony Fantasia A/Manager Data Governance and Quality Assurance	Yes	AF
2.0	30th September 2022	Anthony Fantasia A/Manager Data Governance and Quality Assurance	Yes	AF
3.0	2nd December 2022	Anthony Fantasia A/Manager Data Governance and Quality Assurance	Yes	AF
4.0	18th March 2023	Anthony Fantasia Manager Data Governance and Quality Assurance	Yes	AF
5.0	31st August 2023	Anthony Fantasia Manager Data Governance and Quality Assurance	Yes	AF
6.0	12th March 2024	Anthony Fantasia Manager Data Governance and Quality Assurance	Yes	AF

INTRODUCTION

Purpose

The Admitted Patient Care data set covers all (majority) of inpatient hospitalisations in South Australia and provides SA Health with the information necessary to effectively fund, organise, evaluate, and plan health services. It also allows SA Health to meet national obligations through submissions to the Australian Institute of Health and Welfare (AIHW), the Independent Hospital Pricing Authority (IHPA), the National Health Performance Authority and the National Health Funding Body. The Admitted Patient Care data set forms part of the Admitted Patient Care National Minimum Data Set through submission to AIHW.

The data set for South Australia's morbidity data is called the Integrated South Australian Activity Data Set (Admitted Patient Care).

The purpose of this document is to describe the data elements and associated data set guidelines required for the Admitted Patient Care data set. The primary audience is expected to be hospitals submitting to Admitted Patient Care. Others who will find this document useful are those working with the data (e.g. for planning, monitoring, research) and those assuring quality and integrity of the data.

Scope

All public hospitals in South Australia are required to submit information to Admitted Patient Care. The data set also includes data submitted by private hospitals in South Australia.

Data submitted to Admitted Patient Care should be timely, accurate and complete, reflecting the types of patients admitted and the treatment provided. These guidelines represent SA Health policy and are intended to be a reference for all hospital personnel who are involved in the data set and use of Admitted Patient Care data.

Admitted Patient Care data must be received by the Submit Date in the Data Submission Schedule Appendix

The Admitted Patient Care data set covers all admitted patient separations (discharges, transfers and deaths) from every South Australian:

- Public Acute Hospital
- Public Psychiatric Hospital
- Private Acute Hospital (licensed by SA Health)
- Private Psychiatric Hospital (licensed by SA Health)
- Private Day Surgery (licensed by Commonwealth)

Admitted patient activity data relating to SA residents hospitalised in interstate public hospitals is collected by the other State/Territory health authorities.

Exclusions

The following patients are excluded from the Integrated South Australian Activity data set:

- Patients in developmental disability institutions
- Patients in private residential aged care facilities
- Patients in outpatient and community health services
- Patients in multi-purpose service hospital hostel accommodation who are not classified as admitted patients

- Residents of community residential care units
- Residents of transitional living units under the brain injury rehabilitation program
- Defence force personnel treated on base
- Boarders
- Still births

Contact details

The **Data Governance and Quality Assurance** unit can assist with information about:

- Data submissions
- Due dates for submissions
- Obtaining reports or data
- Category definitions
- Data standards
- Error report distribution
- Correcting errors
- Content and maintenance of this manual
- Non-clinical data quality checks (data quality checks/queries)

The Data Governance and Quality Assurance unit can be contacted via:

Email: EnterpriseDataandInformation@sa.gov.au

Health Information Governance Unit (HIGU) formally Medical Record Advisory Unit can supply further information about:

- Clinical coding
- Clinical coder workforce issues
- Clinical data quality checks (data quality checks/queries)
- AR-DRG assignment issues

You can contact the Health Information Governance Unit (HIGU) via**:**

Email: medicalrecords@sa.gov.au

DATA QUALITY STATEMENT

The management of this data set aligns to SA Health's Data Quality Management Framework policy directive and guidelines.

To ensure data is fit for multiple uses the submission and data set processes include the following features:

Accuracy: The Admitted Patient Care reference manual is published on the SA Health website as a reference for the Admitted Patient Care data submissions and data set requirements. It provides details of data definitions and describes the data tests (i.e. data quality check tests) undertaken to verify the accuracy of the data. Where quality issues are detected the health data suppliers are required to promptly correct the identified data quality issue.

Validity: The validation process includes making available validation reports to assist health data suppliers in identifying data elements requiring attention and correcting and resubmitting the data.

Completeness: The completeness of submitted data is monitored monthly to identify when submission deadlines are not met or when records are outstanding. Significant instances of incomplete submissions are published in the monthly data set refresh notices to ensure data end users such as analysts and researchers are notified of this quality issue.

Coherence: The Admitted Patient Care data set is reviewed annually to ensure it provides SA Health with the information necessary to effectively fund, organise, evaluate, and plan health services and to meets its national obligations through submissions to the Australian Institute of Health and Welfare (AIHW), the Independent Hospital Pricing Authority (IHPA), and the National Health Funding Body. Common data elements are defined and consistent within and across data sets.

Interpretability: The Admitted Patient Care data set reference manual provides details of the data concepts, definitions, data quality checks and rules across the Admitted Patient Care data set. The data set is reviewed annually in consultation with SA Health data suppliers.

Timeliness: The Admitted Patient Care data set is updated in accordance with submissions made each month from data held in the Admitted Patient Care processing database. Health services must submit data at least monthly.

With the introduction of the IHPA national quarterly submissions from 2018-2019, data suppliers must ensure their supplied data quality reporting must be completed on a quarterly basis.

Accessibility: SA Health makes data accessible through various dashboards, reports, portals (e.g. QIP Hub) and the LARS website.

REFERENCE FILES

Reference files are available on the SA Health website for download from the APC web page

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

RELATED DOCUMENTS

Readers of this document may also be interested in the associated documents:

- Admitted Patient Care – File Extract – Technical Specification
- Admitted Patient Care – Data Quality Checks – Reference Manual

CONFIDENTIALITY, PRIVACY AND SECURITY

Although no patient names or addresses are stored in the Admitted Patient Care data set, the sensitive nature of clinical information is recognised. Staff are bound by the Public Sector Act and the Code of Ethics to ensure that patient confidentiality is protected and maintained.

The use and release of the Admitted Patient Care data set (e.g. through the Health Information Portal (HIP)) is governed by SA Health's Privacy Policy Directive, data management protocols, various legislation and other relevant privacy codes and regulations. Other usage is properly authorised before release.

The Admitted Patient Care database and the SA Health Central Data Warehouse reside on physically and logically secure computer systems which are accessible to authorised staff only.

Admitted Patient Care data set are made available for research where approval by relevant Ethics Committees is evident.

DATA DEFINITIONS

Introduction

This section describes the data elements required to complete the Admitted Patient Care data set. Each element belongs to one broad category, which is related to timing points during the episode of care. Chronologically, these timing points are:

- At admission
- During treatment
- At separation

At admission contains three sub-categories:

- Demographics
- General
- Identifiers

During treatment contains five sub-categories:

- Clinical
- Contracted Service
- General
- Leave
- Status Change

At separation contains one sub-category:

- General

Data definition format

Each data element is described using standard metadata. Meanings of these metadata are described below.

[Data element name] - *the commonly used name of the data element*

Identification – ***the group of items that identify the data element***

Technical name:	*The name of the data element in the context of other metadata*
APC data item:	*Data item number within the data set – use in conjunction with file specifications.* ***Some quality data quality checks reference this number to help identify which data item requires quality review***
SAHMR identifier:	*SA Health metadata item number reference*
Registration status:	*Refers to the date upon which the data element became an authorised standard. This is not necessarily the same as the date from which it became actively used (i.e. a data element may become standard on 24 June but active from 1 July)*
Definition:	*Describes in detail the meaning and intent of the data element*
Data element concept:	*Provides contextual understanding of the metadata*

Value domain – ***the group of items that describe acceptable values and format for the data element***

Class:	*Data value classification*
Type:	*Type of data to be recorded (e.g. string, numeric, etc)*
Format:	*Format the data must take where A – alphanumeric, N – numeric, [?] – optional characters*
Length:	*The maximum length of the data for the data element*
Values:	*Describes the values or refers to a Reference File*

Obligation – ***describes any dependencies associated with the data element***

Class:	*Conditional / Mandatory / Optional*
Dependency:	*Describes any dependencies (e.g. of other data elements) associated with this data element*

Collection – ***any supporting information to assist with consistent interpretation and meaning of capture of the data element values***

Data Quality Checks – ***lists any associated data quality checks for the data element***

[Activity When Injured]

Identification

Technical name:	Injury event – activity type, code AN[NNN]
APC data item:	93
SAHMR identifier:	SA1060
Registration status:	SA Health, Standard 24/04/2013
Definition:	The type of activity being undertaken by the person when injured, as represented by a code.
Data element concept:	Injury event – activity type

Value domain

Class:	Code
Type:	String
Format:	AN[NNN]
Length:	5
Values:	Reference file

Obligation

Class:	Conditional
Dependency:	Mandatory for records supplied with: > [External Cause] > [Place Of Occurrence]

Collection

[Activity When Injured]:

- Is an ICD-10-AM (12th Edition) diagnosis code from range U5000-U7399.
- External cause codes V00 to Y34 must be accompanied by an activity code U50-U73.
- Submitted with [External Cause] and [Place Of Occurrence].
- Is sequenced in [Additional Diagnosis] before [Place Of Occurrence].
- May be assigned multiple times to a record.
- May not be duplicated.

The first [Activity When Injured] code must be reported as [Activity When Injured]; additional [Activity When Injured] codes are reported in [Additional Diagnosis].

See Diagnosis and Procedure Codes, page 198.

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.

Data Quality Checks

- 2690: [Activity When Injured] not (U5000-U739, or blank)
- 4860: [Activity When Injured] of (U5000-U739) REQUIRES [External Cause]
- 4870: [Activity When Injured] of (U5000-U739), and [Additional Diagnosis] or [External Cause] not (V0000-Y34)
- 4880: [External Cause] of (V0000-Y34), and [Activity When Injured] not (U5000-U739)
- 4885: [Additional Diagnosis] of (V0000-Y34) REQUIRES [Additional Diagnosis] or [Activity When Injured] of (U5000-U739)
- 4900: Duplicate Diagnosis code from [Principal Diagnosis], [Additional Diagnosis], [External Cause], [Place Of Occurrence], and/or [Activity When Injured] DELETES duplicate Diagnosis code

[Additional Diagnosis]

Identification

Technical name:	Episode of care – additional diagnosis, code AN[NNN]
APC data item:	46
SAHMR identifier:	SA1096
Registration status:	SA Health, Standard 24/04/2013
Definition:	A condition or complaint either coexisting with the principal diagnosis or arising during the episode of admitted patient care, episode of residential care or attendance at a health-care establishment, as represented by a code.
Data element concept:	Episode of care – additional diagnosis

Value domain

Class:	Code
Type:	String
Format:	AN[NNN]
Length:	5
Values:	Reference file

Obligation

Class:	Optional
Dependency:	None

Collection

[Additional Diagnosis] codes are conditions that significantly affect patient management in terms of requiring any of the following:

- commencement, alteration or adjustment of therapeutic treatment
- diagnostic procedures
- increased clinical care

In addition to clinical diagnosis codes, [Additional Diagnosis] includes [External Cause], [Place Of Occurrence], and [Activity When Injured] codes so that meaning is given to the data for use in injury surveillance and other monitoring activities.

In accordance with the Australian Coding Standards, a condition may be documented by the treating clinician/team due to its 'clinical significance'; however, some conditions are not normally assigned [Additional Diagnosis] codes in certain circumstances.

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

See Diagnosis and Procedure Codes, page 198.

Data Quality Checks

- 2077: [Additional Diagnosis] of (U0770-U0774) REQUIRES [Additional Diagnosis] or [External Cause] of (Y590)
- 2079: [Additional Diagnosis] (U073, or U074) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U075), or [Additional Diagnosis] (U073, or U074)
- 2081: [Additional Diagnosis] of (B948) NOT COMPATIBLE WITH [Additional Diagnosis] (U074)
- 2082: [Principal Diagnosis] or [Additional Diagnosis] of (B342) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] (U0711, U0712 or U072)
- 2083: [Principal Diagnosis] or [Additional Diagnosis] of (U0711, U0712, or U072) NOT COMPATIBLE WITH [Additional Diagnosis] or [Principal Diagnosis] (U075)
- 2084: [Principal Diagnosis] or [Additional Diagnosis] of (M303) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U075)
- 2086: [Principal Diagnosis] or [Additional Diagnosis] of (U0711, U0712, or U072) NOT COMPATIBLE with [Principal Diagnosis] or [Additional Diagnosis] of (Z0381)
- 2087: [Principal Diagnosis] or [Additional Diagnosis] of (U0711 or U0712) NOT COMPATIBLE with [Principal Diagnosis] or [Additional Diagnosis] of (U072)
- 2088: [Principal Diagnosis] or [Additional Diagnosis] of (O000 to O984) or (O986 to O998), and [Additional Diagnosis] of (U0711, U0712 or U072) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O985)
- 2090: [Additional Diagnosis] of (U061-U068, U076, U078-U079, U130–U499 or U750-U779) NOT PERMITTED
- 2091: [Principal Diagnosis] of (O422) NOT COMPATIBLE WITH [Additional Diagnosis] of (O4211, or O4212), or [Principal Diagnosis] of (O4211, or O4212) NOT COMPATIBLE WITH [Additional Diagnosis] of (O422)
- 2093: [Principal Diagnosis] or [Additional Diagnosis] of (O80-O83) REQUIRES [Additional Diagnosis] of (Z370-Z371)
- 2094: [Additional Diagnosis] of (Z370-Z371) REQUIRES [Principal Diagnosis] of (O040-O049, or O80-O83), or [Additional Diagnosis] of (O80-O83)
- 2095: [Additional Diagnosis] of (Z370-Z371) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O300-O309, or O840-O849)
- 2097: [Additional Diagnosis] of (Z372-Z377] REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O840-O849)
- 2098: [Additional Diagnosis] of (Z372-Z377) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O80-O83)
- 2099: [Additional Diagnosis] of (Z370-Z374) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O301-O309)
- 2105: [Additional Diagnosis] of (Z370-Z371, or Z375-Z377) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O661)
- 2106: [Additional Diagnosis] of (Z370-Z371) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O632)
- 2111: [Additional Diagnosis] of (Z370-Z371, or Z375-Z377) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O300)

- 2112: [Principal Diagnosis] or [Additional Diagnosis] of (O80, or O840) NOT COMPATIBLE WITH [Procedure] from (Block 1337, Block 1338, Block 1339, Block 1340, Block 1341, Block 1342, Block 1343 (except 9047200), or 9048200)
- 2113: [Principal Diagnosis] or [Additional Diagnosis] of (O81, or O841) REQUIRES [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9047002, or 9047004)
- 2114: [Principal Diagnosis] or [Additional Diagnosis] of (O81, or O841) NOT COMPATIBLE WITH [Procedure] from (9046803, 9047001, 9047003, 9047702, Block 1336, or Block 1340)
- 2115: [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9047002, or 9047004) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O81, O841, or O8482)
- 2116: [Principal Diagnosis] or [Additional Diagnosis] of (O82, or O842) REQUIRES [Procedure] from (Block 1340)
- 2117: [Principal Diagnosis] or [Additional Diagnosis] of (O82, or O842) NOT COMPATIBLE WITH [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9048200, Block 1336 or Block 1339)
- 2118: [Procedure] from (Block 1340) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O82, O842, or O8482)
- 2163: [Principal Diagnosis] or [Additional Diagnosis] of (O00-O998, or Z340-Z349) NOT COMPATIBLE WITH [Additional Diagnosis] of (Z33)
- 2164: [Principal Diagnosis] or [Additional Diagnosis] of (O00-O998, Z33 or Z340-Z349) NOT COMPATIBLE WITH [Additional Diagnosis] of (Z340-Z349)
- 2511: [Hospital Number] of (< 4000), and [Principal Diagnosis] or [Additional Diagnosis] contains [Diagnosis] in system reference table with [Unacceptable Diagnosis Flag] of (2)
- 2520: [Additional Diagnosis] is INVALID, not a [Diagnosis] code or not a [RUG-ADL] score
- 2531: [Principal Diagnosis] or [Additional Diagnosis] of (O83, or O0841) NOT COMPATIBLE WITH [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9047002, 9047004, Block 1336, or Block 1340)
- 2583: Age at admission of (> 28 days) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 2736: Record presents as both [HITH] Rehab@Home ([Additional Diagnosis] Z509) and [HITH] GEM@Home ([Additional Diagnosis] Z769)
- 2747: [Principal Diagnosis] or [Additional Diagnosis] of (Z525 or Z527) REQUIRES [Episode Of Care] of (P)
- 2753: Non-emergency selected same day scope procedures where no general anaesthetic is administered are INVALID inpatient admissions; REPLACE inpatient admission with an outpatient occasion of service
- 2754: Non-emergency same day chemotherapy procedures where no general anaesthetic is administered are INVALID inpatient episodes for funding
- 2770: [Condition Onset Flag] for [Principal Diagnosis] or [Additional Diagnosis] or [Activity When Injured] or [External Cause] or [Place Of Occurrence] not (1, or 2)
- 2774: [Additional Diagnosis] of (B972) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U0711, U0712, or U072)
- 2775: [Principal Diagnosis] or [Additional Diagnosis] of (U049) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U0711, U0712, U072 or B342)

- 2776: [Principal Diagnosis] or [Additional Diagnosis] of (U0711) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U0712)
- 2777: [Principal Diagnosis] or [Additional Diagnosis] of (Z115) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (Z0381 or Z110)
- 2778: [Principal Diagnosis] or [Additional Diagnosis] of (Z2081) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U0711, U0712, or U072)
- 2779: [Principal Diagnosis] or [Additional Diagnosis] of (Z252) REQUIRES [Procedure] from 9215703-9215706
- 4005: [Principal Diagnosis] or [Additional Diagnosis] in system reference table with [Death Diagnosis Flag] of (Y) REQUIRES [Nature Of Separation] of (5, or 6)
- 4036: [Episode Of Care] of (4, or K) REQUIRES [Additional Diagnosis] of (Z509)
- 4040: [Principal Diagnosis] or [Additional Diagnosis] of (Z511 or Z2921) REQUIRES [Additional Diagnosis] of (C000-D489)
- 4041: Voluntary Assisted Dying flag code (Z01.9 or Z41.9) used
- 4046: [Additional Diagnosis] of (Z509) REQUIRES [Episode Of Care] of (4, 7, or K)
- 4058: RUG-ADL in [Additional Diagnosis] not in system reference table
- 4060: [Additional Diagnosis] of (Z500-Z501, or Z504-Z509) NOT COMPATIBLE WITH [Principal Diagnosis] of (Z540-Z549)
- 4061: [Episode Of Care] of (3) REQUIRES [Additional Diagnosis] of (Z515)
- 4066: [Principal Diagnosis] or [Additional Diagnosis] of (Z511 or Z2921) INVALID WITH [Admission Date] <>[Separation Date]
- 4070: [Principal Diagnosis] or [Additional Diagnosis] of (G300-G309) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (F0000-F0091)
- 4075: [Additional Diagnosis] of (Z511 or Z2921) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4080: [Principal Diagnosis] or [Additional Diagnosis] of (F0000-F0091) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (G300-G309)
- 4087: [Additional Diagnosis] of (U0770-U0774) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (T800-T809)
- 4090: [Procedure] from (4178900, or 4178901) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (J030-J039)
- 4091: [Principal Diagnosis] or [Additional Diagnosis] of (J450-J459, or J46) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] (J450-J459, or J46)
- 4095: [Additional Diagnosis] of (Z510) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4105: [Additional Diagnosis] of (Z491, or Z492) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when Length of stay = 1 day
- 4110: [Additional Diagnosis] of (A090-A099, or K520-K529) SHOULD BE [Principal Diagnosis] with [Additional Diagnosis] of (E86)
- 4125: [Principal Diagnosis] or [Additional Diagnosis] of (Z491, or Z492) REQUIRES [Additional Diagnosis] of (Z530-Z539) or [Procedure] from (Block 1060, or Block 1061)
- 4130: [Principal Diagnosis] or [Additional Diagnosis] of (Z490-Z492) DOES NOT REQUIRE [Additional Diagnosis] of (Z992)

- 4140: [Principal Diagnosis] or [Additional Diagnosis] of (S0600, or S099) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (S0601-S0604)
- 4145: [Principal Diagnosis] or [Additional Diagnosis] of (C770-C799) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (C000-C768, or C800-C809)
- 4146: [Principal Diagnosis] or [Additional Diagnosis] of (C770-C809) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (C810-C8891)
- 4165: [Hospital Number] of (0001-0500), [Episode Of Care] of (5, or 6), [Date Of Birth] = [Admission Date], and [Source Of Referral] not (4, X) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 4185: [Principal Diagnosis] or [Additional Diagnosis] of (O000-O079, O200, O470, O600-O603, or O364) REQUIRES [Additional Diagnosis] of (O090-O099)
- 4195: [Additional Diagnosis] of (Z370-Z379) NOT COMPATIBLE WITH [Additional Diagnosis] of (Z3900-Z392)
- 4201: [Principal Diagnosis] of (Z310-Z313), and [Additional Diagnosis] not (Z530-Z539) REQUIRES [Procedure]
- 4203: [Principal Diagnosis] of (Z5181), and [Additional Diagnosis] not (Z530-Z539) REQUIRES [Admission Date] = [Separation Date]
- 4204: [Additional Diagnosis] of (Z5181), and [Additional Diagnosis] not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4225: [Principal Diagnosis], [Additional Diagnosis], or [External Cause] contains [Diagnosis] in system reference table with [Rare Diagnosis] of (1)
- 4235: [Principal Diagnosis] or [Additional Diagnosis] of (I500, or I501) DOES NOT REQUIRE [Additional Diagnosis] of (I500, or I501)
- 4237: [Principal Diagnosis] or [Additional Diagnosis] of (Z450) NOT COMPATIBLE WITH [Additional Diagnosis] of (Z950)
- 4245: [Principal Diagnosis] or [Additional Diagnosis] of (I500, or J81) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] (I500, or J81)
- 4246: [Principal Diagnosis] of (I501, or J81) DOES NOT REQUIRE [Additional Diagnosis] of (I501, or J81)
- 4276: [Additional Diagnosis] of (T203, T2130-T2139, T2230-T2232, T233, T243, T253, T293, or T303) MUST BE SEQUENCED BEFORE [Principal Diagnosis] of (T200-T202, T2100-T2129, T2200-T2222, T230-T232, T240-T242, T250-T252, T290-T292, or T300-T302)
- 4285: [Principal Diagnosis] or [Additional Diagnosis] of (T200-T253, T290-T293, or L550-L559) REQUIRES [Additional Diagnosis] of (T3100-T3199)
- 4295: [Additional Diagnosis] of (T3100-T3199) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (T200-T253, T290-T293, or L550-L559)
- 4305: [Principal Diagnosis] or [Additional Diagnosis] of (T360-T509) NOT COMPATIBLE WITH [External Cause] or [Additional Diagnosis] of (Y400-Y599)
- 4315: [Principal Diagnosis] or [Additional Diagnosis] (R400-R402) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] (S0000-S099)
- 4341: [Admission Weight] of (> 499 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0701)
- 4342: [Admission Weight] of (< 500, or > 749 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0702)

- 4343: [Admission Weight] of (< 750, or > 999 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0703)
- 4344: [Admission Weight] of (< 1000, or > 1249 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0711)
- 4346: [Admission Weight] of (< 1250, or > 1499) grams NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0712)
- 4347: [Admission Weight] of (< 1500, or > 2499 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0713)
- 4426: [Hospital Number] of (>= 4302), and [Principal Diagnosis] or [Additional Diagnosis] contains [Diagnosis] in system reference table with [Unacceptable Diagnosis Flag] of (2) = Unacceptable Diagnosis
- 4430: [Principal Diagnosis] of (N320) and [Additional Diagnosis] of (N40) MUST BE [Principal Diagnosis] of (N40) and [Additional Diagnosis] of (N320)
- 4440: [Principal Diagnosis] or [Additional Diagnosis] of (E1011–E149) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (R73)
- 4600: [Principal Diagnosis] or [Additional Diagnosis] of (E0921-E099) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (E1001-E149)
- 4648: [Principal Diagnosis] of (Z718) DOES NOT REQUIRE [Additional Diagnosis] of (E1001-E149)
- 4649: [Principal Diagnosis] of (E1001-E149) and [Additional Diagnosis] of (Z718) REQUIRES [Procedure] from (9555014)
- 4650: [Principal Diagnosis] or [Additional Diagnosis] of (E1000-E1099) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (E1100-E1199, E1300-E1399, E1400-E1499, or O2440-O2449)
- 4651: [Principal Diagnosis] or [Additional Diagnosis] of (E1100-E1199) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (E1000-E1099, E1300-E1399, E1400-E1499, or O2440-O2449)
- 4652: [Principal Diagnosis] or [Additional Diagnosis] of (E1300-E1399) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (E1000-E1099, E1100-E1199, E1400-E1499, or O2440-O2449)
- 4653: [Principal Diagnosis] or [Additional Diagnosis] of (E1400-E1499) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (E1000-E1099, E1100-E1199, E1300-E1399, or O2440-O2449)
- 4654: [Principal Diagnosis] or [Additional Diagnosis] of (O2440-O2449) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (E1000-E1099, E1100-E1199, E1300-E1399, or E1400-E1499)
- 4655: [Principal Diagnosis] or [Additional Diagnosis] of (S1410-S1413) REQUIRES [Additional Diagnosis] from (S1470-S1478, or S2470-S2477)
- 4656: [Principal Diagnosis] or [Additional Diagnosis] of (S2410-S2412) REQUIRES [Additional Diagnosis] of (S2470-S2477, or S3470-S3476)
- 4657: [Principal Diagnosis] or [Additional Diagnosis] of (S341) REQUIRES [Additional Diagnosis] of (S3470-S3476)
- 4660: [Additional Diagnosis] of (Z8610 – Z8618) NOT COMPATIBLE WITH [Additional Diagnosis] of (U073 or U074)

- 4662: [Additional Diagnosis] of (B230, R75, or Z21) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (B20, B21, B22, B238, B24, R75, or Z21)
- 4664: [Principal Diagnosis] or [Additional Diagnosis] of (B21) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (C000-C969)
- 4665: [Principal Diagnosis] of (Z080-Z089) NOT COMPATIBLE WITH [Additional Diagnosis] of (C000-C969)
- 4666: [Principal Diagnosis] of (O040-O049) IS RARE WITH [Additional Diagnosis] of (O093, or O094)
- 4668: [Principal Diagnosis] or [Additional Diagnosis] of (D683, or R7983) DOES NOT REQUIRE [Additional Diagnosis] of (Z921)
- 4669: [Principal Diagnosis] or [Additional Diagnosis] of (B150-B199, or O984) DOES NOT REQUIRE [Additional Diagnosis] of (B942)
- 4791: [Additional Diagnosis] of (Z940) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (N183, N184, N185, or I120)
- 4793: [Principal Diagnosis] or [Additional Diagnosis] of (I129, I130, or I139) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (N181-N184, or N189)
- 4794: [Additional Diagnosis] of (Z992) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (N185, or I120)
- 4795: [Principal Diagnosis] or [Additional Diagnosis] of (I120, or I131) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (N181-N189)
- 4796: [Principal Diagnosis] or [Additional Diagnosis] of (N185) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (I129, I130, or I139)
- 4800: [Sex] from patient record NOT COMPATIBLE WITH [Sex] in system reference table with [Sex Flag] of (1) for [Principal Diagnosis] or [Additional Diagnosis]
- 4810: Age at admission NOT COMPATIBLE WITH [Age Range] in system reference table for [Principal Diagnosis] or [Additional Diagnosis]
- 4811: [External Cause] or [Additional Diagnosis] of (Y900-Y908) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (F100-F102, or T510)
- 4812: [Principal Diagnosis] or [Additional Diagnosis] of (F101) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (F102-F109)
- 4814: [Principal Diagnosis] or [Additional Diagnosis] of (F111) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (F112–F119)
- 4816: [Principal Diagnosis] or [Additional Diagnosis] of (F121) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (F122–F129)
- 4818: [Principal Diagnosis] or [Additional Diagnosis] of (F171) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (F172–F179)
- 4819: [Principal Diagnosis] or [Additional Diagnosis] of (F171, or F172) DOES NOT REQUIRE [Additional Diagnosis] of (Z587, Z720, or Z8643)
- 4819A: [Additional Diagnosis] of (Z8643, or Z720) NOT COMPATIBLE WITH [Additional Diagnosis] of (Z587)
- 4832: Principal [Procedure] contains [Procedure] in system reference table with [Unacceptable First Procedure Flag] of (Y), or Principal [Procedure] of (9623100, 9623300, or 9623400), and [Additional Diagnosis] not Z533

- 4834: [Principal Diagnosis] or [Additional Diagnosis] of (D63) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (A188, A527, B54, B700, B769, or E039)
- 4840: [Principal Diagnosis] or [Additional Diagnosis] is [Diagnosis] in system reference table with [External Cause Flag] of (Y) REQUIRES [External Cause]
- 4870: [Activity When Injured] of (U5000-U739), and [Additional Diagnosis] or [External Cause] not (V0000-Y34)
- 4885: [Additional Diagnosis] of (V0000-Y34) REQUIRES [Additional Diagnosis] or [Activity When Injured] of (U5000-U739)
- 4890: ([Principal Diagnosis] or [Additional Diagnosis] of (O601-O603, O620-O879, or O900-O909), or [Procedure] from (Block 1336–1340, Block 1343-1344, Block 1346-1347)) REQUIRES [Additional Diagnosis] from (Z370-Z379, or Z3900-Z392)
- 4890A: ([Principal Diagnosis] or [Additional Diagnosis] of (O601-O603, O620-O879, or O900-O909), or [Procedure] from (1656400-1656401, or 9047102-9047106)) REQUIRES [Additional Diagnosis] from (Z370-Z379, or Z3900-Z392)
- 4891: [Principal Diagnosis] or [Additional Diagnosis] of (O600) DOES NOT REQUIRE [Additional Diagnosis] of (Z370-Z379)
- 4892: [Principal Diagnosis] or [Additional Diagnosis] of (O600) DOES NOT REQUIRE [Additional Diagnosis] of (Z3900-Z392)
- 4893: [Procedure] from (1657300, or 9048100) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O700-O709)
- 4895: [Principal Diagnosis] or [Additional Diagnosis] of (O700-O709) REQUIRES [Procedure] from (1657300, 9047200, or 9048100)
- 4896: [Hospital Number] not (0035) NOT COMPATIBLE WITH [Additional Diagnosis] of (Z379)
- 4897: [Principal Diagnosis] or [Additional Diagnosis] of (O601-O759, O85-O879, or O900-O909) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O80-O849, or Z3900-Z3903)
- 4898: [Additional Diagnosis] of (Z370-Z379) REQUIRES [Principal Diagnosis] of (O040-O049, or O80-O849), or [Additional Diagnosis] of (O80-O849)
- 4900: Duplicate Diagnosis code from [Principal Diagnosis], [Additional Diagnosis], [External Cause], [Place Of Occurrence], and/or [Activity When Injured] DELETES duplicate Diagnosis code
- 4904: [Principal Diagnosis] or [Additional Diagnosis] of (O80, or O840) REQUIRES [Procedure] Code Block 1336
- 4905: [Principal Diagnosis] or [Additional Diagnosis] of (O757) NOT COMPATIBLE WITH [Procedure] from (1652000, 1652001, 1652002, 1652003, 1652004, or 1652005)
- 4906: [Principal Diagnosis] or [Additional Diagnosis] of (O83, or O8481) REQUIRES [Procedure] from (9046803, 9046805, 9046901, 9047001, 9047003, 9047300, 9047400, 9047500, 9047600, 9047700, 9047702, 9048200, 1651400, or Block 1342)
- 4907: [Principal Diagnosis] or [Additional Diagnosis] of (O8482) REQUIRES one procedure from each of Blocks (1336 & 1337, 1336 & 1338, 1336 & 1339, 1336 & 1340, 1337 & 1338, 1337 & 1339, 1337 & 1340, 1338 & 1339, 1338 & 1340, or 1339 & 1340)
- 4950: Place Of Occurrence = Y9200-Y929 and [External Cause] or [Additional Diagnosis] not (V0000-Y899)

- 4960: [Place Of Occurrence] not (Y9200-Y929), and [External Cause] or [Additional Diagnosis] not (V0000-Y899)
- 4963: [Condition Onset Flag] for [Additional Diagnosis] SHOULD BE (2)
- 4964: [Condition Onset Flag] for [Additional Diagnosis] SHOULD BE (1)
- 4968: [Condition Onset Flag] for [Principal Diagnosis] or [Additional Diagnosis] SHOULD BE (1) for [Principal Diagnosis] or [Additional Diagnosis] of (O85–O909), and [Additional Diagnosis] of (Z370–Z379)
- 4976: [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388) REQUIRES [Episode Of Care] of (5, or 6)
- 4996: [Additional Diagnosis] of (Z5181, or Z523) SHOULD BE [Principal Diagnosis]

[Admission Category]

Identification

Technical name:	Episode of admitted patient care – admission urgency status, code N
APC data item:	15
SAHMR identifier:	SA1072
Registration status:	SA Health, Standard 24/04/2013
Definition:	Whether the admission has an urgency status assigned and, if so, whether admission occurred on an emergency basis, as represented by a code.
Data element concept:	Episode of admitted patient care – admission urgency status

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values	1 (Elective) 2 (Emergency) 3 (Elective: Waiting list) 4 (Not applicable)

Obligation

Class:	Mandatory
Dependency:	None

Collection

An admission category can be assigned for admissions of the types listed below, even though an admission category is not usually assigned. For example, a patient having an obstetric admission may have one or more of the clinical conditions listed in the emergency definition and therefore should be admitted as an emergency.

1 (Elective)

Admission of a patient for care or treatment, which, in the opinion of the treating clinician is necessary and for where admission can be delayed for at least 24 hours.

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 can be delayed by at least 24 hours.

2 (Emergency)

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. A patient on a waiting list for elective surgery can be assigned an Admission Category of emergency. For example, the patient was on the elective surgery waiting list for a particular condition. The patient's condition worsened resulting in an emergency admission to hospital for urgent surgery. The Admission Category in this instance should be 2 (Emergency).

3 (Elective: Waiting list)

An Elective-Booking List Admission is an admission of a patient from a designated booking list for surgery. Only designated Elective Surgery Waiting List hospitals may use the value 3 (Elective: Waiting list):

Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting must be assigned an urgency of admission of 2 (Emergency). See [Admission Category] 2 (Emergency) for further explanation.

4 (Not applicable)

Admissions for which an admission category status is **not usually assigned**.

Such admissions include:

- Admission for normal delivery (obstetric).
- Admissions which begin with the birth of the patient, or when it is 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, chemotherapy or radiotherapy.

An urgency status can be assigned for admissions of the types listed above for which an urgency status is not usually assigned. For example, a patient who is to have an obstetric admission may have one or more of the clinical conditions listed above and is admitted on an emergency basis.

Data Quality Checks

- 2753: Non-emergency selected same day scope procedures where no general anaesthetic is administered are INVALID inpatient admissions; REPLACE inpatient admission with an outpatient occasion of service
- 2754: Non-emergency same day chemotherapy procedures where no general anaesthetic is administered are INVALID inpatient episodes for funding
- 4001: [Source Of Referral] of (A, or E), and [Admission Category] not (4)
- 4002: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (Z491), and [Admission Category] not (4)
- 4003: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (Z511 or Z2921) and [Admission Category not (4)
- 4004: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (Z510) and not (Z491, or Z511), and [Admission Category] not (4)
- 4006: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (O80, or O840) and not (Z491, Z510, or Z511), AND [Admission Category] not (4)
- 4007: [Source Of Referral] not (A, or E), [Principal Diagnosis] not (O80, O840, Z491, Z510, or Z511), [Episode Of Care] of (5), and [Admission Category] not (4)
- 4008: [Source Of Referral] not (4, A, E, or X), [Principal Diagnosis] not (O80, O840, Z491, Z510, or Z511), [Episode Of Care] not (5), [Admission Date] = [Date Of Birth], and [Admission Category] not (4)
- 4400: [Admission Category] not (1, 2, 3, or 4)

[Admission Date]

Identification

Technical name:	Episode of admitted patient care – admission date, DDMMYYYY
APC data item:	21
SAHMR identifier:	SA1077
Registration status:	SA Health, Standard 24/04/2013
Definition:	The date on which an admitted patient commences an episode of care, expressed as DDMMYYYY.
Data element concept:	Episode of admitted patient care – admission date

Value domain

Class:	Date
Type:	Date/Time
Format:	DDMMYYYY
Length:	8

Obligation

Class:	Mandatory
Dependency:	None

Collection

See Dates and Times, page 195.

See Formal Admission and Formal Separation, page 202.

Data Quality Checks

- 1131: Record with [Admission Date] & [Admission Time] already in database for same [Patient Unit Record Number] and [Hospital Number]
- 1341: [Separation Date] & [Separation Time] is between [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] of another record in database
- 1351: [Admission Date] & [Admission Time] is between [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] of another record in database
- 1361: [Admission Date] & [Admission Time] < [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] > [Separation Date] & [Separation Time] of another record in database
- 2000: [Admission Date] format is INVALID
- 2001: [Date Of First Operating Theatre Procedure] < [Admission Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033), and [Procedure Location Indicator] of (1)
- 2003: [Time Of First Operating Theatre Procedure] < [Admission Time] where [Date Of First Operating Theatre Procedure] = [Admission Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)

- 2010: [Admission Date] ≥ [Hospital Closure Date] for [Hospital Number] in system reference table
- 2050: [Date Of Birth] > [Admission Date], and [Date Of Birth] ≠ 01-Jul-1890
- 2170: Age at admission of (≤27 days) REQUIRES [Admission Weight]
- 2190: [Leave From Date] & [Leave From Time] < [Admission Date] & [Admission Time], or [Leave From Date] & [Leave From Time] > [Separation Date] & [Separation Time]
- 2200: [Leave To Date] & [Leave To Time] < [Admission Date] & [Admission Time], or [Leave To Date] & [Leave To Time] > [Separation Date] & [Separation Time]
- 2240: [Admission Date] = [Separation Date], and [Admission Time] > [Separation Time]
- 2250: Age at admission > (124 years) NOT COMPATIBLE WITH [Date Of Birth] not (01-Jul-1890), and [Date Of Birth Accuracy Flag] not (2)
- 2255: Age at admission > (9 days) NOT COMPATIBLE WITH [Episode Of Care] of (5, or 6)
- 2260: [Hours In ICU] > Length of stay in hours
- 2270: [Hours On Mechanical Ventilation] > Length of stay in hours
- 2340: [Admission Type] of (1), and Length of stay of (> 35 days), and [Funding Source] not (01, 02, 03, 07, or 08) REQUIRES [Status Change Type] of (2, or 3)
- 2580: [Episode Of Care] not (1, 2, 3, 4, 5, 6, 7, 8, 9, I, J, K, L, or P) NOT COMPATIBLE WITH Age at admission of (> 9 days)
- 2580A: [Episode Of Care] not (5, or 6) NOT COMPATIBLE WITH Age at admission of (≤ 9 days)
- 2583: Age at admission of (> 28 days) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 2696: [Episode Of Care] of (2), [Admission Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Admission Time] of (2359) REQUIRES [Nature Of Separation] of (E)
- 2710: [Episode Of Care] of (2), [Source Of Referral] of (E), and [Admission Date] of (YYYY0331, YYYY0630, YYYY0930, or YYYY1231) REQUIRES [Admission Time] of (2359)
- 2715: [Episode Of Care] of (2), and [Source Of Referral] of (E) REQUIRES [Admission Date] of (YYYY0331, YYYY0630, YYYY0930, or YYYY1231)
- 2753: Non-emergency selected same day scope procedures where no general anaesthetic is administered are INVALID inpatient admissions; REPLACE inpatient admission with an outpatient occasion of service
- 2754: Non-emergency same day chemotherapy procedures where no general anaesthetic is administered are INVALID inpatient episodes for funding
- 2763: [Date Of Transfer To Discharge Lounge] < [Admission Date]
- 2765: [Time Of Transfer To Discharge Lounge] < [Admission Time] where [Date Of Transfer To Discharge Lounge] = [Admission Date]
- 2771: [Condition Onset Flag] for [Principal Diagnosis] MUST BE (2) when Age at admission of (> 28 days)
- 4000: Principal [Procedure] may be INVALID for same day inpatient episodes (may violate Technical Bulletins 28 or 29); CONSIDER replacing inpatient record with outpatient record
- 4008: [Source Of Referral] not (4, A, E, or X), [Principal Diagnosis] not (O80, O840, Z491, Z510, or Z511), [Episode Of Care] not (5), [Admission Date] = [Date Of Birth], and [Admission Category] not (4)

- 4066: [Principal Diagnosis] or [Additional Diagnosis] of (Z511 or Z2921) INVALID WITH [Admission Date] <>[Separation Date]
- 4075: [Additional Diagnosis] of (Z511 or Z2921) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4085: [Principal Diagnosis] of (Z510) NOT COMPATIBLE WITH [Admission Date] ≠ [Separation Date]
- 4095: [Additional Diagnosis] of (Z510) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4105: [Additional Diagnosis] of (Z491, or Z492) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when Length of stay = 1 day
- 4115: [Principal Diagnosis] of (Z491, or Z492) NOT COMPATIBLE WITH Length of stay of (> 1 day)
- 4160: Length of Stay of (> 92 days), and [Admission Type] in (2, or 3)
- 4165: [Hospital Number] of (0001-0500), [Episode Of Care] of (5, or 6), [Date Of Birth] = [Admission Date], and [Source Of Referral] not (4, X) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 4175: Length of stay of (> 9999 days)
- 4180: Age at admission of (> 100 years)
- 4190: [Marital Status] not (1, 2, 3, 4, 5, or 9), and Age at admission of (≥ 16 years)
- 4190A: [Marital Status] not (1, 2, 3, 4, 5, or 9), and Age at admission of (< 16 years)
- 4203: [Principal Diagnosis] of (Z5181), and [Additional Diagnosis] not (Z530-Z539) REQUIRES [Admission Date] = [Separation Date]
- 4204: [Additional Diagnosis] of (Z5181), and [Additional Diagnosis] not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4340: Age at admission of (> 365 days), and [Admission Weight] not blank and not of (0000)
- 4390: [Patient Category] not (1, 2, or 4), and [Admission Date] ≠ [Separation Date]
- 4390A: [Patient Category] not (1, 2, or 4), and [Admission Date] = [Separation Date]
- 4505: [Sex] of (3) NOT COMPATIBLE WITH Age at admission of (> 90 days)
- 4580: [Contracted Service Admission Date] is an invalid date, [Contracted Service Admission Date] < [Admission Date], or [Contracted Service Admission Date] > [Separation Date]
- 4710: Length of stay of (> 1 year)
- 4810: Age at admission NOT COMPATIBLE WITH [Age Range] in system reference table for [Principal Diagnosis] or [Additional Diagnosis]
- 4830: Age at admission NOT COMPATIBLE WITH [Age Range] in system reference table for [Procedure]
- 4975: [Episode Of Care] of (6) NOT COMPATIBLE WITH Age at admission of (> 1 year)
- 4980: [Episode Of Care] not (5, or 6) NOT COMPATIBLE WITH Age at admission of (< 10 days)
- 4990: [Episode Of Care] not (1, or 6) NOT COMPATIBLE WITH Age at admission of (> 9 days, or < 29 days) for [Hospital Number] of (< 4000)
- 4992: [Episode Of Care] not (2, 3, 4, 8, 9, J, K, or L) NOT COMPATIBLE WITH [Admission Type] or [Status Change Type] of (3), or [Status Change Date 1], [Status Change Date 2], or [Status Change Date 3] < [Admission Date]

[Admission Election]

Identification

Technical name:	Episode of admitted patient care – patient election status, code N
APC data item:	19
SAHMR identifier:	SA1073
Registration status:	SA Health, Standard 24/04/2013
Definition:	Accommodation chargeable status elected by a patient on admission, as represented by a code.
Data element concept:	Episode of admitted patient care – patient election status

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Hospital) 2 (Private)

Obligation

Class:	Mandatory
Dependency:	None

Collection

Country hospitals

Compensable patients need to elect to be either public compensable or private compensable, with the difference being by whom the patient is charged.

Non-Medicare patients will be treated as public or private in accordance with hospital practices in the same way as Medicare eligible patients.

Metropolitan hospitals

Compensable patients admitted to a metropolitan hospital can be admitted as either private or hospital.

1 (Hospital)

A Hospital Patient is a person who is:

- On or soon after admission to a hospital, elects to be a public patient treated by a medical practitioner nominated by the hospital.
- Additionally, patients in public psychiatric hospitals who do not have the choice to be treated as a private patient. Also includes overseas visitors who are covered by a reciprocal health care agreement, and who elect to be treated as public patients.

2 (Private)

A Private Patient is a person who is:

- On or soon after admission to a public hospital, elects to be a private patient treated by a medical practitioner of his or her choice.
- Admitted to a private hospital.
- An eligible Veteran's Affairs patient.

A Private Patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner.

Data Quality Checks

- 2320: [Funding Source] of (06, 07, or 11) REQUIRES [Admission Election] of (1)
- 2585: [Admission Election] or [Status Change Election] not (2) NOT COMPATIBLE WITH [Funding Source] of (04, 05, 09, or 10) for [Hospital Number] of (≥ 0049 and ≤ 0250)
- 2753: Non-emergency selected same day scope procedures where no general anaesthetic is administered are INVALID inpatient admissions; REPLACE inpatient admission with an outpatient occasion of service
- 2754: Non-emergency same day chemotherapy procedures where no general anaesthetic is administered are INVALID inpatient episodes for funding
- 2772: [Funding Source] of (12) or (14) REQUIRES [Admission Election] of (1) AND [Hospital Insurance] of (2) AND [Source of Referral] of (7)
- 4410: [Admission Election] not (2), and [Hospital Number] of (≥ 4000)
- 4410A: [Admission Election] not (1), and [Hospital Number] of (< 4300)
- 4474: [Status Change Election] same as [Admission Election], or [Status Change Type] same as [Admission Type]

[Admission Number]

Identification

Technical name:	Episode of admitted patient care – admission number identifier N(8)
APC data item:	68
SAHMR identifier:	SA1075
Registration status:	SA Health, Standard 24/04/2013
Definition:	This is not a mandatory reporting data element. An admission number is used in conjunction with the patient's medical record number to group episodes for a single period of hospitalisation. Where utilised by hospitals, the admission number is unique for each hospitalisation.
Data element concept:	Episode of admitted patient care - admission number

Value domain

Class:	Code
Type:	Number
Format:	NNNNNNNN
Length:	8
Values:	Free text

Obligation

Class:	Optional
Dependency:	None

Collection

[Admission Number] is an identifier which group contiguous episodes of care.

For example, during one stay in hospital, a patient may move between multiple episodes of care:

Admission Date Time	Separation Date Time	Episode of Care
10:36 21-Sep-2018	09:00 04-Oct-2018	1 (Acute)
09:01 04-Oct-2018	12:00 19-Oct-2018	4 (Rehabilitation)
12:01 19-Oct-2018	09:00 20-Dec-2018	1 (Acute)
09:01 20-Dec-2018	09:00 21-Jan-2019	4 (Rehabilitation)

The patient journey between the episodes of care is linked by a common [Admission Number], unique to the hospital.

Data Quality Checks

- 4510: [Admission Number] of blank, or not numeric

[Admission Time]

Identification

Technical name:	Episode of admitted patient care - admission time, hhmm
APC data item:	67
SAHMR identifier:	SA1076
Registration status:	SA Health, Standard 24/04/2013
Definition:	The time at which an admitted patient commences an episode of care.
Data element concept:	Episode of admitted patient care - admission time

Value domain

Class:	Time
Type:	Date/Time
Format:	hhmm
Length:	4

Obligation

Class:	Mandatory
Dependency:	None

Collection

This data element is required to identify the time of commencement of the episode or hospital stay, for calculation of waiting times and length of stay.

See Dates and Times, page 195.

See Formal Admission and Formal Separation, page 202.

Data Quality Checks

- 1131: Record with [Admission Date] & [Admission Time] already in database for same [Patient Unit Record Number] and [Hospital Number]
- 1341: [Separation Date] & [Separation Time] is between [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] of another record in database
- 1351: [Admission Date] & [Admission Time] is between [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] of another record in database
- 1361: [Admission Date] & [Admission Time] < [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] > [Separation Date] & [Separation Time] of another record in database
- 2003: [Time Of First Operating Theatre Procedure] < [Admission Time] where [Date Of First Operating Theatre Procedure] = [Admission Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2060: [Admission Time] of invalid format

- 2190: [Leave From Date] & [Leave From Time] < [Admission Date] & [Admission Time], or [Leave From Date] & [Leave From Time] > [Separation Date] & [Separation Time]
- 2200: [Leave To Date] & [Leave To Time] < [Admission Date] & [Admission Time], or [Leave To Date] & [Leave To Time] > [Separation Date] & [Separation Time]
- 2240: [Admission Date] = [Separation Date], and [Admission Time] > [Separation Time]
- 2260: [Hours In ICU] > Length of stay in hours
- 2270: [Hours On Mechanical Ventilation] > Length of stay in hours
- 2696: [Episode Of Care] of (2), [Admission Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Admission Time] of (2359) REQUIRES [Nature Of Separation] of (E)
- 2710: [Episode Of Care] of (2), [Source Of Referral] of (E), and [Admission Date] of (YYYY0331, YYYY0630, YYYY0930, or YYYY1231) REQUIRES [Admission Time] of (2359)
- 2765: [Time Of Transfer To Discharge Lounge] < [Admission Time] where [Date Of Transfer To Discharge Lounge] = [Admission Date]
- 4000: Principal [Procedure] may be INVALID for same day inpatient episodes (may violate Technical Bulletins 28 or 29); CONSIDER replacing inpatient record with outpatient record

[Admission Type]

Identification

Technical name:	Episode of admitted patient care - intended length of stay, code N
APC data item:	20
SAHMR identifier:	SA1079
Registration status:	SA Health, Standard 24/04/2013
Definition:	Indicates the type and duration of care the patient will be receiving based on the principal clinical intent of the care received.
Data element concept:	Episode of admitted patient care - intended length of stay

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Ordinary) 2 (Long stay: Acute) 3 (Long stay: Non-acute care)

Obligation

Class:	Mandatory
Dependency:	None

Collection

This field must be used in conjunction with Episode of Care.

See Episode of Care, page 66.

Qualifying Period

The qualifying period may accrue in one or more public or private hospitals within Australia, but not in a residential aged care facility.

Transferring between hospitals, including interstate hospitals, has no effect on the qualifying period.

Periods of less than seven days out of hospital do not break the qualifying period; however, no accrual is made to the qualifying period.

If a patient is not readmitted to a hospital within 7 days, their qualifying period is reset, and restarts on the date of the next admission.

Days spent on leave or between separations do not count e.g., a patient who has accrued 20 days then takes three days of leave will start day 21 on return to the hospital.

1 (Ordinary)

Upon admission, [Admission Type] is set to 1 (Ordinary). The patient then accrues time for the qualifying period while in hospital. A patient is classified as 1 (Ordinary) regardless of their [Episode Of Care].

A patient who has not completed the 35-day qualifying period cannot have [Status Change Type] set to either:

- 2 (Long Stay: Acute)
- 3 (Long stay: Non-acute care).

Following the completion of the 35-day qualifying period, a patient's prognosis must be assessed by the treating Medical Officer to determine the severity of the condition(s) being treated, and whether the patient requires ongoing acute care.

If the patient is not deemed acute after 35 days, then the patient defaults to [Admission Type] 2 (Long stay: Non-acute care).

However, a patient with the following [Funding Source] remains as [Admission Type] of 1 (Ordinary), regardless of their length of stay:

- 01 (Compensable: MVA)
- 02 (Compensable: WC)
- 03 (Compensable: Other)
- 07 (Overseas: RHCA)
- 08 (Non-Medicare)

2 (Long stay: Acute)

At the completion of the 35-day qualifying period, a patient assessed by the treating Medical Officer and deemed as requiring ongoing acute care with:

- [Episode Of Care] of:
    - 1 (Acute)
    - 3 (Palliative care)
    - 4 (Rehabilitation)
    - 8 (Psychogeriatric care)
    - 9 (Geriatric evaluation and management)
    - I (Mental health: Acute)
- [Admission Type] of 1 (Ordinary)

Changes:

- [Status Change Type] to 2 (Long stay: Acute)

However, a patient with the following [Funding Source] cannot have as [Status Change Type] set to 2 (Long stay: Acute):

- 01 (Compensable: MVA)
- 02 (Compensable: WC)
- 03 (Compensable: Other)
- 08 (Non-Medicare)
- 07 (Overseas: RHCA)

Commonwealth legislation no longer mandates completion of the Acute Care Certificate; however, SA Health mandates that clinicians complete an Acute Care Certificate, or similar documentation, if the patient has the following:

- [Episode Of Care] is 1 (Acute) or I (Mental health: Acute)
- [Status Change Type] of 2 (Long stay: Acute)

3 (Long stay: Non-acute care)

At the completion of the 35-day qualifying period, a patient with assessed by the treating Medical Officer and deemed as NOT requiring ongoing acute care with:

- [Episode Of Care] of:
    - 2 (Maintenance care)
    - 3 (Palliative care)
    - 4 (Rehabilitation)
    - 8 (Psychogeriatric care)
    - 9 (Geriatric evaluation and management)
    - J (Mental health: Maintenance)
    - K (Mental health: Rehabilitation)
    - I (Mental health: Psychogeriatric care)
- [Admission Type] of 1 (Ordinary)

Changes:

- [Status Change Type] to 3 (Long stay: Non-acute care)

However, a patient with the following [Funding Source] cannot have as [Status Change Type] set to 3 (Long stay: Non-acute care):

- 01 (Compensable: MVA)
- 02 (Compensable: WC)
- 03 (Compensable: Other)
- 08 (Non-Medicare)
- 07 (Overseas: RHCA)

For patients 65 and over, [Status Change Type] of 3 (Long stay: Non-acute care) includes an Aged Care Assessment Team (ACAT) assessment, while for patients under 65 this includes access to specialist disability services. However, an ACAT assessment is not a requirement for being assigned to 3 (Long stay: Non-acute care).

Data Quality Checks

- 2340: [Admission Type] of (1), and Length of stay of (> 35 days), and [Funding Source] not (01, 02, 03, 07, or 08) REQUIRES [Status Change Type] of (2, or 3)
- 2342: [Episode Of Care] of (2, or J) NOT COMPATIBLE WITH [Admission Type] or [Status Change Type] of (2)
- 4160: Length of Stay of (> 92 days), and [Admission Type] in (2, or 3)
- 4170: Length of stay of (> 1 day), and [Hospital Number] in system reference table where [Day Hospital] of (1)
- 4420: [Admission Type] not (1, 2, or 3)

- 4474: [Status Change Election] same as [Admission Election], or [Status Change Type] same as [Admission Type]

- 4992: [Episode Of Care] not (2, 3, 4, 8, 9, J, K, or L) NOT COMPATIBLE WITH [Admission Type] or [Status Change Type] of (3), or [Status Change Date 1], [Status Change Date 2], or [Status Change Date 3] < [Admission Date]

[Admission Weight]

Identification

Technical name:	Neonates - admission weight, total grams NNNN
APC data item:	11
SAHMR identifier:	SA1067
Registration status:	SA Health, Standard 24/04/2013
Definition:	Record the neonates' weight in grams.
Data element concept:	Neonates - Admission weight

Value domain

Class:	Total
Type:	Number
Format:	NNNN
Length:	4
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: • babies ≤ 27 days old at admission • all babies aged ≤ 365 days whose weight at birth < 2,500 grams

Collection

[Admission Weight] captures the weight at birth for a neonate.

- If a neonate is born in hospital during a current admission, the [Admission Weight] is the documented birth weight.
- If the neonate was born elsewhere or was born during a previous admission, the [Admission Weight] is the neonate's documented weight on admission.

Each change in [Episode Of Care] while the patient is less than 10 days old requires for either the birth weight or initial admission weight to be recorded in the [Admission Weight] field. There is no need to re-weigh the baby.

The inclusion of this data item does not mean that all neonates can be admitted. Refer to [Episode Of Care] 5 (Unqualified newborns) and 6 (Qualified newborns), for more information regarding admitting neonates.

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

Leading zeros should be used when necessary. If the neonate's weight is 405 grams, enter the data as:

- [Admission Weight]: 0405

Data Quality Checks

- 2170: Age at admission of (≤27 days) REQUIRES [Admission Weight]
- 4340: Age at admission of (> 365 days), and [Admission Weight] not blank and not of (0000)
- 4341: [Admission Weight] of (> 499 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0701)
- 4342: [Admission Weight] of (< 500, or > 749 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0702)
- 4343: [Admission Weight] of (< 750, or > 999 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0703)
- 4344: [Admission Weight] of (< 1000, or > 1249 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0711)
- 4346: [Admission Weight] of (< 1250, or > 1499) grams NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0712)
- 4347: [Admission Weight] of (< 1500, or > 2499 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0713)
- 4350: [Admission Weight] of (< 400 grams)
- 4360: [Admission Weight] of (> 6000 grams)

[Adult / Child Flag]

Identification

Technical name:	Patient - Adult / Child Flag, code [A]
APC data item:	86
SAHMR identifier:	SA1090
Registration status:	SA Health, Standard 24/04/2013
Definition:	Indicate if the patient is a child or not.
Data element concept:	Patient - Age classification

Value domain

Class:	Code
Type:	String
Format:	A
Length:	1
Values:	C (Child) O (Other)

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Women's and Children's Hospital

Collection

Data Quality Checks

- 4670: [Hospital Number] of (0003) REQUIRES [Adult / Child Flag] of (C, or O)
- 4730: [Adult / Child Flag] not blank, and [Hospital Number] not (0003, or 0296)

[Clinical Unit]

Identification

Technical name:	Clinical unit - designation of unit, code NNN
APC data item:	2
SAHMR identifier:	SA407
Registration status:	SA Health, Standard 01/07/1985
Definition:	Identify the clinical unit under which the patient is admitted.
Data element concept:	Clinical unit - Clinical designation of unit

Value domain

Class:	Code
Type:	Number
Format:	NNN
Length:	3
Values:	Free text

Obligation

Class:	Optional
Dependency:	None

Collection

Hospitals may choose to develop their own Clinical Unit Codes but must then map these to the SA Health Codes.

Discussion between Data Governance & Quality Assurance unit and individual hospitals is necessary before allocating any of the "reserved" numbers. This allows for consistency in definition.

Data Governance & Quality Assurance unit should be advised by a hospital when the hospital begins to use clinic codes.

Additional notes

The main reasons for using standard clinic codes are:

- For studies where total patients seen by a specialty in one institution are compared with patients of the specialty seen in other institutions.
- For data quality check/audit checks by the system. That is, ensuring patients with orthopaedic disease codes do not have a clinic code for obstetrics.

Hospitals which do not have defined clinics should record the clinic code as "000".

The first digit is reserved to identify a doctor within a code. Hospitals wishing only to identify a clinic should enter the two-digit code with a leading zero. Hospitals wishing to identify a particular group or doctor within a clinic may use a digit from 1-9 to precede the two digit Clinic code.

Lists showing the individual doctors' names are not required for submission.

Example of identifying doctor:

- Dr X Cardiology: 112
- Dr Y Cardiology: 212
- No Doctor identified: 012

Mental Health Service Clinics

Within Glenside Health Services, patients are admitted to distinct wards to receive a specific type of care, i.e. acute, intensive care, rehabilitation, etc. Clinic codes are therefore assigned according to the ward to which the patient is admitted.

Additional Notes for Mental Health

A transfer to another ward of a different type of care necessitates a change in the episode of care, requiring an administrative discharge and an administrative admission.

Data Quality Checks

- 4370: [Clinical Unit] not in system reference table
- 4641: [Clinical Unit] of (78, 79, 80, 85, 86, or 95), or [Principal Diagnosis] in system reference table with [Mental Health Diagnosis Flag] of (Y) REQUIRES [Episode Of Care] of (I, J, K, or L)
- 4643: [Episode Of Care] of (I, J, K, or L) REQUIRES [Clinical Unit] of (78, 79, 80, 85, 86, or 95), or [Principal Diagnosis] in system reference table with [Mental Health Diagnosis Flag] of (Y)

[Condition Onset Flag]

Identification

Technical name:	Episode of admitted patient care - condition onset flag, code N
APC data item:	92, 97, 98, 99
SAHMR identifier:	SA1093
Registration status:	SA Health, Standard 24/04/2013
Definition:	A qualifier for each coded diagnosis to indicate the onset of the condition relative to the beginning of the admitted patient episode of care, as represented by a code.
Data element concept:	Episode of admitted patient care - condition onset flag

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (During care) 2 (Not during care) 9 (Not reported)

Obligation

Class:	Mandatory
Dependency:	None

Collection

Assign the relevant [Condition Onset Flag] to each ICD-10-AM (12th Edition) diagnosis code assigned to the [Principal Diagnosis] and [Additional Diagnosis] fields.

The sequencing of diagnosis codes must comply with the Australian Coding Standards and therefore diagnosis codes should not be re-sequenced in an attempt to list diagnosis codes with the same Condition Onset Flag together.

The [Condition Onset Flag] for [External Cause], [Place Of Occurrence], and [Activity When Injured] should match that of the corresponding injury or disease code.

The [Principal Diagnosis] should always have a [Condition Onset Flag] of 2 (Not during care), except that 1 (During care) is permitted for a neonate.

For combination codes where a diagnosis within the code meets the criteria of [Condition Onset Flag] 1 (During care), and is not represented by another code with [Condition Onset Flag] 1 (During care), then assign [Condition Onset Flag] 1 (During care) to the combination code e.g. diabetes with kidney complication.

When it is difficult to decide if a condition was present at the beginning of the episode of admitted patient care or if it arose during the episode, assign a value of 2 (Not during care).

When a condition requires more than one diagnosis code to describe it, it is possible for each diagnosis code to have a different Condition Onset Flag.

The [Condition Onset Flag] for a [Principal Diagnosis] of Z37 (Outcome of delivery) on the mother's record should always be assigned a value of 2 (Not during care). While the outcome of delivery is not known until after the commencement of the [Episode Of Care], its onset is not during the episode.

The [Condition Onset Flag] for a [Principal Diagnosis] of Z37 (Outcome of delivery) on the baby's record should always be assigned a value of 2 (Not during care).

1 (During care)

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

Includes:

- Conditions resulting from an unintentional event or misadventure during medical or surgical care during the episode of admitted patient care.
- Abnormal reactions to, or later complication of, surgical or medical care arising during the episode of admitted patient care.
- Conditions newly arising during the episode of admitted patient care not related to surgical or medical care (for example, pneumonia).

2 (Not during care)

A condition present or suspected on admission such as the presenting problem, or co-morbidity, chronic disease or disease status. A previously existing condition not diagnosed until the episode of admitted patient care.

Includes:

- In the case of the neonates, the conditions present at birth.
- A previously existing condition that is exacerbated during the episode of admitted patient care.
- Conditions that are suspected at the time of admission and subsequently confirmed during the episode of admitted patient care.
- Conditions that were not diagnosed at the time of admission but clearly did not develop after admission (for example, malignant neoplasm).
- Conditions where the onset relative to the beginning of the episode of admitted patient care is unclear or unknown.

9 (Not reported)

The Condition Onset Flag could not be reported due to limitations of the data management system.

Data Quality Checks

- 2770: [Condition Onset Flag] for [Principal Diagnosis] or [Additional Diagnosis] or [Activity When Injured] or [External Cause] or [Place Of Occurrence] not (1, or 2)
- 2771: [Condition Onset Flag] for [Principal Diagnosis] MUST BE (2) when Age at admission of (> 28 days)
- 4870: [Activity When Injured] of (U5000-U739), and [Additional Diagnosis] or [External Cause] not (V0000-Y34)
- 4880: [External Cause] of (V0000-Y34), and [Activity When Injured] not (U5000-U739)

- 4950: Place Of Occurrence = Y9200-Y929 and [External Cause] or [Additional Diagnosis] not (V0000-Y899)
- 4960: [Place Of Occurrence] not (Y9200-Y929), and [External Cause] or [Additional Diagnosis] not (V0000-Y899)
- 4963: [Condition Onset Flag] for [Additional Diagnosis] SHOULD BE (2)
- 4964: [Condition Onset Flag] for [Additional Diagnosis] SHOULD BE (1)
- 4968: [Condition Onset Flag] for [Principal Diagnosis] or [Additional Diagnosis] SHOULD BE (1) for [Principal Diagnosis] or [Additional Diagnosis] of (O85–O909), and [Additional Diagnosis] of (Z370–Z379)

[Contracted Service Admission Date]

Identification

Technical name:	Contracted hospital care – contracted care commencement date, DDMMYYYY
APC data item:	64
SAHMR identifier:	SA1071
Registration status:	SA Health, Standard 24/04/2013
Definition:	The date the period of contracted care commenced.
Data element concept:	Contracted hospital care – contracted care commencement date

Value domain

Class:	Date
Type:	Date/Time
Format:	DDMMYYYY
Length:	8

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Contracted Service

Collection

Date on which the patient has been admitted for contracted services.

See Dates and Times, page 195.

See Component Care and Contracted Care, page 191.

Data Quality Checks

- 4561: [Source Of Referral] not (7) and [Contracted Service Hospital Number] not in system reference table, [Contract Hospital Patient Unit Record Number] of (0000000000), or [Contracted Service Admission Date] is not a valid date
- 4580: [Contracted Service Admission Date] is an invalid date, [Contracted Service Admission Date] < [Admission Date], or [Contracted Service Admission Date] > [Separation Date]
- 4930: [Contracted Service Hospital Number] ≠ 0000, [Contracted Service Patient Unit Record Number] ≠ 0000000000, or [Contracted Service Admission Date] ≠ 00000000 REQUIRES [Procedure Location Indicator] of (2)

[Contracted Service Hospital Number]

Identification

Technical name:	Contracted hospital care – contracted care service name, hospital code NNNN
APC data item:	65
SAHMR identifier:	SA1052
Registration status:	SA Health, Standard 24/04/2013
Definition:	The hospital code of the originating hospital or the destination hospital providing the contracted service.
Data element concept:	Contracted hospital care – contracted care service name

Value domain

Class:	Code
Type:	Number
Format:	NNNN
Length:	4
Values:	Reference file

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Contracted Service

Collection

Hospital number to which the patient has been sent for contracted services.

See Hospital Number, page 207.

See Component Care and Contracted Care, page 191.

Data Quality Checks

- 4560: [Contracted Service Hospital Number] = [Hospital Number], or [Contracted Service Hospital Number] not in system reference table
- 4561: [Source Of Referral] not (7) and [Contracted Service Hospital Number] not in system reference table, [Contract Hospital Patient Unit Record Number] of (0000000000), or [Contracted Service Admission Date] is not a valid date
- 4570: [Contracted Service Hospital Number] = [Hospital Number] AND [Contracted Service Patient Unit Record Number] = [Patient Unit Record Number]
- 4930: [Contracted Service Hospital Number] ≠ 0000, [Contracted Service Patient Unit Record Number] ≠ 0000000000, or [Contracted Service Admission Date] ≠ 00000000 REQUIRES [Procedure Location Indicator] of (2)

Reference file

- **Admitted Activity Reference Table – Admitted Patient Care Hospital Codes** listing available from:

  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

[Contracted Service Patient Unit Record Number]

Identification

Technical name:	Contracted hospital care - patient unit record number, identifier N(10)
APC data item:	63
SAHMR identifier:	SA1070
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient unit record number of the hospital providing the contracted service.
Data element concept:	Contracted hospital care - patient unit record number

Value domain

Class:	Identifier
Type:	Number
Format:	NNNNNNNNNN
Length:	10
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Contracted Service

Collection

Patient Unit Record Number at hospital to which the patient has been sent for contracted services.

See Patient number, page 125.

See Component Care and Contracted Care, page 191.

Data Quality Checks

- 4561: [Source Of Referral] not (7) and [Contracted Service Hospital Number] not in system reference table, [Contract Hospital Patient Unit Record Number] of (0000000000), or [Contracted Service Admission Date] is not a valid date
- 4570: [Contracted Service Hospital Number] = [Hospital Number] AND [Contracted Service Patient Unit Record Number] = [Patient Unit Record Number]
- 4571: [Contracted Service Patient Unit Record Number] is invalid
- 4930: [Contracted Service Hospital Number] ≠ 0000, [Contracted Service Patient Unit Record Number] ≠ 0000000000, or [Contracted Service Admission Date] ≠ 00000000 REQUIRES [Procedure Location Indicator] of (2)

[Country Of Birth]

Identification

Technical name:	Patient - country of birth, code NNNN
APC data item:	10
SAHMR identifier:	SA1094
Registration status:	SA Health, Candidate 31/10/2011
Definition:	The country in which the patient was born, as represented by a code.
Data element concept:	Patient - Country of birth

Value domain

Class:	Code
Type:	Number
Format:	NNNN
Length:	4
Values:	Reference file

Obligation

Class:	Mandatory
Dependency:	None

Collection

Enter the country code from the reference file as follows, using leading zeros where necessary. For example, Australia:

- [Country Of Birth]: 1101

Reference File:

- **Admitted Activity Reference Table - Country of Birth** available from:

  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Data Quality Checks

- 4020: [Country Of Birth] not in system reference table
- 4021: [Country Of Birth] of (1100, 1101, 1102, or 1199) NOT COMPATIBLE WITH [Funding Source] of (07, or 08)
- 4022: [Country Of Birth] changed from/to (0001, ≥ 1000, or ≤ 9299) and (0000, 0002, 0003) since last admission record
- 4205: [Indigenous Status] of (1, 2, or 3) NOT COMPATIBLE WITH [Country Of Birth] of (≤ 1100, ≥ 1199, and ≠ 1302)

[Date Of Birth]

Identification

Technical name:	Patient - date of birth, DDMMYYYY
APC data item:	9
SAHMR identifier:	SA1095
Registration status:	SA Health, Standard 24/04/2013
Definition:	The date of birth of the patient, expressed as DDMMYYYY.
Data element concept:	Patient - Date of birth

Value domain

Class:	Date
Type:	Date/Time
Format:	DDMMYYYY
Length:	8

Obligation

Class:	Mandatory
Dependency:	None

Collection

Enter the patient's full date of birth using day, month and year and leading zeros where necessary.

See Dates and Times, page 195.

See Date Of Birth, page 196.

Data Quality Checks

- 2040: [Date Of Birth] format is INVALID
- 2050: [Date Of Birth] > [Admission Date], and [Date Of Birth] ≠ 01-Jul-1890
- 2170: Age at admission of (≤27 days) REQUIRES [Admission Weight]
- 2250: Age at admission > (124 years) NOT COMPATIBLE WITH [Date Of Birth] not (01-Jul-1890), and [Date Of Birth Accuracy Flag] not (2)
- 2255: Age at admission > (9 days) NOT COMPATIBLE WITH [Episode Of Care] of (5, or 6)
- 2580: [Episode Of Care] not (1, 2, 3, 4, 5, 6, 7, 8, 9, I, J, K, L, or P) NOT COMPATIBLE WITH Age at admission of (> 9 days)
- 2580A: [Episode Of Care] not (5, or 6) NOT COMPATIBLE WITH Age at admission of (≤ 9 days)
- 2583: Age at admission of (> 28 days) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 2771: [Condition Onset Flag] for [Principal Diagnosis] MUST BE (2) when Age at admission of (> 28 days)

- 4008: [Source Of Referral] not (4, A, E, or X), [Principal Diagnosis] not (O80, O840, Z491, Z510, or Z511), [Episode Of Care] not (5), [Admission Date] = [Date Of Birth], and [Admission Category] not (4)
- 4165: [Hospital Number] of (0001-0500), [Episode Of Care] of (5, or 6), [Date Of Birth] = [Admission Date], and [Source Of Referral] not (4, X) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 4180: Age at admission of (> 100 years)
- 4190: [Marital Status] not (1, 2, 3, 4, 5, or 9), and Age at admission of (≥ 16 years)
- 4190A: [Marital Status] not (1, 2, 3, 4, 5, or 9), and Age at admission of (< 16 years)
- 4340: Age at admission of (> 365 days), and [Admission Weight] not blank and not of (0000)
- 4505: [Sex] of (3) NOT COMPATIBLE WITH Age at admission of (> 90 days)
- 4690: [Date Of Birth] is INVALID or missing
- 4691: [Date Of Birth] changed since last admission record
- 4789: [Date Of Birth Accuracy Flag] not (2), and [Date Of Birth] = 01-Jul-1890
- 4790: [Date Of Birth Accuracy Flag] not (1, or 2)
- 4810: Age at admission NOT COMPATIBLE WITH [Age Range] in system reference table for [Principal Diagnosis] or [Additional Diagnosis]
- 4830: Age at admission NOT COMPATIBLE WITH [Age Range] in system reference table for [Procedure]
- 4975: [Episode Of Care] of (6) NOT COMPATIBLE WITH Age at admission of (> 1 year)
- 4980: [Episode Of Care] not (5, or 6) NOT COMPATIBLE WITH Age at admission of (< 10 days)
- 4990: [Episode Of Care] not (1, or 6) NOT COMPATIBLE WITH Age at admission of (> 9 days, or < 29 days) for [Hospital Number] of (< 4000)

[Date Of Birth Accuracy Flag]

Identification

Technical name:	Patient - accuracy of date (birth), code N
APC data item:	91
SAHMR identifier:	SA1091
Registration status:	SA Health, Standard 24/04/2013
Definition:	Indicates whether the date of birth is accurate or whether any part of the date of birth is unknown.
Data element concept:	Patient - Accuracy of date (birth)

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Accurate) 2 (Estimate / Incomplete)

Obligation

Class:	Optional
Dependency:	None

Collection

If the date of birth is known, then set [Date Of Birth Accuracy Flag] to 1 (Accurate).

If the date of birth is unknown, then the default [Date Of Birth] is 01-Jul-1890. Set [Date Of Birth Accuracy Flag] to 2 (Estimate / Incomplete).

See Date Of Birth, page 196.

Data Quality Checks

- 2250: Age at admission > (124 years) NOT COMPATIBLE WITH [Date Of Birth] not (01-Jul-1890), and [Date Of Birth Accuracy Flag] not (2)
- 4180: Age at admission of (> 100 years)
- 4789: [Date Of Birth Accuracy Flag] not (2), and [Date Of Birth] = 01-Jul-1890
- 4790: [Date Of Birth Accuracy Flag] not (1, or 2)

[Date Of First Operating Theatre Procedure]

Identification

Technical name:	Operating theatre procedure - date of event (first performed), DDMMYYYY
APC data item:	96
SAHMR identifier:	SA1068
Registration status:	SA Health, Standard 24/04/2013
Definition:	Date of the first procedure performed in an Operating Theatre for an episode of care.
Data element concept:	Operating theatre procedure - Date of event (first performed)

Value domain

Class:	Date
Type:	Date/Time
Format:	DDMMYYYY
Length:	8
Values:	N/A

Obligation

Class:	Conditional
Dependency:	Mandatory for hospitals: • Flinders Medical Centre • Lyell McEwin Health Service • Modbury Hospital • Noarlunga Community Hospital • Repatriation General Hospital • Royal Adelaide Hospital • The Queen Elizabeth Hospital • Women's & Children's Hospital

Collection

Enter the date of the first operating theatre procedure.

See Dates and Times, page 195.

See First Operating Theatre Procedure, page 201.

Data Quality Checks

- 2001: [Date Of First Operating Theatre Procedure] < [Admission Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033), and [Procedure Location Indicator] of (1)

- 2002: [Date Of First Operating Theatre Procedure] > [Separation Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033), and [Procedure Location Indicator] of (1)
- 2003: [Time Of First Operating Theatre Procedure] < [Admission Time] where [Date Of First Operating Theatre Procedure] = [Admission Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2004: [Time Of First Operating Theatre Procedure] > [Separation Time] where [Date Of First Operating Theatre Procedure] = [Separation Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2005: [Date Of First Operating Theatre Procedure] REQUIRES [Time Of First Operating Theatre Procedure] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2006: [Time Of First Operating Theatre Procedure] REQUIRES [Date Of First Operating Theatre Procedure] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)

[Date Of Transfer To Discharge Lounge]

Identification

Technical name:	Episode of care - transfer to discharge lounge, date DDMMYYYY
APC data item:	52
SAHMR identifier:	SA1010
Registration status:	SA Health, Standard 24/04/2013
Definition:	The date the patient was transferred to a Discharge/Transit Lounge during their hospital admission.
Data element concept:	Episode of care - transfer to discharge lounge

Value domain

Class:	Date
Type:	Date/Time
Format:	DDMMYYYY
Length:	8
Values:	N/A

Obligation

Class:	Conditional
Dependency:	Mandatory for hospitals: • Flinders Medical Centre • Modbury Hospital • Noarlunga Community Hospital • Repatriation General Hospital • Royal Adelaide Hospital • Lyell McEwin Health Service • The Queen Elizabeth Hospital • Women's & Children's Hospital

Collection

Enter the date of the transfer to discharge lounge.

See Dates and Times, page 195.

See Transfer to Discharge Lounge, page 235.

Data Quality Checks

- 2761: [Date Of Transfer To Discharge Lounge] REQUIRES [Time of Transfer To Discharge Lounge]
- 2762: [Time of Transfer To Discharge Lounge] REQUIRES [Date of Transfer To Discharge Lounge]

- 2763: [Date Of Transfer To Discharge Lounge] < [Admission Date]
- 2764: [Date Of Transfer To Discharge Lounge] > [Separation Date]
- 2765: [Time Of Transfer To Discharge Lounge] < [Admission Time] where [Date Of Transfer To Discharge Lounge] = [Admission Date]
- 2766: [Time Of Transfer To Discharge Lounge] > [Separation Time] where [Date Of Transfer To Discharge Lounge] = [Separation Date]

[Employment Status]

Identification

Technical name:	Patient - employment status, code N
APC data item:	88
SAHMR identifier:	SA1100
Registration status:	SA Health, Standard 24/04/2013
Definition:	Indicates the employment status immediately prior to admission, as reported by the patient and as defined by the categories given.
Data element concept:	Patient - Employment status

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	0 (Not applicable) 1 (Child not at school) 2 (Student) 3 (Employed) 4 (Unemployed) 5 (Home duties) 6 (Other) 9 (Unknown)

Obligation

Class:	Conditional
Dependency:	Mandatory for hospitals: • Flinders Medical Centre • Glenside Hospital • James Nash House • Lyell McEwin Health Service • Modbury Hospital • Noarlunga Community Hospital • Repatriation General Hospital • Royal Adelaide Hospital • The Queen Elizabeth Hospital • Women's & Children's Hospital

Collection

0 (Not applicable)

Patient is not a psychiatric admission of the designated psychiatric units listed above.

It is optional for hospitals not included in the list above to collect and report this data item.

1 (Child not at school)

Includes:

- Pre-school children
- Handicapped children under 16 not otherwise employed

2 (Student)

Includes:

- Child at school, full-time or with study occupying > 20 hours per week or more. If less than 20 hours study and does not fit into any other category record [Employment Status] as 6 (Other).

3 (Employed)

Employed (part-time or full-time); self-employed; employer.

4 (Unemployed)

Unemployed, whether looking for work or not OR receiving unemployment benefits or not.

5 (Home duties)

Use this when it is the sole role of the patient.

6 (Other)

Includes retired persons and/or pensioner, volunteers.

9 (Unknown)

The patient's employment status is unknown.

Data Quality Checks

- 4760: [Employment status] not (0, 1, 2, 3, 4, 5, 6, or 9)

[EMR Service ID]

Identification

Technical name:	EMR Service ID
APC data item:	N/A
SAHMR identifier:	N/A
Registration status:	N/A
Definition:	EPAS Chart GUID
Data element concept:	EPAS Chart GUID

Value domain

Class:	Identifier
Type:	Number
Format:	NNNNNNNNNNNNNNN
Length:	16
Values:	Free text

Obligation

Class:	Optional
Dependency:	Conditional for hospitals: • Using Sunrise EMR

Collection

The EMR Service ID is assigned in Sunrise EMR.

Non-Sunrise EMR and Private sites and supply 16 spaces for this field.

Data Quality Checks

- None

[EPAS Site Visit ID]

Identification

Technical name:	EPAS Site Visit ID, identifier N(20)
APC data item:	102
SAHMR identifier:	SA
Registration status:	SA Health, Standard 24/04/2013
Definition:	The site visit ID from Sunrise EMR
Data element concept:	EPAS Site Visit ID

Value domain

Class:	Identifier
Type:	Number
Format:	NNNNNNNNNNNNNNNNNNN
Length:	20
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for hospitals: • Using Sunrise EMR

Collection

The EPAS site visit ID is assigned automatically when a patient is admitted. Assigned ID will be included in Sunrise EMR hospital data extractions.

Non-Sunrise EMR sites supply 20 zeros (00000000000000000000) for this field.

Data Quality Checks

- None

[Episode Of Care]

Identification

Technical name:	Episode of care - nature of episode, code N
APC data item:	51
SAHMR identifier:	SA1056
Registration status:	SA Health, Standard 01/07/2015
Definition:	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care) or the type of service provided by the hospital for posthumous organ procurement (care other than admitted care), as represented by a code.
Data element concept:	Episode of care - Nature of episode

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Acute) 2 (Maintenance care) 3 (Palliative care) 4 (Rehabilitation) 5 (Unqualified newborn) 6 (Qualified newborn) 7 (Hospital at home / Rehab at home) 8 (Psychogeriatric care) 9 (Geriatric evaluation and management) I (Mental health: Acute) J (Mental health: Maintenance care) K (Mental health: Rehabilitation) L (Mental health: Psychogeriatric care) P (Posthumous organ procurement)

Obligation

Class:	Mandatory
Dependency:	None

Collection

An episode of care describes the overall nature of a clinical service provided to an admitted patient. There may be multiple episodes of care during a patient visit to a hospital; however, an episode of care type cannot be followed by the same episode of care type.

Generally, an episode of care must be provided for a minimum period of 24 hours to warrant a change in care type; however, there are exceptions for:

- posthumous organ procurement,
- newborns, where the minimum period is 1 hour, and
- Glenside patients, where different arrangements apply.

Emergency patients who are admitted out of normal hours to the unit rostered “on take” are to be recorded with an episode of care relating to their reason for admission, and not the “on take” unit. For example, consider a patient who presents to the Emergency Department out of normal office hours and the Palliative Unit is rostered “on take” for any emergency admissions. The patient is therefore initially admitted to the Palliative Unit, until the morning when the patient has been formally assessed and admitted to the appropriate unit.

This scenario does not warrant an episode of care change. The patient's admission should reflect the episode of care for which the patient was formally assessed.

1 (Acute)

Acute care excludes care which meets the definition of mental health care, e.g. I (Mental health: Acute).

Acute care is where the primary clinical purpose or treatment goal is one or more of the following:

- Manage labour (obstetric)
- Cure illness or provide definitive treatment of injury
- Perform surgery
- Relieve symptoms or illness or injury (excluding palliative care)
- Reduce severity of an illness or injury
- Protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function and/or
- Perform diagnostic or therapeutic procedures

Note:

- An acute mental health [Episode Of Care] is shown by: I (Mental health acute).

2 (Maintenance care)

Maintenance care excludes care which meets the definition of mental health care, e.g. J (Mental health: Maintenance care).

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

Maintenance Care is closely related to [Admission Type]. If a patient's [Episode Of Care] is 2 (Maintenance care), then the [Admission Type] must be either:

- 1 (Ordinary)
- 3 (Long stay: Non-acute care)

<u>Principal Diagnosis for Maintenance Care Patients</u>

Maintenance care requires a [Principal Diagnosis] starting with Z75 (Prob rel med facilities oth health care).

<u>End of Quarter Maintenance Care Patient Reporting</u>

Maintenance care patients, who are an in-patient at the end of the quarter in a public hospital, are required to be administratively discharged from the Maintenance care episode of care and administratively readmitted to the Maintenance Care episode of care.

See End of Quarter Reporting, page 200.

Multi-Purpose Service (MPS) Reporting

Maintenance care patients occupying an MPS bed in one of the following designated Country hospitals should not be reported to the Admitted Patient Care data set:

- Burra Hospital
- Ceduna District Health Service
- Cleve District Hospital and Aged Care
- Coober Pedy Hospital and Health Service
- Cowell District Hospital and Aged Care
- Crystal Brook and District Hospital
- Cummins and District Memorial Hospital
- Elliston Hospital
- Hawker Memorial Hospital
- Kangaroo Island Health Service
- Karoonda and District Soldiers' Memorial Hospital
- Kimba District Hospital and Aged Care
- Kingston Soldiers' Memorial Hospital
- Lameroo District Health Service
- Laura and District Hospital
- Meningie and Districts Memorial Hospital and Health Services
- Penola War Memorial Hospital
- Pinnaroo Soldiers' Memorial Hospital
- Quorn Health Service
- Snowtown Hospital and Health Service
- Streaky Bay Hospital
- Tailem Bend District Hospital
- Tumby Bay Hospital and Health Services
- Waikerie Health Service
- Wudinna Hospital

If you require any further information regarding the MPS program contact Country Health SA.

3 (Palliative care)

Palliative care excludes care which meets the definition of mental health care.

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

Palliative care is always:

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

If patient's length of stay exceeds > 35 days, then [Admission Type] is to be recorded as 3 (Long stay: Non-acute care).

4 (Rehabilitation)

Rehabilitation care excludes care which meets the definition of mental health care, e.g. K (Mental health: Rehabilitation).

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

Rehabilitation care is always:

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

Types of rehabilitation

Rehabilitation episodes of care (as defined by the above definition) in the above hospitals will be funded according to the following patient types:

- Spinal
- Stroke, acquired brain injury, neurological, amputee
- Orthopaedic/other
- Psychiatric (only at Glenside)

The allocation of the patient to one of the above groups is the responsibility of the treating medical officer.

If patient's length of stay exceeds > 35 days, then [Admission Type] is to be recorded as 3 (Long stay: Non-acute care).

5 (Unqualified newborn)

See Newborns, page 218 for the distinction between unqualified and qualified newborns.

6 (Qualified newborn)

See Newborns, page 218 for the distinction between unqualified and qualified newborns.

7 (Hospital at home / Rehab at home)

Use this value to record Hospital at Home, Rehabilitation at Home, Geriatric Evaluation and Management at Home, Mental Health at Home, and Home Birth episodes.

Hospital at Home

An episode of Hospital at Home care occurs when a patient is provided with care in their own home which otherwise would have been provided as an in-patient service.

Rehabilitation at Home

An episode of Rehabilitation at Home care occurs when a patient is provided with care in their own home which otherwise would have been provided as an in-patient service.

8 (Psychogeriatric care)

Psychogeriatric care excludes care which meets the definition of mental health care, e.g. L (Mental health: Psychogeriatric care).

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

Psychogeriatric care is always:

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

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

In essence, episode psychogeriatric care delivered outside of a mental health unit.

9 (Geriatric evaluation and management)

Geriatric Evaluation and Management care excludes care which meets the definition of mental health.

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

Geriatric evaluation and management is always:

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

I (Mental Health: Acute)

Mental Health Acute care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder.

Mental Health Acute care:

- is delivered under the management of, or regularly informed by, a clinician with specialist expertise in mental health and may include input from a Community/Integrated Mental Health Team. Care managed by a General Practitioner does not qualify as Mental Health Acute Care type.
- is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan
- may include significant psychosocial components, including family and carer support.

Specifically, the principal clinical intent or treatment goal is one or more of the following:

- provide definitive treatment for a mental illness.
- Provide interventions designed to reduce the intensity of positive symptoms, (e.g. reduce hallucinations and delusions, ameliorate thought disorder; reduce severity of depressive symptoms or the level of anxiety, manage hostile or aggressive behaviour related to mental illness).
- reduce severity of a mental health illness.
- protect against exacerbation and/or complication of a mental health illness which could threaten life or normal function.
- perform diagnostic or therapeutic procedures.

J (Mental Health: Maintenance care)

Mental Health Maintenance (or non-acute) care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder.

The focus is support for a patient with impairment, activity limitation or participation restriction due to a patient's mental disorder. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of Mental Health Maintenance Care often require care over an indefinite period.

Mental Health Maintenance care:

- is delivered under the management of, or regularly informed by, a clinician with specialist expertise in mental health; and may include input from a Community/Integrated Mental Health Team. Care managed by a General Practitioner does not qualify as Mental Health Maintenance Care type.
- is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; and
- may include significant psychosocial components, including family and carer support.

As a guide the principal clinical intent or treatment goal is:

- to maintain the level of functioning, or improve functioning during a period of recovery, minimise deterioration or prevent relapse where the consumer has stabilised and functions relatively independently

- minimise the risks and handicaps associated with the ongoing symptoms and psychosocial dysfunctions arising from a mental health disorder to strengthen the consumers' capacity to use supportive professional networks

K (Mental Health: Rehabilitation)

Mental Health Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder.

The focus is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a Mental Health condition. The patient will be capable of actively participating.

Mental Health Rehabilitation care:

- is delivered under the management of, or regularly informed by, a clinician with specialist expertise in mental health and may include input from a Community/Integrated Mental Health Team. Care managed by a General Practitioner does not qualify as Mental Health Acute Care type.
- is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan
- may include significant psychosocial components, including family and carer support; and
- is in a designated mental health rehabilitation unit.

As a guide the principal clinical intent or treatment goal is:

- to improve personal, social or occupational functioning or to promote psychosocial adaptation in a consumer with impairment arising from a mental health disorder
- Interventions designed to result in a significant improvement in the consumer's personal, social and/or occupational functioning in the short term (weeks to months). This may include the development of basic community survival skills (e.g. shopping, cooking), social skills (e.g. conversation) or vocational skills (e.g. job seeking or job maintenance).

L (Mental Health: Psychogeriatric care)

Mental Health Psychogeriatric care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder.

The focus is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance caused by mental illness, an age-related organic brain impairment or a physical condition.

Mental Health Psychogeriatric care:

- is delivered under the management of, or regularly informed by, a clinician with specialist expertise in mental health and may include input from a Community/Integrated Mental Health Team. Care managed by a General Practitioner does not qualify as Mental Health Psychogeriatric Care type.
- is evidenced by an individualised formal mental health assessment
- the includes a documented mental health plan that covers the physical, psychosocial, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability

- may include family and carer support roles or input.

Specifically, the principal clinical intent or treatment goal is not mental health psychogeriatric care if the primary focus of care is acute symptom control.

P (Posthumous organ procurement)

Posthumous organ procurement is the procurement of human tissue for the purpose of transplantation from a donor whose brain function or circulation of blood has permanently stopped.

Posthumous Organ Procurement episodes of care begin when the patient is transferred to theatre for the procurement process.

Diagnoses and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM (12th Edition) Australian Coding Standards.

It is important that only procurement of organs after the patient whose brain function or circulation of blood has permanently stopped are submitted using the episode of care value for Posthumous Organ Procurement.

Data Quality Checks

- 2085: [Episode Of Care] of (7) NOT COMPATIBLE WITH [Nature Of Separation] of (0, 3, 4, A, E, or X)
- 2255: Age at admission > (9 days) NOT COMPATIBLE WITH [Episode Of Care] of (5, or 6)
- 2285: [Funding Source] of (04) AND [Episode of Care] of (1) for [Hospital Number] of (< 4000) NOT COMPATIBLE WITH [Principal Diagnosis] (Z742)
- 2301: [Episode Of Care] of (5, or 7) NOT COMPATIBLE WITH [Hours In ICU] not (0)
- 2302: [Episode Of Care] of (5, or 7) NOT COMPATIBLE WITH [Hours On Mechanical Ventilation] not (0)
- 2342: [Episode Of Care] of (2, or J) NOT COMPATIBLE WITH [Admission Type] or [Status Change Type] of (2)
- 2580: [Episode Of Care] not (1, 2, 3, 4, 5, 6, 7, 8, 9, I, J, K, L, or P) NOT COMPATIBLE WITH Age at admission of (> 9 days)
- 2580A: [Episode Of Care] not (5, or 6) NOT COMPATIBLE WITH Age at admission of (≤ 9 days)
- 2582: [Episode Of Care] not (1, 5, or 6) NOT COMPATIBLE WITH [Hospital Number] in system reference table with [Hospital Role] of (6)
- 2695: [Episode Of Care] of (2), [Separation Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Separation Time] of (2358) REQUIRES [Nature Of Separation] of (E)
- 2696: [Episode Of Care] of (2), [Admission Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Admission Time] of (2359) REQUIRES [Nature Of Separation] of (E)
- 2700: [Episode Of Care] of (2), [Separation Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Nature Of Separation] of (E) REQUIRES [Separation Time] of (2358)
- 2705: [Episode Of Care] of (2), and [Nature Of Separation] of (E) REQUIRES [Separation Date] of (YYYY0331, YYYY0630, YYYY0930, or YYYY1231)
- 2710: [Episode Of Care] of (2), [Source Of Referral] of (E), and [Admission Date] of (YYYY0331, YYYY0630, YYYY0930, or YYYY1231) REQUIRES [Admission Time] of (2359)

- 2715: [Episode Of Care] of (2), and [Source Of Referral] of (E) REQUIRES [Admission Date] of (YYYY0331, YYYY0630, YYYY0930, or YYYY1231)
- 2730: [Episode Of Care] of (7) NOT COMPATIBLE WITH [Referral For Further Health Care] of (07)
- 2745: [Episode Of Care] of (P) REQUIRES [Nature Of Separation] of (5, or 6)
- 2747: [Principal Diagnosis] or [Additional Diagnosis] of (Z525 or Z527) REQUIRES [Episode Of Care] of (P)
- 2750: [Episode Of Care] of (5, 6, 7, 8, or L) NOT COMPATIBLE WITH [Referral For Further Health Care] of (07) and [Nature Of Separation] of (A)
- 2751: [Episode Of Care] of (2), and [Source Of Referral] not (E) REQUIRES [RUG-ADL]
- 4007: [Source Of Referral] not (A, or E), [Principal Diagnosis] not (O80, O840, Z491, Z510, or Z511), [Episode Of Care] of (5), and [Admission Category] not (4)
- 4008: [Source Of Referral] not (4, A, E, or X), [Principal Diagnosis] not (O80, O840, Z491, Z510, or Z511), [Episode Of Care] not (5), [Admission Date] = [Date Of Birth], and [Admission Category] not (4)
- 4036: [Episode Of Care] of (4, or K) REQUIRES [Additional Diagnosis] of (Z509)
- 4046: [Additional Diagnosis] of (Z509) REQUIRES [Episode Of Care] of (4, 7, or K)
- 4051: [Episode Of Care] of (P) REQUIRES [Principal Diagnosis] of (Z5200-Z529)
- 4055: [Episode Of Care] of (2) REQUIRES [Principal Diagnosis] of (Z750-Z759) for [Hospital Number] of (0003-0306)
- 4056: [Principal Diagnosis] of (Z750-Z759) REQUIRES [Episode Of Care] of (2) for [Hospital Number] in (0003-0300)
- 4061: [Episode Of Care] of (3) REQUIRES [Additional Diagnosis] of (Z515)
- 4165: [Hospital Number] of (0001-0500), [Episode Of Care] of (5, or 6), [Date Of Birth] = [Admission Date], and [Source Of Referral] not (4, X) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 4265: [Episode Of Care] of (4) REQUIRES [Procedure] from (Block 1916)
- 4641: [Clinical Unit] of (78, 79, 80, 85, 86, or 95), or [Principal Diagnosis] in system reference table with [Mental Health Diagnosis Flag] of (Y) REQUIRES [Episode Of Care] of (I, J, K, or L)
- 4643: [Episode Of Care] of (I, J, K, or L) REQUIRES [Clinical Unit] of (78, 79, 80, 85, 86, or 95), or [Principal Diagnosis] in system reference table with [Mental Health Diagnosis Flag] of (Y)
- 4824: [Episode Of Care] of (7) NOT COMPATIBLE WITH [Source Of Referral] not (A) and [Principal Diagnosis] of (Z519)
- 4975: [Episode Of Care] of (6) NOT COMPATIBLE WITH Age at admission of (> 1 year)
- 4976: [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388) REQUIRES [Episode Of Care] of (5, or 6)
- 4980: [Episode Of Care] not (5, or 6) NOT COMPATIBLE WITH Age at admission of (< 10 days)
- 4985: [Episode Of Care] of (5) NOT COMPATIBLE WITH [Nature Of Separation] of (5, or 6)
- 4990: [Episode Of Care] not (1, or 6) NOT COMPATIBLE WITH Age at admission of (> 9 days, or < 29 days) for [Hospital Number] of (< 4000)

- 4992: [Episode Of Care] not (2, 3, 4, 8, 9, J, K, or L) NOT COMPATIBLE WITH [Admission Type] or [Status Change Type] of (3), or [Status Change Date 1], [Status Change Date 2], or [Status Change Date 3] < [Admission Date]

[External Cause]

Identification

Technical name:	Patient - condition external cause, code AN[NNN]
APC data item:	47
SAHMR identifier:	SA1092
Registration status:	SA Health, Standard 24/04/2013
Definition:	The environmental event, circumstance or condition as the cause of injury, as represented by a code.
Data element concept:	Patient - condition external cause, code AN[NNN]

Value domain

Class:	Code
Type:	String
Format:	AN[NNN]
Length:	5
Values:	Reference file

Obligation

Class:	Conditional
Dependency:	Mandatory for records supplied with: > [Activity When Injured] > [Place Of Occurrence]

Collection

[External Cause]:

- Is an ICD-10-AM (12th Edition) diagnosis code from range U7400-Y9899
- Submitted with [Activity When Injured] and [Place Of Occurrence]
- May be assigned multiple times to a record
- May not be duplicated

The first [External Cause] code must be reported as [External Cause]; additional [External Cause] codes are reported in [Additional Diagnosis].

See Diagnosis and Procedure Codes, page 198.

Data Quality Checks

- 2077: [Additional Diagnosis] of (U0770-U0774) REQUIRES [Additional Diagnosis] or [External Cause] of (Y590)
- 2540: [External Cause] not (V0000-Y919, Y95-Y98, or blank)
- 4225: [Principal Diagnosis], [Additional Diagnosis], or [External Cause] contains [Diagnosis] in system reference table with [Rare Diagnosis] of (1)

- 4305: [Principal Diagnosis] or [Additional Diagnosis] of (T360-T509) NOT COMPATIBLE WITH [External Cause] or [Additional Diagnosis] of (Y400-Y599)
- 4811: [External Cause] or [Additional Diagnosis] of (Y900-Y908) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (F100-F102, or T510)
- 4840: [Principal Diagnosis] or [Additional Diagnosis] is [Diagnosis] in system reference table with [External Cause Flag] of (Y) REQUIRES [External Cause]
- 4860: [Activity When Injured] of (U5000-U739) REQUIRES [External Cause]
- 4870: [Activity When Injured] of (U5000-U739), and [Additional Diagnosis] or [External Cause] not (V0000-Y34)
- 4880: [External Cause] of (V0000-Y34), and [Activity When Injured] not (U5000-U739)
- 4900: Duplicate Diagnosis code from [Principal Diagnosis], [Additional Diagnosis], [External Cause], [Place Of Occurrence], and/or [Activity When Injured] DELETES duplicate Diagnosis code
- 4940: [Place Of Occurrence] of (Y9200-Y929) REQUIRES [External Cause]
- 4950: Place Of Occurrence = Y9200-Y929 and [External Cause] or [Additional Diagnosis] not (V0000-Y899)
- 4960: [Place Of Occurrence] not (Y9200-Y929), and [External Cause] or [Additional Diagnosis] not (V0000-Y899)

[Funding Source]

Identification

Technical name:	Funding of service - source category, code NN
APC data item:	95
SAHMR identifier:	SA1061
Registration status:	SA Health, Standard 24/04/2013
Definition:	The source of funds for an admitted patient episode, as represented by a code. The major funding source should be recorded if there is more than one source of funding.
Data element concept:	Funding of service - Source category

Value domain

Class:	Code
Type:	Number
Format:	NN
Length:	2
Values:	01 (Compensable: MVA) 02 (Compensable: WC) 03 (Compensable: Other) 04 (Veteran) 05 (Defence) 06 (Correctional) 07 (Overseas: RHCA) 08 (Non-Medicare) 09 (Private health insurance) 10 (Self-Funded) 11 (Medicare) 12 (Other hospital or Public authority) 13 (No charge raised) 14 (Private Hospital Funding Agreement)

Obligation

Class:	Mandatory
Dependency:	None

Collection

Certain sources of funding take precedence over others:

1. Defence
2. Compensable
3. Veteran

For example:

1. Is the patient funded as Defence?
    - Yes: [Funding Source] must be 05 (Defence)
    - No: continue to (2)
2. Is the non-Defence patient funded as Compensable?
    - Yes: [Funding Source] must be one of 01 (Compensable: MVA), 02 (Compensable: WC), or 03 (Compensable: Other)
    - No: continue to (3)
3. Is the non-Defence and non-Compensable patient funded as a Veteran?
    - Yes: [Funding Source] must be 04 (Veteran)
    - No: select appropriate [Funding Source]

01 (Compensable: MVA)

Use this value when a patient is eligible to make a claim for damages under Motor Vehicle Third Party insurance.

See Compensable, page 190.

02 (Compensable: WC)

Use this value when a patient is eligible to make a claim for damages under Worker's Compensation.

See Compensable, page 190.

03 (Compensable: Other)

Use this value when a patient has an entitlement to claim under public liability or common law damages.

See Compensable, page 190.

04 (Veteran)

A Veteran's Affairs patient is a person who holds a current Department of Veteran's Affairs Health entitlement card AND has approval from the Department of Veteran's Affairs for admission as a Veteran's Affairs patient.

See Veteran, page 236.

05 (Defence)

Use for any patient admitted who is currently a member of the Australian Defence Force.

In cases where Defence Force Personnel present for admission with a condition covered by workers compensation, motor vehicle accident, or other compensable claim, the patient should be admitted as private and classified as Defence (not compensable)

06 (Correctional)

Use for any patient admitted who is currently being held in a correctional facility. It does not include patients being held in a secure ward of a public hospital.

07 (Overseas: RHCA)

Use for any patient admitted who is an overseas visitor who resides in a country which has a Reciprocal Health Care Agreement (RHCA) with Australia.

See Reciprocal Health Care Agreements (RCHA), page 227.

08 (Non-Medicare)

Use for any patient admitted who is:

- An overseas visitor who resides in a country which does not have a Reciprocal Health Care Agreement (RHCA) with Australia.

Patients for whom travel insurance is the major funding source should be recorded in this category.

For eligible RHCA patients who do not choose to be admitted under RCHA.

09 (Private Health)

Insurance Fund Use for any patient admitted who is privately insured with a health insurance fund and elects to be a private patient.

10 (Self-Funded)

Use for any patient admitted who is funding their own admission or whose stay is funded by the patient's family, friends or by other benefactors.

11 (Medicare)

Use for any patient admitted who's funding will be sourced from the public health care system.

These are patients who elect to be a public patient and who do not have any other source of funding for their admission.

People who reside in Australia are eligible to receive services under Medicare if they meet any of the following four criteria:

- Hold Australian citizenship;
- Have been issued with a permanent visa;
- Hold New Zealand citizenship; OR
- Have applied for a permanent visa, restrictions apply to persons who have applied for a parent visa (other requirements apply).

12 (Other Hospital or Public Authority)

Use for any patient receiving treatment under contracted care or partial service provision arrangement (inter-hospital contracted patient) with another hospital.

This is to be recorded by the hospital providing the Contract Service or Component of Care.

13 (No charge raised)

Use when the fee for a Medicare eligible patient receiving public hospital services is waived.

14 (Private Hospital Funding Agreement)

Use for any patient receiving treatment under contracted care or partial service provision arrangement (inter-hospital contracted patient) with another hospital under the Private Hospital Funding Agreement 2022 (COVID-19) ONLY.

This is to be recorded by the hospital providing the Contract Service or Component of Care under the Private Hospital Funding Agreement 2022 (COVID-19) ONLY.

Data Quality Checks

- 2280: [Veteran Card Type] of (G, W, or N) or [Funding Source] = (04), and [Veteran Card Number] is blank, or invalid format
- 2285: [Funding Source] of (04) AND [Episode of Care] of (1) for [Hospital Number] of (< 4000) NOT COMPATIBLE WITH [Principal Diagnosis] (Z742)
- 2296: [Funding Source] of (04) REQUIRES [Veteran Card Number] and [Veteran Card Type]
- 2320: [Funding Source] of (06, 07, or 11) REQUIRES [Admission Election] of (1)
- 2330: [Funding Source] of (09) REQUIRES [Hospital Insurance] of (1)
- 2340: [Admission Type] of (1), and Length of stay of (> 35 days), and [Funding Source] not (01, 02, 03, 07, or 08) REQUIRES [Status Change Type] of (2, or 3)
- 2585: [Admission Election] or [Status Change Election] not (2) NOT COMPATIBLE WITH [Funding Source] of (04, 05, 09, or 10) for [Hospital Number] of (≥ 0049 and ≤ 0250)
- 2610: [Funding Source] not (01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13 or 14)
- 2611: [Source of Referral] of (7) REQUIRES [Funding Source] of (12) or (14)
- 2612: [Funding Source] (04) REQUIRES Statistical Area Level 2 not BLANK; check [Suburb / Locality] and/or [Postcode]
- 2772: [Funding Source] of (12) or (14) REQUIRES [Admission Election] of (1) AND [Hospital Insurance] of (2) AND [Source of Referral] of (7)
- 4021: [Country Of Birth] of (1100, 1101, 1102, or 1199) NOT COMPATIBLE WITH [Funding Source] of (07, or 08)
- 4396: [Indigenous Status] of (1, 2, or 3) NOT COMPATIBLE WITH [Funding Source] of (07, or 08)
- 4521: [Funding Source] changed from/to (4) and not (4) since last admission record

[Gender]

Identification

Technical name:	Person—gender, code X
APC data item:	110
Meteor identifier:	741842
Registration status:	Health, Standard 15/02/2022
Definition:	How a person describes their gender, as represented by a code.
Data element concept:	How a person describes their gender.

Value domain

Class:	Code
Type:	String
Format:	X
Length:	1
Values:	1 (Man, or boy, or male) 2 (Woman, or girl, or female) 3 (Non-binary) 4 (Different term) 5 (Prefer not to answer) 9 (Not stated/inadequately described)

Obligation

Class:	Optional
Dependency:	None

Collection

This Value Domain is based on the Australian Bureau of Statistics Standard for sex, gender, variations of sex characteristics and sexual orientation variables (ABS 2021). The values are defined as follows:

CODE 1 Man, or boy, or male

A person who describes their gender as man, or boy, or male.

CODE 2 Woman, or girl, or female

A person who describes their gender as woman, or girl, or female.

CODE 3 Non-binary

A person who describes their gender as non-binary.

CODE 4 Different term

A person who describes their gender as a term other than man/boy/male, woman/girl/female or non-binary.

CODE 5 Prefer not to answer

A person who prefers not to respond on how they describe their gender.

CODE 9 Not stated or inadequately described.

This supplementary value is used to code inadequately described responses and non-responses for gender. It is not to be used on primary collection forms. It is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

Guide for use:

Gender is a social and cultural concept. It is about social and cultural differences in identity, expression and experience as a man, boy, woman, girl, or non-binary person. Non-binary is an umbrella term describing gender identities that are not exclusively male or female.

Gender includes the following concepts:

- Gender identity is about who a person feels themself to be
- Gender expression is the way a person expresses their gender. A person's gender expression may also vary depending on the context, for instance expressing different genders at work and home
- Gender experience describes a person's alignment with the sex recorded for them at birth i.e. a cis experience or a trans experience.

The terms sex and gender are interrelated, and are often used interchangeably, however they are distinct concepts:

- Sex is understood in relation to sex characteristics. Sex recorded at birth refers to what was determined by sex characteristics observed at birth or in infancy
- Gender is about social and cultural differences in identity, expression and experience.

While they are related concepts, caution should be exercised when comparing counts for sex with those for gender.

"The preferred Australian Government approach is to collect and use gender information. Information regarding sex would ordinarily not be required and should only be collected where there is a legitimate need for that information and it is consistent with Australian Privacy Principle 3." (AGD 2015)

Collection methods:

Standard Question Module

The following standard question module is based on that recommended in the Australian Bureau of Statistics Standard for sex, gender, variations of sex characteristics and sexual orientation variables (ABS 2021):

How [do/does] [you/Person's name/they] describe [your/their] gender?

Gender refers to current gender, which may be different to sex recorded at birth and may be different to what is indicated on legal documents.

Comments:

A person's gender may stay the same or can change over the course of their lifetime. The gender response option chosen will reflect a person's gender at that point in time. Some people may not identify with a specific gender or with the concept of gender at all.

Data Quality Checks

- None

[Hospital Insurance]

Identification

Technical name:	Patient - hospital insurance status, code N
APC data item:	17
SAHMR identifier:	SA1107
Registration status:	SA Health, Standard 24/04/2013
Definition:	The insurance status of the patient, as represented by a code.
Data element concept:	Patient - Hospital insurance status

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Hospital insurance) 2 (No hospital insurance) 9 (Unknown)

Obligation

Class:	Mandatory
Dependency:	None

Collection

This data item is independent from [Admission Election]. [Hospital Insurance] indicates the patient's level of private health insurance, specifically whether the patient has:

- Extras
- Hospital

See Hospital Insurance, page 206.

1 (Hospital insurance)

Hospital insurance includes:

- Insurance with a private health fund for private admitted patient hospital accommodation

Hospital insurance does not include:

- Extras cover

2 (No hospital insurance)

No hospital insurance includes:

- No private health insurance
- Extras cover only

9 (Unknown)

The patient has private health insurance; however, the level of coverage is unknown.

Data Quality Checks

- 2330: [Funding Source] of (09) REQUIRES [Hospital Insurance] of (1)
- 2772: [Funding Source] of (12) or (14) REQUIRES [Admission Election] of (1) AND [Hospital Insurance] of (2) AND [Source of Referral] of (7)
- 4210: [Hospital Insurance] not (1, 2, or 9)

[Hospital Number]

Identification

Technical name:	Hospital - Administrative identifier, hospital code NNNN
APC data item:	1
SAHMR identifier:	SA1053
Registration status:	SA Health, Standard 24/04/2013
Definition:	The treating hospital, as represented by a unique code.
Data element concept:	Hospital - Administrative identifier

Value domain

Class:	Code
Type:	Number
Format:	NNNN
Length:	4
Values:	Reference file

Obligation

Class:	Mandatory
Dependency:	None

Collection

[Hospital Number] represents the hospital to which the patient has been admitted.

See Hospital Number, page 207.

Reference File:

- **Admitted Activity Reference Table – Admitted Patient Care Hospital Code Listing** available from:

  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Data Quality Checks

- 1131: Record with [Admission Date] & [Admission Time] already in database for same [Patient Unit Record Number] and [Hospital Number]
- 2001: [Date Of First Operating Theatre Procedure] < [Admission Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033), and [Procedure Location Indicator] of (1)
- 2002: [Date Of First Operating Theatre Procedure] > [Separation Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033), and [Procedure Location Indicator] of (1)

- 2003: [Time Of First Operating Theatre Procedure] < [Admission Time] where [Date Of First Operating Theatre Procedure] = [Admission Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2004: [Time Of First Operating Theatre Procedure] > [Separation Time] where [Date Of First Operating Theatre Procedure] = [Separation Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2005: [Date Of First Operating Theatre Procedure] REQUIRES [Time Of First Operating Theatre Procedure] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2006: [Time Of First Operating Theatre Procedure] REQUIRES [Date Of First Operating Theatre Procedure] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2010: [Admission Date] ≥ [Hospital Closure Date] for [Hospital Number] in system reference table
- 2285: [Funding Source] of (04) AND [Episode of Care] of (1) for [Hospital Number] of (< 4000) NOT COMPATIBLE WITH [Principal Diagnosis] (Z742)
- 2290: [Veteran Card Number] War Code INVALID for [Hospital Number] of (< 4000)
- 2510: [Hospital Number] of (< 4000), and [Principal Diagnosis] contains [Diagnosis] in system reference table with [Unacceptable Diagnosis Flag] of (1) = Unacceptable Principal Diagnosis
- 2582: [Episode Of Care] not (1, 5, or 6) NOT COMPATIBLE WITH [Hospital Number] in system reference table with [Hospital Role] of (6)
- 2585: [Admission Election] or [Status Change Election] not (2) NOT COMPATIBLE WITH [Funding Source] of (04, 05, 09, or 10) for [Hospital Number] of (≥ 0049 and ≤ 0250)
- 2753: Non-emergency selected same day scope procedures where no general anaesthetic is administered are INVALID inpatient admissions; REPLACE inpatient admission with an outpatient occasion of service
- 2754: Non-emergency same day chemotherapy procedures where no general anaesthetic is administered are INVALID inpatient episodes for funding
- 4000: Principal [Procedure] may be INVALID for same day inpatient episodes (may violate Technical Bulletins 28 or 29); CONSIDER replacing inpatient record with outpatient record
- 4055: [Episode Of Care] of (2) REQUIRES [Principal Diagnosis] of (Z750-Z759) for [Hospital Number] of (0003-0306)
- 4056: [Principal Diagnosis] of (Z750-Z759) REQUIRES [Episode Of Care] of (2) for [Hospital Number] in (0003-0300)
- 4165: [Hospital Number] of (0001-0500), [Episode Of Care] of (5, or 6), [Date Of Birth] = [Admission Date], and [Source Of Referral] not (4, X) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 4170: Length of stay of (> 1 day), and [Hospital Number] in system reference table where [Day Hospital] of (1)
- 4280: [Hospital Transferred To] = [Hospital Number]
- 4320: [Hospital Transferred From] = [Hospital Number]
- 4410: [Admission Election] not (2), and [Hospital Number] of (≥ 4000)
- 4410A: [Admission Election] not (1), and [Hospital Number] of (< 4300)

- 4425: [Hospital Number] of (>= 4302), and [Principal Diagnosis] contains [Diagnosis] in system reference table with [Unacceptable Diagnosis Flag] of (1) = Unacceptable Principal Diagnosis
- 4560: [Contracted Service Hospital Number] = [Hospital Number], or [Contracted Service Hospital Number] not in system reference table
- 4570: [Contracted Service Hospital Number] = [Hospital Number] AND [Contracted Service Patient Unit Record Number] = [Patient Unit Record Number]
- 4640: [Hospital Number] not (0300), and [Mental Health Linking Number] = [Patient Unit Record Number] or is invalid format
- 4670: [Hospital Number] of (0003) REQUIRES [Adult / Child Flag] of (C, or O)
- 4730: [Adult / Child Flag] not blank, and [Hospital Number] not (0003, or 0296)
- 4740: [Source Of Referral] of (E) or [Nature Of Separation] of (E) NOT COMPATIBLE WITH [Hospital Number] of (≥ 4000 and ≤ 4999)
- 4780: [Type Of Usual Accommodation] not (1, 2, 3, 4, 5,6, 7, 8, A, B, C, D, H, M, N,O, P, R, S or Y), and [Hospital Number] < 4000
- 4896: [Hospital Number] not (0035) NOT COMPATIBLE WITH [Additional Diagnosis] of (Z379)
- 4990: [Episode Of Care] not (1, or 6) NOT COMPATIBLE WITH Age at admission of (> 9 days, or < 29 days) for [Hospital Number] of (< 4000)

[Hospital Transferred From]

Identification

Technical name:	Hospital - transferring hospital name, code NNNN
APC data item:	18
SAHMR identifier:	SA1064
Registration status:	SA Health, Standard 24/04/2013
Definition:	The hospital from which the patient was transferred, as represented by a code.
Data element concept:	Hospital - Transferring Hospital Name

Value domain

Class:	Code
Type:	Number
Format:	NNNN
Length:	4
Values:	Reference file

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Patient transfers

Collection

[Hospital Transferred From] represents the hospital from which the patient has been transferred.

See Hospital Number, page 207.

See Inter-Hospital Transfer, page 212.

Related Data Items

If [Source Of Referral] is 4 (Inter-Hospital transfer), then [Hospital Transferred From] is the [Hospital number] that identifies the hospital from which the patient was transferred.

If the [Source Of Referral] is not equal to 4 (Inter-Hospital transfer), then [Hospital Transferred From] is blank.

Data Quality Checks

- 4290: [Hospital Transferred From] not in system reference table
- 4300: [Hospital Transferred From] is not blank and [Source Of Referral] not (4, or X)
- 4310: [Hospital Transfer From] is blank and [Source Of Referral] of (4)
- 4320: [Hospital Transferred From] = [Hospital Number]

Reference file

- **Admitted Activity Reference Table – Admitted Patient Care Hospital Code listing** available from:

  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

[Hospital Transferred To]

Identification

Technical name:	Hospital - receiving hospital name, code NNNN
APC data item:	44
SAHMR identifier:	SA1063
Registration status:	SA Health, Standard 24/04/2013
Definition:	The hospital to which the patient was transferred, as represented by a code.
Data element concept:	Hospital - Receiving hospital name

Value domain

Class:	Code
Type:	Number
Format:	NNNN
Length:	4
Values:	Reference file

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Patient transfers

Collection

[Hospital Transferred To] represents the hospital to which the patient has been transferred.

See Hospital Number, page 207.

See Inter-Hospital Transfer, page 212.

Data Quality Checks

- 4250: [Hospital Transferred To] not in system reference table
- 4260: [Nature Of Separation] not (2, 7, or X)
- 4270: [Nature Of Separation] of (2, 7, or X) REQUIRES [Hospital Transferred To]
- 4280: [Hospital Transferred To] = [Hospital Number]

Reference file

- **Admitted Activity Reference Table – Admitted Patient Care Hospital Code** listing available from:

  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

[Hours In ICU]

Identification

Technical name:	Intensive care unit - Time spent, Time Total Hours NNNNN
APC data item:	40
SAHMR identifier:	SA1065
Registration status:	SA Health, Standard 24/04/2013
Definition:	The total number of hours an admitted patient has spent in a designated intensive care bed during an episode of care in a hospital, rounded to the nearest hour. Includes paediatric intensive care beds.
Data element concept:	Intensive care unit - Time spent

Value domain

Class:	Total
Type:	Number
Format:	NNNNN
Length:	5
Values:	Free text

Obligation

Class:	Conditional
Dependency:	None

Collection

Accumulate hours in a designated ICU unit for each episode of care. Do not accumulate hours across multiple episodes of care, and do not report only the total ICU hours on the final formal discharge.

See Hours, page 208.

See Hours in Intensive Care Unit, page 209.

Data Quality Checks

- 2260: [Hours In ICU] > Length of stay in hours
- 2300: [Hours In ICU] not (0-99999 hours)
- 2301: [Episode Of Care] of (5, or 7) NOT COMPATIBLE WITH [Hours In ICU] not (0)

[Hours On Mechanical Ventilation]

Identification

Technical name:	Mechanical ventilation - time spent, total hours NNNNN
APC data item:	41
SAHMR identifier:	SA1066
Registration status:	SA Health, Standard 24/04/2013
Definition:	The total number of hours an admitted patient has spent on continuous mechanical ventilation during an episode of care in a hospital, rounded to the nearest hour.
Data element concept:	Mechanical ventilation - Time spent

Value domain

Class:	Total
Type:	Number
Format:	NNNNN
Length:	5
Values:	Free text

Obligation

Class:	Conditional
Dependency:	None

Collection

Accumulate hours for continuous mechanical ventilation for each episode of care. Do not accumulate hours across multiple episodes of care, and do not report only the total hours spent on mechanical ventilation on the final formal discharge.

See Hours, page 208.

See Hours On Mechanical Ventilation, page 210.

Data Quality Checks

- 2180: [Hours On Mechanical Ventilation] (< 0 or > 99999 hours)
- 2270: [Hours On Mechanical Ventilation] > Length of stay in hours
- 2302: [Episode Of Care] of (5, or 7) NOT COMPATIBLE WITH [Hours On Mechanical Ventilation] not (0)
- 4355: [Hours on Mechanical Intervention] of (0, or > 24 hours) NOT COMPATIBLE WITH [Procedure] from (1388200)
- 4365: [Hours on Mechanical Intervention] of (< 24, or > 95 hours) NOT COMPATIBLE WITH [Procedure] from (1388201)
- 4375: [Hours on Mechanical Intervention] of (< 96 hours) NOT COMPATIBLE WITH [Procedure] from (1388202)

[IHI Number Status]

Identification

Technical name:	IHI – Number Status
APC data item:	113
Meteor identifier:	743466
Registration status:	Health, Standard 20/10/2021
Definition:	An identifier to describe the status of the Individual Healthcare Identifier (IHI) number.
Data element concept:	Identifier—identifier status

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Active) 2 (Deceased) 3 (Retired) 4 (Expired) 5 (Resolved) 9 (Not stated / inadequately described)

Obligation

Class:	Optional
Dependency:	None

Collection

The number status includes:

CODE 1 Active

Use for IHI numbers attached to a Verified, Unverified or Provisional IHI record where a date of death is not present, where the recorded age is < 130 years, and which is not expired.

CODE 2 Deceased

Use for IHI numbers attached to a Verified, Unverified or Provisional IHI record where a date of death is present, but which has not yet been matched with Fact of Death Data (FoDD) from Births, Deaths and Marriages Registries, and where the recorded age is < 130 years.

For Provisional records only, the record should have < 90 days of no activity.

CODE 3 Retired

Use for IHI numbers attached to a Verified or Unverified IHI record where a date of death is present and either (a) the record has been matched with Fact of Death Data (FoDD) from Births, Deaths and Marriages Registries and has had no activity for 90 days, or (b) the age recorded is ≥ 130 years (Verified IHI records only).

CODE 4 Expired

Use for IHI numbers attached to either (a) a Provisional IHI record where there has been no activity on the record for 90 days, or (b) an Unverified IHI record where the age recorded is ≥ 130 years.

CODE 5 Resolved

Use for IHI numbers attached to a Verified, Unverified or Provisional IHI record which is linked with another record as part of resolving a provisional record or resolving a duplicate record and end dated as part of the replica resolution process.

[IHI Record Status]

Identification

Technical name:	IHI – Record Status
APC data item:	112
Meteor identifier:	743464
Registration status:	Health, Standard 20/10/2021
Definition:	The standing or position of a record for an Individual Healthcare Identifier (IHI).
Data element concept:	Identifier—record status

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Verified) 2 (Unverified) 3 (Provisional) 9 (Not stated / inadequately described)

Obligation

Class:	Optional
Dependency:	None

Collection

The IHI number does not change regardless of the person's IHI record status.

The record status includes:

CODE 1 Verified

Use when the person is a known customer of Medicare Australia or Department of Veterans' Affairs, or has provided evidence of identity information that has been recorded in the Healthcare Identifiers (HI) Service by the Service Operator to establish the identity of the Healthcare Individual.

CODE 2 Unverified

Use when the identifier was created at a healthcare facility and the individual has not contacted the HI Service to verify the IHI by providing their evidence of identity. Unverified IHI records can be merged to another unverified or verified IHI record. This may include newborns and overseas visitors.

CODE 3 Provisional

Use when the identifier was created at a healthcare facility when the individual was not able to or not willing to identify themselves. Provisional records are able to be updated to an Unverified IHI record or merged with an existing (Unverified or Verified) IHI record via a healthcare facility or updated to a Verified IHI via the HI Service by providing evidence of identity. Individuals who present at the point of care unconscious or unknown may be assigned a provisional IHI by the healthcare provider. This IHI expires after 90 days of inactivity on the assumption the patient will become known and a verified IHI obtained for them, or their IHI will be converted to an unverified IHI.

[Indigenous Status]

Identification

Technical name:	Patient - indigenous status, code N
APC data item:	13
SAHMR identifier:	SA1104
Registration status:	SA Health, Standard 24/04/2013
Definition:	Whether a person identifies as being Aboriginal or Torres Strait Islander origin, as represented by a code.
Data element concept:	Patient - Indigenous categorisation

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Aboriginal but not Torres Strait Islander origin) 2 (Torres Strait Islander but not Aboriginal origin) 3 (Both Aboriginal and Torres Strait Islander origin) 4 (Neither Aboriginal nor Torres Strait Islander origin) 9 (Not stated / Inadequately described)

Obligation

Class:	Mandatory
Dependency:	None

Collection

This metadata item is based on the Australian Bureau of Statistics (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS Website.

1 (Aboriginal but not Torres Strait Islander origin)

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

2 (Torres Strait Islander but not Aboriginal origin)

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 origin)

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

4 (Neither Aboriginal nor Torres Strait Islander origin)

A person who identifies as neither an Australian Aboriginal nor Torres Strait Islander. Termed non-indigenous.

9 (Not stated)

Use this category if the indigenous status of the patient cannot be accurately established (not stated).

This category is not to be available as a valid answer to the questions but is intended for use:

- Primarily when importing data from other data sets that do not contain mapped data.
- Where an answer was refused.
- Where the question was not able to be asked prior to completion of admission because the client was unable to communicate or a person who knows the client was not available.

Data Quality Checks

- 4205: [Indigenous Status] of (1, 2, or 3) NOT COMPATIBLE WITH [Country Of Birth] of (≤ 1100, ≥ 1199, and ≠ 1302)
- 4206: [Indigenous Status] changed from/to (1, 2, 3, or 4) since last admission record
- 4395: [Indigenous Status] (not 1, 2, 3, 4, or 9)
- 4396: [Indigenous Status] of (1, 2, or 3) NOT COMPATIBLE WITH [Funding Source] of (07, or 08)

[Individual Healthcare Identifier (IHI)]

Identification

Technical name:	Individual Healthcare Identifier (IHI)
APC data item:	111
Meteor identifier:	743458
Registration status:	Health, Standard 20/10/2021
Definition:	The numerical identifier that uniquely identifies each individual in the Australian healthcare system.
Data element concept:	Person—Individual Healthcare Identifier.

Value domain

Class:	Code
Type:	Number
Format:	N(16)
Length:	16
Values:	Free text

Obligation

Class:	Optional
Dependency:	None

Collection

Each person's Individual Healthcare Identifier (IHI) is unique within the Australian healthcare system.

Record the full IHI for an individual.

The IHI is part of the Australian Government's digital health initiative developed to enhance the way information is exchanged, shared and managed in the Australian health sector. Electronic identifiers and the systems underpinning them were developed and are maintained by the Healthcare Identifiers (HI) Service.

IHIs are automatically assigned to all individuals registered with Medicare Australia or enrolled in the Department of Veterans' Affairs (DVA) programs. Those not enrolled in Medicare Australia or with the DVA are assigned a temporary number when they next seek health care; this is then validated by the HI Service Operator and becomes their unique IHI.

Each IHI has a Record Status; this describes whether verification of the identifier of the individual has occurred and is based on the evidence available of a person's identity.

The IHI number does not change regardless of the person's Record Status.

Each IHI also has a Number Status; this describes whether the IHI number is in use:

The format of the number is as follows:

Digits N1-N6: The issuer identification number, which in turn is made up of:

N1-N2, Major industry identifier: 80 = health

N3-N5, Country code: 036 = Australia

N6, Number type: 0 = IHI

Digits N7-N15: Individual account identification (9 digits for the unique identifier)

Digit N16: Check digit

[Interpreter Service Required]

Identification

Technical name:	Interpreter services required, code N
APC data item:	107
SAHMR identifier:	None
Registration status:	SA Health, Standard 08/02/2006
Definition:	Did the patient require an interpreter service?
Data element concept:	Person – interpreter service required

Value domain

Class:	Total
Type:	Number
Format:	N
Length:	1
Values:	1 (Yes: Female interpreter) 2 (Yes: Male interpreter) 3 (Yes: Any interpreter) 4 (Yes: Non-spoken) 5 (No) 9 (Not stated)

Obligation

Class:	Optional
Dependency:	None

Collection

Includes verbal language, non-verbal language and languages other than English.

1 (Yes: Female interpreter)

A female interpreter was required.

2 (Yes: Male interpreter)

A male interpreter was required.

3 (Yes: Any interpreter)

An interpreter was required; gender unspecified.

4 (Yes: Non-spoken)

A sign language interpreter required was required.

5 (No)

No interpreter was required.

9 (Not stated)

No response given.

Data Quality Checks

- 4715: [Interpreter Required] not (1, 2, 3, 4, or 9)

[Leave From Date]

Identification

Technical name:	Patient's leave from service - date of leaving service, date DDMMYYYY
APC data item:	32, 34, 36, 38
SAHMR identifier:	SA1118
Registration status:	SA Health, Standard 24/04/2013
Definition:	Date the patient went on leave
Data element concept:	Patient's leave from service - Date of leaving service

Value domain

Class:	Date/Time
Type:	Date
Format:	DDMMYYYY
Length:	8
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: Period of leave

Collection

See Dates and Times, page 195.

See Periods of Leave, page 224.

Data Quality Checks

- 2190: [Leave From Date] & [Leave From Time] < [Admission Date] & [Admission Time], or [Leave From Date] & [Leave From Time] > [Separation Date] & [Separation Time]
- 2210: [Leave From Date] and/or [Leave To Date] format is INVALID, or [Leave To Date] < [Leave From Date]
- 2220: [Leave From Date] format is INVALID
- 4610: [Leave From Date] is valid, and [Leave From Time] is an invalid time or blank
- 4625: Length of leave of (> 7 consecutive days) NOT COMPATIBLE WITH [Legal Status] not (1)
- 4995: [Nature Of Separation] of (0) REQUIRES [Leave From Date]

[Leave From Time]

Identification

Technical name:	Patient's leave from service - time of leaving service, hhmm
APC data item:	73, 75, 77, 79
SAHMR identifier:	SA1120
Registration status:	SA Health, Standard 24/04/2013
Definition:	Time the patient went on leave
Data element concept:	Patient's leave from service - Time of leaving service

Value domain

Class:	Date/Time
Type:	Time
Format:	hhmm
Length:	4
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Period of leave

Collection

See Dates and Times, page 195.

See Periods of Leave, page 224.

Data Quality Checks

- 2190: [Leave From Date] & [Leave From Time] < [Admission Date] & [Admission Time], or [Leave From Date] & [Leave From Time] > [Separation Date] & [Separation Time]
- 4610: [Leave From Date] is valid, and [Leave From Time] is an invalid time or blank

[Leave To Date]

Identification

Technical name:	Patient's leave from service - date of resuming service, date DDMMYYYY
APC data item:	33, 35, 37, 39
SAHMR identifier:	SA1119
Registration status:	SA Health, Standard 24/04/2013
Definition:	Date the patient returned from leave
Data element concept:	Patient's leave from service - Date of resuming service

Value domain

Class:	Date/Time
Type:	Date
Format:	DDMMYYYY
Length:	8
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Period of leave

Collection

See Dates and Times, page 195.

See Periods of Leave, page 224.

Data Quality Checks

- 2200: [Leave To Date] & [Leave To Time] < [Admission Date] & [Admission Time], or [Leave To Date] & [Leave To Time] > [Separation Date] & [Separation Time]
- 2210: [Leave From Date] and/or [Leave To Date] format is INVALID, or [Leave To Date] < [Leave From Date]
- 2230: [Leave To Date] format is INVALID
- 4620: [Leave To Date] is valid, and [Leave To Time] is an invalid time or blank
- 4625: Length of leave of (> 7 consecutive days) NOT COMPATIBLE WITH [Legal Status] not (1)

[Leave To Time]

Identification

Technical name:	Patient's leave from service - time of resuming service, hhmm
APC data item:	74, 76, 78, 80
SAHMR identifier:	SA1121
Registration status:	SA Health, Standard 24/04/2013
Definition:	Time the patient returned from leave
Data element concept:	Patient's leave from service - Time of resuming service

Value domain

Class:	Date/Time
Type:	Time
Format:	DDMMYYYY
Length:	8
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Period of leave

Collection

See Dates and Times, page 195.

See Periods of Leave, page 224.

Data Quality Checks

- 2200: [Leave To Date] & [Leave To Time] < [Admission Date] & [Admission Time], or [Leave To Date] & [Leave To Time] > [Separation Date] & [Separation Time]
- 4620: [Leave To Date] is valid, and [Leave To Time] is an invalid time or blank

[Legal Status]

Identification

Technical name:	Patient - Mental Health Legal Status, code N
APC data item:	71
SAHMR identifier:	SA1626
Registration status:	SA Health, Candidate 01/07/2015
Definition:	Identify the patient's legal status when admitted
Data element concept:	Patient - Mental Health Legal Status

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Involuntary) 2 (Forensic) 3 (Voluntary) 4 (Involuntary Forensic)

Obligation

Class:	Mandatory
Dependency:	None

Collection

Certain legal statuses take precedence over others:

a) Involuntary Forensic
b) Forensic
c) Involuntary
d) Voluntary

For example:

a) Is the patient receiving treatment under Section 269 of the *Criminal Law Consolidation Act 1935* (SA), AND an Inpatient Treatment Order under the *Mental Health Act 2009* (SA)?
   - Yes: [Legal Status] must be 4 (Involuntary Forensic)
   - No: continue to (b)

b) Is the patient receiving treatment under Section 269 of the *Criminal Law Consolidation Act 1935* (SA)?
   - Yes: [Legal Status] must be 2 (Forensic)
   - No: continue to (c)

c) Is the patient receiving treatment due to an Inpatient Treatment Order under the *Mental Health Act 2009* (SA)?
   - Yes: [Legal Status] must be 1 (Involuntary)
   - No: continue to (d)

d) Is the patient is receiving treatment voluntarily?
   - Yes: [Legal Status] must be 3 (Voluntary)

1 (Involuntary)

Involuntary patients are on an Inpatient Treatment Order under the *Mental Health Act 2009* (SA) at any time during an episode of care.

Exclusions

This category excludes patients who are on both an order under Section 269 of the *Criminal Law Consolidation Act 1935* (SA) at any time during an episode of care, and an Inpatient Treatment Order under the Mental Health Act 2009 (SA) at any time during an episode of care.

2 (Forensic)

Forensic patients are on an order under Section 269 of the *Criminal Law Consolidation Act 1935* (SA) at any time during an episode of care.

Exclusions

This category excludes patients who are on both an order under Section 269 of the *Criminal Law Consolidation Act 1935* (SA) at any time during an episode of care, and an Inpatient Treatment Order under the Mental Health Act 2009 (SA) at any time during an episode of care.

3 (Voluntary)

All who are neither Involuntary nor Forensic are Voluntary.

4 (Involuntary Forensic)

Involuntary Forensic patients are on an Inpatient Treatment Order under the Mental Health Act 2009 (SA) at any time during an episode of care, and on an order under Section 269 of the Criminal Law Consolidation Act 1935 (SA) at any time during an episode of care.

Data Quality Checks

- 4220: [Legal Status] not (1, 2, 3 or 4)
- 4625: Length of leave of (> 7 consecutive days) NOT COMPATIBLE WITH [Legal Status] not (1)

[Marital Status]

Identification

Technical name:	Patient - marital status, code N
APC data item:	12
SAHMR identifier:	SA1109
Registration status:	SA Health, Standard 24/04/2013
Definition:	The nature of the patient's relationship status
Data element concept:	Patient - Marital status

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Never married) 2 (Married / De Facto) 3 (Widowed) 4 (Divorced) 5 (Separated) 9 (Unknown / Not stated)

Obligation

Class:	Mandatory
Dependency:	None

Collection

1 (Never married)

A person who has not entered into a couple relationship. If the patient is less than 16 years of age, then default to 1 (Never married).

2 (Married / De facto)

This refers to registered marriages and de facto marriages. Includes people who have been divorced or widowed but have since re-married, and should be generally accepted as applicable to all de facto couples, including couples of the same sex.

3 (Widowed)

This code usually refers to registered marriages but when self-reported may refer to de facto marriages.

4 (Divorced)

This code usually refers to registered marriages but when self-reported may refer to de facto marriages.

5 (Separated)

This code usually refers to registered marriages but when self-reported may refer to de facto marriages.

9 (Unknown / Not stated)

This code is not for use on primary collection forms. This code is primarily for use in administrative data sets when transferring data where the item has not been collected.

Data Quality Checks

- 4190: [Marital Status] not (1, 2, 3, 4, 5, or 9), and Age at admission of (≥ 16 years)
- 4190A: [Marital Status] not (1, 2, 3, 4, 5, or 9), and Age at admission of (< 16 years)

[Medicare Number]

Identification

Technical name:	Patient - Medicare number, identifier N(10)
APC data item:	4
SAHMR identifier:	SA1110
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient's Medicare number
Data element concept:	Patient - Medicare Number

Value domain

Class:	Identifier
Type:	Number
Format:	NNNNNNNNNN
Length:	10
Values:	Free text

Obligation

Class:	Mandatory
Dependency:	None

Collection

Most patients will have their Medicare cards, or will be able to obtain them within a few days of the admission. Every effort should be made to obtain the number. If the patient does not have a card, or a record of the number, the patient should be asked to arrange for a relative or friend to obtain the number.

See Medicare Number, page 216

Data Quality Checks

- 4380: [Medicare Number] of invalid format
- 4382: [Medicare Number IRN] not (1, 2, 3, 4, 5, 6, 7, 8, or 9), and [Medicare Number] not blank and not (0000000000, or 0000000009)
- 4382A: [Medicare Number IRN] not (0), and [Medicare Number] of (0000000000, or 0000000009)

[Medicare Number IRN]

Identification

Technical name:	Patient - Medicare Individual reference number, identifier N(1)
APC data item:	100
SAHMR identifier:	SA1374
Registration status:	None
Definition:	The patient's Medicare number Individual Reference Number
Data element concept:	Patient - Medicare Individual Reference Number

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	Free text

Obligation

Class:	Mandatory
Dependency:	None

Collection

See Medicare Number IRN, page 216

Data Quality Checks

- 4382: [Medicare Number IRN] not (1, 2, 3, 4, 5, 6, 7, 8, or 9), and [Medicare Number] not blank and not (0000000000, or 0000000009)
- 4382A: [Medicare Number IRN] not (0), and [Medicare Number] of (0000000000, or 0000000009)

[Mental Health Accommodation Prior]

Identification

Technical name:	Patient - mental health accommodation prior, code N
APC data item:	103
METeOR identifier:	647330
Registration status:	AIHW Health, Standard 05/10/2016
Definition:	The patient's prior accommodation status
Data element concept:	Patient – accommodation prior

Value domain

Class:	Code
Type:	Number
Format:	NN
Length:	2
Values:	00 (Unknown) 01 (Private residence) 02 (Boarding room house) 03 (Domestic scale supported living facility) 04 (Homeless: Homeless persons shelter) 05 (Homeless: Boarding room house) 06 (Homeless: No usual accommodation) 08 (Hospital: Psychiatric) 09 (Hospital: Other) 10 (Independent unit as part of retirement village or similar) 11 (Other supported accommodation) 12 (Palliative care facility / Hospice) 14 (Hostel or hostel type accommodation) 15 (Residential aged care facility: High) 16 (Residential aged care facility: Low) 17 (Shelter refuge: not including homeless persons shelter) 18 (Specialised alcohol/other drug treatment service) 19 (Specialised mental health community based residential support service) 20 (Other accommodation) 21 (Unable to determine) 22 (Prison) 23 (Remand) 24 (YTC)

Obligation

Class:	Conditional
Dependency:	Mandatory for:

	• Sunrise EMR psychiatric patients

Collection

This data item is submitted by Sunrise EMR sites only, and is collected for patients separated from designated mental health wards.

00 (Unknown)

A valid response was not provided.

01 (Private residence)

People who usually reside in a private residence (e.g. house, flat, unit, caravan, boat, including private and public rented homes).Includes caravans and boats used as a private residence.

02 (Boarding room house)

Boarding / Rooming houses do not require tenancy agreements; they may be single or shared rooms.

03 (Domestic scale supported living facility)

Domestic-scale supported living facility (e.g. group home for people with disability)**.**

04 (Homeless: Homeless persons shelter)

People who move frequently between various forms of temporary shelter e.g. friends, emergency accommodation, hostels and boarding houses.

05 (Homeless: Boarding room house)

People in marginal accommodation, who live in single rooms in private boarding or rooming houses, without their own bathroom, kitchen or security of tenure, on a medium or long term basis.

06 (Homeless: No usual accommodation)

People without conventional or usual accommodation, such as people living on the streets, sleeping in parks, squats, cars or makeshift dwellings for temporary shelter.

08 (Hospital: Psychiatric)

People who reside long term in a psychiatric health care facility.

09 (Hospital: Other)

People who reside long term in a non-psychiatric health care facility.

10 (Independent unit as part of retirement village or similar)

Includes independent units in a retirement village. Implies that the resident does not require full time care.

11 (Other supported accommodation)

Includes other supported accommodation facilities such as hostels for people with disability and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

12 (Palliative care facility / Hospice)

Facility providing palliative care.

14 (Hostel or hostel type accommodation)

Includes youth hostels.

15 (Residential aged care facility: High)

Includes nursing home beds in acute care hospitals

16 (Residential aged care facility: Low)

Includes nursing home beds in acute care hospitals

17 (Shelter refuge: not including homeless persons shelter)

A shelter facility which is not a homeless persons shelter.

18 (Specialised alcohol/other drug treatment service)

Includes alcohol/other drug treatment units in psychiatric hospitals.

19 (Specialised mental health community based residential support service)

Specialised mental health community-based residential support services are defined as community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.

20 (Other accommodation)

Other accommodation not elsewhere classified under the other domains. Includes: hotel/motel, specialised mental health community based residential support, shelter/refuge (other than homeless shelter or refuge).

21 (Unable to determine)

Details of type of usual accommodation could not be determined.

22 (Prison)

Includes Prisons but not including Remand centres and/or Youth Training centres.

23 (Remand)

Includes Remand centres but not including Prisons and/or Youth Training centres.

24 (YTC)

Includes Youth Training centres(YTC) but not including Prisons and/or Remand centres.

Data Quality Checks

- 4720: [Mental Health Accommodation Prior] not (00, 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23 or 24)

[Mental Health Linking Number]

Identification

Technical name:	Patient - mental health linking number, identifier N(10)
APC data item:	83
SAHMR identifier:	SA1112
Registration status:	SA Health, Standard 24/04/2013
Definition:	The state-wide mental health services number for the patient.
Data element concept:	Patient - Mental health linking number

Value domain

Class:	Identifier
Type:	Number
Format:	NNNNNNNNNN
Length:	10
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Psychiatric patients

Collection

Used to link mental health episodes of care.

Data Quality Checks

- 4640: [Hospital Number] not (0300), and [Mental Health Linking Number] = [Patient Unit Record Number] or is invalid format

[Nature Of Separation]

Identification

Technical name:	Patient's separation from service - nature of separation, code X
APC data item:	42
SAHMR identifier:	SA1086
Registration status:	SA Health, Standard 21/10/2011
Definition:	Nature of the patient’s discharge
Data element concept:	Patient's separation from service - Nature of separation

Value domain

Class:	Code
Type:	String
Format:	X
Length:	1
Values:	0 (Discharge on leave) 1 (Home) 2 (Other hospital: Up transfer) 3 (Residential aged care facility) 4 (Other health care accommodation) 5 (Died: No autopsy) 6 (Died: Autopsy) 7 (Other hospital: Down transfer) 8 (Self-discharge) 9 (Unknown) A (Administrative discharge) E (End of quarter reporting) X (Retrieval)

Obligation

Class:	Mandatory
Dependency:	None

Collection

0 (Discharge on leave)

Patients who were initially sent on leave, with medical approval for a period not greater than 7 consecutive days and there was an intent to return to hospital for continuation of care or treatment i.e. for a period less than 7 consecutive days e.g. 48 hours, but failed to return within 48 hours.

See Periods of Leave, page 224.

1 (Home)

Patient returning home or to their usual residence or being transferred to other facilities where health care is not available, including:

- Transferred to jail;
- Discharged to accommodation facilities that do not provide medical/nursing care i.e. backpackers hostels and hotels/motels.
- Discharged/transferred to a residential aged care facility if this is their usual residence.

Home excludes patients:

- Discharged to a residential aged care facility for the first time (i.e. not their usual place of residence).

2 (Other hospital: Up transfer)

Patient transferred to another hospital for the purpose of receiving an equivalent or increased level of care relative to that just received.

See Inter-Hospital Transfer page 212.

3 (Residential aged care facility or hostel)

Patient discharged to a residential aged care facility or hostel (which is not the patient's usual residence) providing medical or nursing care.

See Residential Aged Care Facility or Hostel, page 228.

4 (Other health care accommodation)

Patient discharged to other accommodation providing medical/nursing care not specified in other Nature of Separation categories.

5 (Died: No autopsy)

Patient who died in hospital and no autopsy will be/was performed.

Use this category if you do not know whether an autopsy is being performed.

6 (Died: Autopsy)

Patient who died in hospital and an autopsy will be/was performed.

7 (Other hospital: Down transfer)

Patient transferred to another hospital for the purpose of receiving a reduced level of care relative to that just received.

See Inter-Hospital Transfer, page 212.

8 (Self-Discharge)

Patient who has discharged themselves or left against medical advice, including missing or absconded patient.

9 (Unknown)

When it is unknown to where the patient is discharged. There should be minimal incidents of this category.

A (Administrative Discharge)

Used for an Administrative change between [Episode Of Care] types; not a formal separation.

See Administrative Separation and Administrative Admissions, page 186.

E (End of Quarter Reporting)

Used for End of quarter reporting purposes; not a formal separation.

See End of Quarter Reporting, page 200.

X (Retrieval)

A specialist team used to transport a seriously ill or injured patient.

See Retrieval, page 229.

Data Quality Checks

- 2080: [Nature Of Separation] not (0, 1, 2, 3, 4, 5, 6, 7, 8, 9, A, E, F, G, H, I, J, K, or X)
- 2085: [Episode Of Care] of (7) NOT COMPATIBLE WITH [Nature Of Separation] of (0, 3, 4, A, E, or X)
- 2695: [Episode Of Care] of (2), [Separation Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Separation Time] of (2358) REQUIRES [Nature Of Separation] of (E)
- 2700: [Episode Of Care] of (2), [Separation Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Nature Of Separation] of (E) REQUIRES [Separation Time] of (2358)
- 2705: [Episode Of Care] of (2), and [Nature Of Separation] of (E) REQUIRES [Separation Date] of (YYYY0331, YYYY0630, YYYY0930, or YYYY1231)
- 2720: [Referral For Further Health Care] of (07) REQUIRES [Nature Of Separation] of (A)
- 2745: [Episode Of Care] of (P) REQUIRES [Nature Of Separation] of (5, or 6)
- 2750: [Episode Of Care] of (5, 6, 7, 8, or L) NOT COMPATIBLE WITH [Referral For Further Health Care] of (07) and [Nature Of Separation] of (A)
- 4000: Principal [Procedure] may be INVALID for same day inpatient episodes (may violate Technical Bulletins 28 or 29); CONSIDER replacing inpatient record with outpatient record
- 4005: [Principal Diagnosis] or [Additional Diagnosis] in system reference table with [Death Diagnosis Flag] of (Y) REQUIRES [Nature Of Separation] of (5, or 6)
- 4013: [Referral For Health Care] of (21 or 24) NOT COMPATIBLE WITH [Nature of Separation] of (1, or 3)
- 4240: [Nature Of Separation] of (2, 5, 6, 7, or E), and [Referral For Further Health Care] not (01)
- 4260: [Nature Of Separation] not (2, 7, or X)
- 4270: [Nature Of Separation] of (2, 7, or X) REQUIRES [Hospital Transferred To]
- 4740: [Source Of Referral] of (E) or [Nature Of Separation] of (E) NOT COMPATIBLE WITH [Hospital Number] of (≥ 4000 and ≤ 4999)
- 4985: [Episode Of Care] of (5) NOT COMPATIBLE WITH [Nature Of Separation] of (5, or 6)
- 4995: [Nature Of Separation] of (0) REQUIRES [Leave From Date]

[OACIS Linking Variable]

Identification

Technical name:	Patient - OACIS linking variable, identifier N(10)
APC data item:	84
SAHMR identifier:	SA1114
Registration status:	SA Health, Standard 24/04/2013
Definition:	The Open Architecture Clinical Information System (OACIS) number for the patient
Data element concept:	Patient - OACIS identifier

Value domain

Class:	Identifier
Type:	Number
Format:	NNNNNNNNNN
Length:	10
Values:	Free text

Obligation

Class:	Optional
Dependency:	None

Collection

An identifier to link [Patient Unit Record Number] to OACIS.

Data Quality Checks

- None

[Patient Category]

Identification

Technical name:	Patient admission - admission intention (stay type), code N
APC data item:	14
SAHMR identifier:	SA1074
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient admission intention to stay for same day or overnight
Data element concept:	Patient admission - Admission intention - stay type

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Overnight stay) 2 (Day only: Type C exclusion list) 3 (Boarder) 4 (Day only: Type B band)

Obligation

Class:	Mandatory
Dependency:	None

Collection

1 (Overnight stay)

A person admitted for treatment for a minimum of one night.

See Overnight Stay, page 222.

2 (Day only: Type C exclusion list)

A same day patient who received professional attention according to the Day Only Type C exclusion list.

See Same-day Patient, page 230.

3 (Boarder)

A Boarder is any person who receives food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

See Boarder, page 189.

4 (Day only: Type B band)

A same day patient who received professional attention according to the Day Only Type B bands.

See Same-day Patient, page 230.

Data Quality Checks

- 1310: [Patient Category] of (3), or [Principal Diagnosis] of (Z763, or Z764), or [Additional Diagnosis] of (Z763, or Z764)
- 4390: [Patient Category] not (1, 2, or 4), and [Admission Date] ≠ [Separation Date]
- 4390A: [Patient Category] not (1, 2, or 4), and [Admission Date] = [Separation Date]

[Patient Unit Record Number]

Identification

Technical name:	Patient admission - patient unit record number, identifier N(10)
APC data item:	3
SAHMR identifier:	SA1078
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient's Unit Record Number
Data element concept:	Patient admission - Patient unit record number

Value domain

Class:	Identifier
Type:	Number
Format:	NNNNNNNNNN
Length:	10
Values:	Free text

Obligation

Class:	Mandatory
Dependency:	None

Collection

Upon first admission to a hospital, a patient is assigned a unique [Patient Unit Record Number] for that hospital.

The same patient [Patient Unit Record Number] is used for subsequent readmissions to that hospital.

A [Patient Unit Record Number] must not be reused for another patient.

See Patient number, page 223.

Data Quality Checks

- 4570: [Contracted Service Hospital Number] = [Hospital Number] AND [Contracted Service Patient Unit Record Number] = [Patient Unit Record Number]
- 4640: [Hospital Number] not (0300), and [Mental Health Linking Number] = [Patient Unit Record Number] or is invalid format

[Pension Status]

Identification

Technical name:	Patient - pension status, code N
APC data item:	89
SAHMR identifier:	SA1115
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient's pension status
Data element concept:	Patient - Pension status

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	0 (Not applicable) 1 (DHS: Age pension) 2 (DVA: Any payment) 3 (DHS: Disability support pension) 4 (DHS: Newstart / Youth allowance) 5 (DHS: Sickness allowance) 9 (Other / Unknown)

Obligation

Class:	Conditional
Dependency:	Mandatory for psych patients at hospitals: • Flinders Medical Centre • Glenside Health Services • James Nash House • Lyell McEwin Health Service • Modbury Hospital • Mount Gambier and Districts Health Service • Noarlunga Mental Health Service • Repatriation General Hospital • Riverland General Hospital • Royal Adelaide Hospital • The Queen Elizabeth Hospital • Whyalla Hospital and Health Service • Women's and Children's Hospital

Collection

Additional Notes

The collection of this data item is mandatory for hospitals with a designated psychiatric unit. To date these are:

- Flinders Medical Centre
- Glenside Health Services
- Lyell McEwin Health Service
- Modbury Hospital
- Mount Gambier and Districts Health Service
- Noarlunga Health Service
- Repatriation General Hospital
- Riverland General Hospital
- Royal Adelaide Hospital
- The Queen Elizabeth Hospital
- Women's and Children's Hospital
- Whyalla Hospital and Health Service

It is optional for hospitals not included in the above list to collect and report this data item.

Record the appropriate value as reported by the patient.

If the patient receives more than one pension type, select the highest level pension type.

0 (Not applicable)

Patient receives no welfare payment from either:

- the Department of Human Services
- the Department of Veteran's Affairs
- an overseas pension

1 (DHS: Age pension)

Patient receives from the Department of Human Services:

- Age Pension

2 (DVA: Any payment)

Patient receives from the Department of Veteran's Affairs:

- Age service pension
- Invalidity service pension
- Partner service pension
- Service pension
- Veteran payment

3 (DHS: Disability support pension)

Patient receives from the Department of Human Services:

- Disability Support Pension

4 (DHS: Newstart / Youth allowance)

Patient receives from the Department of Human Services:

- Newstart allowance
- Youth allowance for job seekers

5 (DHS: Sickness allowance)

Patient receives from the Department of Human Services:

- Sickness Allowance

9 (Other / Unknown)

Patient receives from the Department of Human Services:

- Assistance for isolated children scheme
- Austudy
- ABSTUDY
- Carer allowance
- Carer payment
- Farm household allowance
- Parenting payment
- Youth allowance for students and Australian apprentices

Patient receives:

- Pension from overseas

Data Quality Checks

- 4770: [Pension Status] not (0, 5, or 9)

[Place Of Occurrence]

Identification

Technical name:	Event leading to hospitalisation - place of occurrence, code AN[NNN]
APC data item:	94
METeOR identifier:	746661
Registration status:	Health, Standard 20/10/2021
Definition:	The place where the external cause of injury, poisoning or adverse effect occurred, as represented by a code.
Data element concept:	Event leading to hospitalisation - place of occurrence, code AN[NNN]

Value domain

Class:	Code
Type:	String
Format:	AN[NNN]
Length:	5
Values:	Reference file

Obligation

Class:	Conditional
Dependency:	Mandatory for records supplied with: • [Activity When Injured] • [External Cause]

Collection

[Place Of Occurrence]:

- Is an ICD-10-AM (12th Edition) diagnosis code from range Y9200-Y9299
- Submitted with [Activity When Injured] and [External Cause]
- May be assigned multiple times to a record
- May not be duplicated
- This code must be used in conjunction with an injury, poisoning or other adverse effect code and can be used with other ICD-10-AM disease codes.
- External cause codes in the range V00 to Y89 must be accompanied by a place of occurrence code

The first [Place Of Occurrence] code must be reported as [Place Of Occurrence]; additional [Place Of Occurrence] codes are reported in [Additional Diagnosis].

See Diagnosis and Procedure Codes, page 198.

Data Quality Checks

- 2680: [Place Of Occurrence] is not blank, or not (Y9200-Y929)

- 4900: Duplicate Diagnosis code from [Principal Diagnosis], [Additional Diagnosis], [External Cause], [Place Of Occurrence], and/or [Activity When Injured] DELETES duplicate Diagnosis code
- 4940: [Place Of Occurrence] of (Y9200-Y929) REQUIRES [External Cause]
- 4950: Place Of Occurrence = Y9200-Y929 and [External Cause] or [Additional Diagnosis] not (V0000-Y899)
- 4960: [Place Of Occurrence] not (Y9200-Y929), and [External Cause] or [Additional Diagnosis] not (V0000-Y899)

[Postcode]

Identification

Technical name:	Patient - home postcode, code NNNN
APC data item:	6
SAHMR identifier:	SA431
Registration status:	SA Health, Standard 01/07/1985
Definition:	The postcode of the patient's home address
Data element concept:	Patient - Home postcode

Value domain

Class:	Code
Type:	Number
Format:	NNNN
Length:	4
Values:	Reference file

Obligation

Class:	Mandatory
Dependency:	None

Collection

See Locality, page 215.

Data Quality Checks

- 2612: [Funding Source] (04) REQUIRES Statistical Area Level 2 not BLANK; check [Suburb / Locality] and/or [Postcode]
- 4010: [Postcode] not in system reference table
- 4015: [Suburb / Locality] and [Postcode] combination not in system reference table

Reference file

- **Admitted Activity Reference Table - Locality** available from:

  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

[Preferred Language]

Identification

Technical name:	Preferred language, code NNNN
APC data item:	105
SAHMR identifier:	None
Registration status:	SA Health, Standard 25/01/2018
Definition:	The language the patient prefer to communicate
Data element concept:	Person – preferred language

Value domain

Class:	Code
Type:	Number
Format:	NNNN
Length:	4
Values:	Reference file

Obligation

Class:	Optional
Dependency:	None

Collection

The Australian Standard Classification of Languages 2016 (ASCL) has a three-level hierarchical structure. Languages are represented by four-digit codes. This may be a language other than English even where the person can speak fluent English.

Reference file:

- **Admitted Activity Reference Table - Language** available from:

  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Data Quality Checks

- 4725: [Preferred Language] not in system reference table

[Previous Specialised Treatment]

Identification

Technical name:	Patient - previous specialised treatment, code N
APC data item:	101
METeOR identifier:	270374
Registration status:	AIHW Health, Standard 01/03/2005
Definition:	The previous admission(s) or service contact(s) for the specialised treatment provided to the patient
Data element concept:	Patient - previous specialised treatment

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (None) 2 (Hospital admission(s)) 3 (Service contact(s)) 4 (Both) 5 (Unknown / Not stated)

Obligation

Class:	Conditional
Dependency:	None

Collection

1 (None)

Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided.

2 (Hospital admission(s))

Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided.

3 (Service contact(s))

Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided.

4 (Both)

Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided.

5 (Unknown / Not stated)

Use this category if the previous specialised treatment category for the patient cannot be accurately established (not stated).

Data Quality Checks

- 4755: [Previous Specialised Treatment] not (0, 1, 2, 3, 4, 5, or blank)

[Principal Diagnosis]

Identification

Technical name:	Patient - diagnosis type, code AN[NNN]
APC data item:	45
SAHMR identifier:	SA1097
Registration status:	SA Health, Standard 24/04/2013
Definition:	The main diagnosis made for the patient
Data element concept:	Patient - Diagnosis type - principal

Value domain

Class:	Code
Type:	String
Format:	AN[NNN]
Length:	5
Values:	Per ICD-10-AM 12th Edition reference data

Obligation

Class:	Mandatory
Dependency:	None

Collection

See Diagnosis and Procedure Codes, page 198.

Data Quality Checks

- 1310: [Patient Category] of (3), or [Principal Diagnosis] of (Z763, or Z764), or [Additional Diagnosis] of (Z763, or Z764)
- 2079: [Additional Diagnosis] (U073, or U074) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U075), or [Additional Diagnosis] (U073, or U074)
- 2081: [Additional Diagnosis] of (B948) NOT COMPATIBLE WITH [Additional Diagnosis] (U074)
- 2082: [Principal Diagnosis] or [Additional Diagnosis] of (B342) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] (U0711, U0712 or U072)
- 2083: [Principal Diagnosis] or [Additional Diagnosis] of (U0711, U0712, or U072) NOT COMPATIBLE WITH [Additional Diagnosis] or [Principal Diagnosis] (U075)
- 2084: [Principal Diagnosis] or [Additional Diagnosis] of (M303) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U075)
- 2086: [Principal Diagnosis] or [Additional Diagnosis] of (U0711, U0712, or U072) NOT COMPATIBLE with [Principal Diagnosis] or [Additional Diagnosis] of (Z0381)
- 2087: [Principal Diagnosis] or [Additional Diagnosis] of (U0711 or U0712) NOT COMPATIBLE with [Principal Diagnosis] or [Additional Diagnosis] of (U072)

- 2088: [Principal Diagnosis] or [Additional Diagnosis] of (O000 to O984) or (O986 to O998), and [Additional Diagnosis] of (U0711, U0712 or U072) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O985)
- 2091: [Principal Diagnosis] of (O422) NOT COMPATIBLE WITH [Additional Diagnosis] of (O4211, or O4212), or [Principal Diagnosis] of (O4211, or O4212) NOT COMPATIBLE WITH [Additional Diagnosis] of (O422)
- 2093: [Principal Diagnosis] or [Additional Diagnosis] of (O80-O83) REQUIRES [Additional Diagnosis] of (Z370-Z371)
- 2094: [Additional Diagnosis] of (Z370-Z371) REQUIRES [Principal Diagnosis] of (O040-O049, or O80-O83), or [Additional Diagnosis] of (O80-O83)
- 2095: [Additional Diagnosis] of (Z370-Z371) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O300-O309, or O840-O849)
- 2097: [Additional Diagnosis] of (Z372-Z377] REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O840-O849)
- 2098: [Additional Diagnosis] of (Z372-Z377) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O80-O83)
- 2099: [Additional Diagnosis] of (Z370-Z374) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O301-O309)
- 2105: [Additional Diagnosis] of (Z370-Z371, or Z375-Z377) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O661)
- 2106: [Additional Diagnosis] of (Z370-Z371) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O632)
- 2111: [Additional Diagnosis] of (Z370-Z371, or Z375-Z377) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (O300)
- 2112: [Principal Diagnosis] or [Additional Diagnosis] of (O80 or O840) NOT COMPATIBLE WITH [Procedure] from (Block 1337, Block 1338, Block 1339 (except 9047200), Block 1340, Block 1341, Block 1342, Block 1343, or 9048200)
- 2113: [Principal Diagnosis] or [Additional Diagnosis] of (O81, or O841) REQUIRES [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9047002, or 9047004)
- 2114: [Principal Diagnosis] or [Additional Diagnosis] of (O81, or O841) NOT COMPATIBLE WITH [Procedure] from (9046803, 9047001, 9047003, 9047702, Block 1336, or Block 1340)
- 2115: [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9047002, or 9047004) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O81, O841, or O8482)
- 2116: [Principal Diagnosis] or [Additional Diagnosis] of (O82, or O842) REQUIRES [Procedure] from (Block 1340)
- 2117: [Principal Diagnosis] or [Additional Diagnosis] of (O82, or O842) NOT COMPATIBLE WITH [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9048200, Block 1336 or Block 1339)
- 2118: [Procedure] from (Block 1340) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O82, O842, or O8482)
- 2163: [Principal Diagnosis] or [Additional Diagnosis] of (O00-O998, or Z340-Z349) NOT COMPATIBLE WITH [Additional Diagnosis] of (Z33)

- 2164: [Principal Diagnosis] or [Additional Diagnosis] of (O00-O998, Z33 or Z340-Z349) NOT COMPATIBLE WITH [Additional Diagnosis] of (Z340-Z349)
- 2285: [Funding Source] of (04) AND [Episode of Care] of (1) for [Hospital Number] of (< 4000) NOT COMPATIBLE WITH [Principal Diagnosis] (Z742)
- 2500: [Principal Diagnosis] is INVALID, not a [Diagnosis] code
- 2500A: [Principal Diagnosis] is blank
- 2510: [Hospital Number] of (< 4000), and [Principal Diagnosis] contains [Diagnosis] in system reference table with [Unacceptable Diagnosis Flag] of (1) = Unacceptable Principal Diagnosis
- 2511: [Hospital Number] of (< 4000), and [Principal Diagnosis] or [Additional Diagnosis] contains [Diagnosis] in system reference table with [Unacceptable Diagnosis Flag] of (2)
- 2531: [Principal Diagnosis] or [Additional Diagnosis] of (O83, or O0841) NOT COMPATIBLE WITH [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9047002, 9047004, Block 1336, or Block 1340)
- 2583: Age at admission of (> 28 days) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 2747: [Principal Diagnosis] or [Additional Diagnosis] of (Z525 or Z527) REQUIRES [Episode Of Care] of (P)
- 2753: Non-emergency selected same day scope procedures where no general anaesthetic is administered are INVALID inpatient admissions; REPLACE inpatient admission with an outpatient occasion of service
- 2754: Non-emergency same day chemotherapy procedures where no general anaesthetic is administered are INVALID inpatient episodes for funding
- 2774: [Additional Diagnosis] of (B972) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U0711, U0712, or U072)
- 2775: [Principal Diagnosis] or [Additional Diagnosis] of (U049) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U0711, U0712, U072 or B342)
- 2776: [Principal Diagnosis] or [Additional Diagnosis] of (U0711) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U0712)
- 2777: [Principal Diagnosis] or [Additional Diagnosis] of (Z115) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (Z0381 or Z110)
- 2778: [Principal Diagnosis] or [Additional Diagnosis] of (Z2081) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (U0711, U0712, or U072)
- 2779: [Principal Diagnosis] or [Additional Diagnosis] of (Z252) REQUIRES [Procedure] from 9215703-9215706
- 4002: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (Z491), and [Admission Category] not (4)
- 4003: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (Z511 or Z2921) and [Admission Category not (4)
- 4004: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (Z510) and not (Z491, or Z511), and [Admission Category] not (4)
- 4005: [Principal Diagnosis] or [Additional Diagnosis] in system reference table with [Death Diagnosis Flag] of (Y) REQUIRES [Nature Of Separation] of (5, or 6)
- 4006: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (O80, or O840) and not (Z491, Z510, or Z511), AND [Admission Category] not (4)

- 4007: [Source Of Referral] not (A, or E), [Principal Diagnosis] not (O80, O840, Z491, Z510, or Z511), [Episode Of Care] of (5), and [Admission Category] not (4)
- 4008: [Source Of Referral] not (4, A, E, or X), [Principal Diagnosis] not (O80, O840, Z491, Z510, or Z511), [Episode Of Care] not (5), [Admission Date] = [Date Of Birth], and [Admission Category] not (4)
- 4040: [Principal Diagnosis] or [Additional Diagnosis] of (Z511 or Z2921) REQUIRES [Additional Diagnosis] of (C000-D489)
- 4041: Voluntary Assisted Dying flag code (Z01.9 or Z41.9) used
- 4051: [Episode Of Care] of (P) REQUIRES [Principal Diagnosis] of (Z5200-Z529)
- 4055: [Episode Of Care] of (2) REQUIRES [Principal Diagnosis] of (Z750-Z759) for [Hospital Number] of (0003-0306)
- 4056: [Principal Diagnosis] of (Z750-Z759) REQUIRES [Episode Of Care] of (2) for [Hospital Number] in (0003-0300)
- 4060: [Additional Diagnosis] of (Z500-Z501, or Z504-Z509) NOT COMPATIBLE WITH [Principal Diagnosis] of (Z540-Z549)
- 4066: [Principal Diagnosis] or [Additional Diagnosis] of (Z511 or Z2921) INVALID WITH [Admission Date] <>[Separation Date]
- 4070: [Principal Diagnosis] or [Additional Diagnosis] of (G300-G309) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (F0000-F0091)
- 4075: [Additional Diagnosis] of (Z511 or Z2921) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4080: [Principal Diagnosis] or [Additional Diagnosis] of (F0000-F0091) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (G300-G309)
- 4085: [Principal Diagnosis] of (Z510) NOT COMPATIBLE WITH [Admission Date] ≠ [Separation Date]
- 4087: [Additional Diagnosis] of (U0770-U0774) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (T800-T809)
- 4090: [Procedure] from (4178900, or 4178901) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (J030-J039)
- 4091: [Principal Diagnosis] or [Additional Diagnosis] of (J450-J459, or J46) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] (J450-J459, or J46)
- 4095: [Additional Diagnosis] of (Z510) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4105: [Additional Diagnosis] of (Z491, or Z492) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when Length of stay = 1 day
- 4110: [Additional Diagnosis] of (A090-A099, or K520-K529) SHOULD BE [Principal Diagnosis] with [Additional Diagnosis] of (E86)
- 4115: [Principal Diagnosis] of (Z491, or Z492) NOT COMPATIBLE WITH Length of stay of (> 1 day)
- 4125: [Principal Diagnosis] or [Additional Diagnosis] of (Z491, or Z492) REQUIRES [Additional Diagnosis] of (Z530-Z539) or [Procedure] from (Block 1060, or Block 1061)
- 4130: [Principal Diagnosis] or [Additional Diagnosis] of (Z490-Z492) DOES NOT REQUIRE [Additional Diagnosis] of (Z992)

- 4140: [Principal Diagnosis] or [Additional Diagnosis] of (S0600, or S099) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (S0601-S0604)
- 4145: [Principal Diagnosis] or [Additional Diagnosis] of (C770-C799) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (C000-C768, or C800-C809)
- 4146: [Principal Diagnosis] or [Additional Diagnosis] of (C770-C809) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (C810-C8891)
- 4165: [Hospital Number] of (0001-0500), [Episode Of Care] of (5, or 6), [Date Of Birth] = [Admission Date], and [Source Of Referral] not (4, X) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 4185: [Principal Diagnosis] or [Additional Diagnosis] of (O000-O079, O200, O470, O600-O603, or O364) REQUIRES [Additional Diagnosis] of (O090-O099)
- 4200: [Principal Diagnosis] of (Z312) REQUIRES [Procedure] from (Block 1297)
- 4201: [Principal Diagnosis] of (Z310-Z313), and [Additional Diagnosis] not (Z530-Z539) REQUIRES [Procedure]
- 4203: [Principal Diagnosis] of (Z5181), and [Additional Diagnosis] not (Z530-Z539) REQUIRES [Admission Date] = [Separation Date]
- 4204: [Additional Diagnosis] of (Z5181), and [Additional Diagnosis] not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4225: [Principal Diagnosis], [Additional Diagnosis], or [External Cause] contains [Diagnosis] in system reference table with [Rare Diagnosis] of (1)
- 4235: [Principal Diagnosis] or [Additional Diagnosis] of (I500, or I501) DOES NOT REQUIRE [Additional Diagnosis] of (I500, or I501)
- 4237: [Principal Diagnosis] or [Additional Diagnosis] of (Z450) NOT COMPATIBLE WITH [Additional Diagnosis] of (Z950)
- 4245: [Principal Diagnosis] or [Additional Diagnosis] of (I500, or J81) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] (I500, or J81)
- 4246: [Principal Diagnosis] of (I501, or J81) DOES NOT REQUIRE [Additional Diagnosis] of (I501, or J81)
- 4276: [Additional Diagnosis] of (T203, T2130-T2139, T2230-T2232, T233, T243, T253, T293, or T303) MUST BE SEQUENCED BEFORE [Principal Diagnosis] of (T200-T202, T2100-T2129, T2200-T2222, T230-T232, T240-T242, T250-T252, T290-T292, or T300-T302)
- 4285: [Principal Diagnosis] or [Additional Diagnosis] of (T200-T253, T290-T293, or L550-L559) REQUIRES [Additional Diagnosis] of (T3100-T3199)
- 4295: [Additional Diagnosis] of (T3100-T3199) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (T200-T253, T290-T293, or L550-L559)
- 4305: [Principal Diagnosis] or [Additional Diagnosis] of (T360-T509) NOT COMPATIBLE WITH [External Cause] or [Additional Diagnosis] of (Y400-Y599)
- 4315: [Principal Diagnosis] or [Additional Diagnosis] (R400-R402) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] (S0000-S099)
- 4341: [Admission Weight] of (> 499 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0701)
- 4342: [Admission Weight] of (< 500, or > 749 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0702)

- 4343: [Admission Weight] of (< 750, or > 999 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0703)
- 4344: [Admission Weight] of (< 1000, or > 1249 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0711)
- 4346: [Admission Weight] of (< 1250, or > 1499) grams NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0712)
- 4347: [Admission Weight] of (< 1500, or > 2499 grams) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (P0713)
- 4425: [Hospital Number] of (>= 4302), and [Principal Diagnosis] contains [Diagnosis] in system reference table with [Unacceptable Diagnosis Flag] of (1) = Unacceptable Principal Diagnosis
- 4426: [Hospital Number] of (>= 4302), and [Principal Diagnosis] or [Additional Diagnosis] contains [Diagnosis] in system reference table with [Unacceptable Diagnosis Flag] of (2) = Unacceptable Diagnosis
- 4430: [Principal Diagnosis] of (N320) and [Additional Diagnosis] of (N40) MUST BE [Principal Diagnosis] of (N40) and [Additional Diagnosis] of (N320)
- 4440: [Principal Diagnosis] or [Additional Diagnosis] of (E1011–E149) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (R73)
- 4600: [Principal Diagnosis] or [Additional Diagnosis] of (E0921-E099) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (E1001-E149)
- 4641: [Clinical Unit] of (78, 79, 80, 85, 86, or 95), or [Principal Diagnosis] in system reference table with [Mental Health Diagnosis Flag] of (Y) REQUIRES [Episode Of Care] of (I, J, K, or L)
- 4643: [Episode Of Care] of (I, J, K, or L) REQUIRES [Clinical Unit] of (78, 79, 80, 85, 86, or 95), or [Principal Diagnosis] in system reference table with [Mental Health Diagnosis Flag] of (Y)
- 4648: [Principal Diagnosis] of (Z718) DOES NOT REQUIRE [Additional Diagnosis] of (E1001-E149)
- 4649: [Principal Diagnosis] of (E1001-E149) and [Additional Diagnosis] of (Z718) REQUIRES [Procedure] from (9555014)
- 4650: [Principal Diagnosis] or [Additional Diagnosis] of (E1000-E1099) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (E1100-E1199, E1300-E1399, E1400-E1499, or O2440-O2449)
- 4651: [Principal Diagnosis] or [Additional Diagnosis] of (E1100-E1199) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (E1000-E1099, E1300-E1399, E1400-E1499, or O2440-O2449)
- 4652: [Principal Diagnosis] or [Additional Diagnosis] of (E1300-E1399) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (E1000-E1099, E1100-E1199, E1400-E1499, or O2440-O2449)
- 4653: [Principal Diagnosis] or [Additional Diagnosis] of (E1400-E1499) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (E1000-E1099, E1100-E1199, E1300-E1399, or O2440-O2449)
- 4654: [Principal Diagnosis] or [Additional Diagnosis] of (O2440-O2449) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (E1000-E1099, E1100-E1199, E1300-E1399, or E1400-E1499)
- 4655: [Principal Diagnosis] or [Additional Diagnosis] of (S1410-S1413) REQUIRES [Additional Diagnosis] from (S1470-S1478, or S2470-S2477)

- 4656: [Principal Diagnosis] or [Additional Diagnosis] of (S2410-S2412) REQUIRES [Additional Diagnosis] of (S2470-S2477, or S3470-S3476)
- 4657: [Principal Diagnosis] or [Additional Diagnosis] of (S341) REQUIRES [Additional Diagnosis] of (S3470-S3476)
- 4662: [Additional Diagnosis] of (B230, R75, or Z21) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (B20, B21, B22, B238, B24, R75, or Z21)
- 4664: [Principal Diagnosis] or [Additional Diagnosis] of (B21) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (C000-C969)
- 4665: [Principal Diagnosis] of (Z080-Z089) NOT COMPATIBLE WITH [Additional Diagnosis] of (C000-C969)
- 4666: [Principal Diagnosis] of (O040-O049) IS RARE WITH [Additional Diagnosis] of (O093, or O094)
- 4667: [Principal Diagnosis] of (I460-I469) SHOULD NOT BE [Principal Diagnosis] if the underlying cause is known
- 4668: [Principal Diagnosis] or [Additional Diagnosis] of (D683, or R7983) DOES NOT REQUIRE [Additional Diagnosis] of (Z921)
- 4669: [Principal Diagnosis] or [Additional Diagnosis] of (B150-B199, or O984) DOES NOT REQUIRE [Additional Diagnosis] of (B942)
- 4791: [Additional Diagnosis] of (Z940) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (N183, N184, N185, or I120)
- 4793: [Principal Diagnosis] or [Additional Diagnosis] of (I129, I130, or I139) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (N181-N184, or N189)
- 4794: [Additional Diagnosis] of (Z992) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (N185, or I120)
- 4795: [Principal Diagnosis] or [Additional Diagnosis] of (I120, or I131) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (N181-N189)
- 4796: [Principal Diagnosis] or [Additional Diagnosis] of (N185) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (I129, I130, or I139)
- 4800: [Sex] from patient record NOT COMPATIBLE WITH [Sex] in system reference table with [Sex Flag] of (1) for [Principal Diagnosis] or [Additional Diagnosis]
- 4810: Age at admission NOT COMPATIBLE WITH [Age Range] in system reference table for [Principal Diagnosis] or [Additional Diagnosis]
- 4811: [External Cause] or [Additional Diagnosis] of (Y900-Y908) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (F100-F102, or T510)
- 4812: [Principal Diagnosis] or [Additional Diagnosis] of (F101) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (F102-F109)
- 4814: [Principal Diagnosis] or [Additional Diagnosis] of (F111) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (F112–F119)
- 4816: [Principal Diagnosis] or [Additional Diagnosis] of (F121) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (F122–F129)
- 4818: [Principal Diagnosis] or [Additional Diagnosis] of (F171) DOES NOT REQUIRE [Principal Diagnosis] or [Additional Diagnosis] of (F172–F179)
- 4819: [Principal Diagnosis] or [Additional Diagnosis] of (F171, or F172) DOES NOT REQUIRE [Additional Diagnosis] of (Z587, Z720, or Z8643)

- 4824: [Episode Of Care] of (7) NOT COMPATIBLE WITH [Source Of Referral] not (A) and [Principal Diagnosis] of (Z519)
- 4834: [Principal Diagnosis] or [Additional Diagnosis] of (D63) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (A188, A527, B54, B700, B769, or E039)
- 4840: [Principal Diagnosis] or [Additional Diagnosis] is [Diagnosis] in system reference table with [External Cause Flag] of (Y) REQUIRES [External Cause]
- 4890: ([Principal Diagnosis] or [Additional Diagnosis] of (O601-O603, O620-O879, or O900-O909), or [Procedure] from (Block 1336–1340, Block 1343-1344, Block 1346-1347)) REQUIRES [Additional Diagnosis] from (Z370-Z379, or Z3900-Z392)
- 4891: [Principal Diagnosis] or [Additional Diagnosis] of (O600) DOES NOT REQUIRE [Additional Diagnosis] of (Z370-Z379)
- 4892: [Principal Diagnosis] or [Additional Diagnosis] of (O600) DOES NOT REQUIRE [Additional Diagnosis] of (Z3900-Z392)
- 4893: [Procedure] from (1657300, or 9048100) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O700-O709)
- 4895: [Principal Diagnosis] or [Additional Diagnosis] of (O700-O709) REQUIRES [Procedure] from (1657300, 9047200, or 9048100)
- 4897: [Principal Diagnosis] or [Additional Diagnosis] of (O601-O759, O85-O879, or O900-O909) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O80-O849, or Z3900-Z3903)
- 4898: [Additional Diagnosis] of (Z370-Z379) REQUIRES [Principal Diagnosis] of (O040-O049, or O80-O849), or [Additional Diagnosis] of (O80-O849)
- 4900: Duplicate Diagnosis code from [Principal Diagnosis], [Additional Diagnosis], [External Cause], [Place Of Occurrence], and/or [Activity When Injured] DELETES duplicate Diagnosis code
- 4904: [Principal Diagnosis] or [Additional Diagnosis] of (O80, or O840) REQUIRES [Procedure] Code Block 1336
- 4905: [Principal Diagnosis] or [Additional Diagnosis] of (O757) NOT COMPATIBLE WITH [Procedure] from (1652000, 1652001, 1652002, 1652003, 1652004, or 1652005)
- 4906: [Principal Diagnosis] or [Additional Diagnosis] of (O83, or O8481) REQUIRES [Procedure] from (9046803, 9046805, 9046901, 9047001, 9047003, 9047300, 9047400, 9047500, 9047600, 9047700, 9047702, 9048200, 1651400, or Block 1342)
- 4907: [Principal Diagnosis] or [Additional Diagnosis] of (O8482) REQUIRES one procedure from each of Blocks (1336 & 1337, 1336 & 1338, 1336 & 1339, 1336 & 1340, 1337 & 1338, 1337 & 1339, 1337 & 1340, 1338 & 1339, 1338 & 1340, or 1339 & 1340)
- 4968: [Condition Onset Flag] for [Principal Diagnosis] or [Additional Diagnosis] SHOULD BE (1) for [Principal Diagnosis] or [Additional Diagnosis] of (O85–O909), and [Additional Diagnosis] of (Z370–Z379)
- 4976: [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388) REQUIRES [Episode Of Care] of (5, or 6)
- 4996: [Additional Diagnosis] of (Z5181, or Z523) SHOULD BE [Principal Diagnosis]
- 4997: [Principal Diagnosis] of (Z5181) REQUIRES [Procedure] from (Block 1892)
- 4998: [Principal Diagnosis] of (Z523) REQUIRES [Procedure] from (1370000)

[Procedure]

Identification

Technical name:	Episode of care - procedure type, code N(7)
APC data item:	49
SAHMR identifier:	SA474
Registration status:	SA Health, Standard 01/07/1985
Definition:	Type of procedure performed on the patient
Data element concept:	Episode of care - Procedure type

Value domain

Class:	Code
Type:	Number
Format:	NNNNNNN
Length:	7
Values:	Per ICD-10-AM 12th Edition reference data

Obligation

Class:	Mandatory
Dependency:	None

Collection

Up to 100 procedures can be added for each Episode Of Care.

See Diagnosis and Procedure Codes, page 198.

Data Quality Checks

- 2112: [Principal Diagnosis] or [Additional Diagnosis] of (O80 or O840) NOT COMPATIBLE WITH [Procedure] from (Block 1337, Block 1338, Block 1339 (except 9047200), Block 1340, Block 1341, Block 1342, Block 1343, or 9048200)
- 2113: [Principal Diagnosis] or [Additional Diagnosis] of (O81, or O841) REQUIRES [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9047002, or 9047004)
- 2114: [Principal Diagnosis] or [Additional Diagnosis] of (O81, or O841) NOT COMPATIBLE WITH [Procedure] from (9046803, 9047001, 9047003, 9047702, Block 1336, or Block 1340)
- 2115: [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9047002, or 9047004) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O81, O841, or O8482)
- 2116: [Principal Diagnosis] or [Additional Diagnosis] of (O82, or O842) REQUIRES [Procedure] from (Block 1340)
- 2117: [Principal Diagnosis] or [Additional Diagnosis] of (O82, or O842) NOT COMPATIBLE WITH [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9048200, Block 1336 or Block 1339)

- 2118: [Procedure] from (Block 1340) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O82, O842, or O8482)
- 2530: [Procedure] is INVALID, not a [Procedure] code
- 2531: [Principal Diagnosis] or [Additional Diagnosis] of (O83, or O0841) NOT COMPATIBLE WITH [Procedure] from (9046800, 9046801, 9046802, 9046804, 9046806, 9046900, 9047002, 9047004, Block 1336, or Block 1340)
- 2550: Principal [Procedure] code blank but Additional [Procedure] present
- 2753: Non-emergency selected same day scope procedures where no general anaesthetic is administered are INVALID inpatient admissions; REPLACE inpatient admission with an outpatient occasion of service
- 2773: [Procedure] from (8800000-8800099, 8800600-8800699) NOT PERMITTED
- 2779: [Principal Diagnosis] or [Additional Diagnosis] of (Z252) REQUIRES [Procedure] from 9215703-9215706
- 4000: Principal [Procedure] may be INVALID for same day inpatient episodes (may violate Technical Bulletins 28 or 29); CONSIDER replacing inpatient record with outpatient record
- 4090: [Procedure] from (4178900, or 4178901) NOT COMPATIBLE WITH [Principal Diagnosis] or [Additional Diagnosis] of (J030-J039)
- 4125: [Principal Diagnosis] or [Additional Diagnosis] of (Z491, or Z492) REQUIRES [Additional Diagnosis] of (Z530-Z539) or [Procedure] from (Block 1060, or Block 1061)
- 4200: [Principal Diagnosis] of (Z312) REQUIRES [Procedure] from (Block 1297)
- 4201: [Principal Diagnosis] of (Z310-Z313), and [Additional Diagnosis] not (Z530-Z539) REQUIRES [Procedure]
- 4236: [Procedure] from (Block 1856, or 3821300) DOES NOT REQUIRE [Procedure] from (Block 650, Block 653, Block 655, or Block 656)
- 4265: [Episode Of Care] of (4) REQUIRES [Procedure] from (Block 1916)
- 4275: [Procedure] of (3001001) REQUIRES [Procedure] from (9251400-9251499, or 925150-9251599)
- 4355: [Hours on Mechanical Intervention] of (0, or > 24 hours) NOT COMPATIBLE WITH [Procedure] from (1388200)
- 4365: [Hours on Mechanical Intervention] of (< 24, or > 95 hours) NOT COMPATIBLE WITH [Procedure] from (1388201)
- 4375: [Hours on Mechanical Intervention] of (< 96 hours) NOT COMPATIBLE WITH [Procedure] from (1388202)
- 4551: [Procedure] from (2200700, 2200800, 9017902, 9203500, or 9203501) NOT COMPATIBLE WITH [Procedure] from (Block 569, or Block 570)
- 4552: [Procedure] from (2200701, 2200801, or 9017906) NOT COMPATIBLE WITH [Procedure] from (Block 569)
- 4553: [Procedure] from (9017905) NOT COMPATIBLE WITH [Procedure] from (Block 570)
- 4649: [Principal Diagnosis] of (E1001-E149) and [Additional Diagnosis] of (Z718) REQUIRES [Procedure] from (9555014)
- 4659: [Procedure] from (Block 1907) REQUIRES [Procedure] from (9251410-9251599)
- 4820: [Sex] from patient record NOT COMPATIBLE WITH, [Sex] in system reference table with [Sex Flag] of (1) for [Procedure]

- 4830: Age at admission NOT COMPATIBLE WITH [Age Range] in system reference table for [Procedure]
- 4832: Principal [Procedure] contains [Procedure] in system reference table with [Unacceptable First Procedure Flag] of (Y), or Principal [Procedure] of (9623100, 9623300, or 9623400), and [Additional Diagnosis] not Z533
- 4833: [Procedure from (Block 451, Block 1940-1941, Block 1943-2016, and not 3068800) WITHOUT [Procedure] from (9251410-9251599), DELETE radiological procedure
- 4890: ([Principal Diagnosis] or [Additional Diagnosis] of (O601-O603, O620-O879, or O900-O909), or [Procedure] from (Block 1336–1340, Block 1343-1344, Block 1346-1347)) REQUIRES [Additional Diagnosis] from (Z370-Z379, or Z3900-Z392)
- 4893: [Procedure] from (1657300, or 9048100) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (O700-O709)
- 4895: [Principal Diagnosis] or [Additional Diagnosis] of (O700-O709) REQUIRES [Procedure] from (1657300, 9047200, or 9048100)
- 4904: [Principal Diagnosis] or [Additional Diagnosis] of (O80, or O840) REQUIRES [Procedure] Code Block 1336
- 4905: [Principal Diagnosis] or [Additional Diagnosis] of (O757) NOT COMPATIBLE WITH [Procedure] from (1652000, 1652001, 1652002, 1652003, 1652004, or 1652005)
- 4906: [Principal Diagnosis] or [Additional Diagnosis] of (O83, or O8481) REQUIRES [Procedure] from (9046803, 9046805, 9046901, 9047001, 9047003, 9047300, 9047400, 9047500, 9047600, 9047700, 9047702, 9048200, 1651400, or Block 1342)
- 4907: [Principal Diagnosis] or [Additional Diagnosis] of (O8482) REQUIRES one procedure from each of Blocks (1336 & 1337, 1336 & 1338, 1336 & 1339, 1336 & 1340, 1337 & 1338, 1337 & 1339, 1337 & 1340, 1338 & 1339, 1338 & 1340, or 1339 & 1340)
- 4910: [Procedure Location Indicator] not (1, or 2) or blank, and Principal [Procedure] or Additional [Procedure] not blank
- 4920: [Procedure Location Indicator] of (1, or 2), and Additional [Procedure] is blank
- 4920A: [Procedure Location Indicator] of (1, or 2), and Principal [Procedure] is blank
- 4997: [Principal Diagnosis] of (Z5181) REQUIRES [Procedure] from (Block 1892)
- 4998: [Principal Diagnosis] of (Z523) REQUIRES [Procedure] from (1370000)
- 4999: [Procedure] contains [Procedure] in system reference table where [Unacceptable Duplicate Procedure Flag] of (Y)

[Procedure Location Indicator]

Identification

Technical name:	Episode of care - procedure location, code N
APC data item:	85
SAHMR identifier:	SA472
Registration status:	SA Health, Standard 01/07/1996
Definition:	The hospital where the procedure was performed
Data element concept:	Episode of care - Procedure location (hospital)

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (This hospital) 2 (Other hospital)

Obligation

Class:	Mandatory
Dependency:	None

Collection

1 (This hospital)

The ICD-10-AM (12th Edition) coded procedure was performed at the admission hospital.

2 (Other hospital)

The ICD-10-AM (12th Edition) coded procedure was performed at another hospital, under a Hospital Contracted Service Agreement or as a Component of Care.

See Component Care and Contracted Care, page 191.

Data Quality Checks

- 2001: [Date Of First Operating Theatre Procedure] < [Admission Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033), and [Procedure Location Indicator] of (1)
- 2002: [Date Of First Operating Theatre Procedure] > [Separation Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033), and [Procedure Location Indicator] of (1)
- 2003: [Time Of First Operating Theatre Procedure] < [Admission Time] where [Date Of First Operating Theatre Procedure] = [Admission Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)

- 2004: [Time Of First Operating Theatre Procedure] > [Separation Time] where [Date Of First Operating Theatre Procedure] = [Separation Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 4910: [Procedure Location Indicator] not (1, or 2) or blank, and Principal [Procedure] or Additional [Procedure] not blank
- 4920: [Procedure Location Indicator] of (1, or 2), and Additional [Procedure] is blank
- 4920A: [Procedure Location Indicator] of (1, or 2), and Principal [Procedure] is blank
- 4930: [Contracted Service Hospital Number] ≠ 0000, [Contracted Service Patient Unit Record Number] ≠ 0000000000, or [Contracted Service Admission Date] ≠ 00000000 REQUIRES [Procedure Location Indicator] of (2)

[Referral For Further Health Care]

Identification

Technical name:	Patient's separation from service - type of further health care referred to, code N
APC data item:	72
SAHMR identifier:	SA1088
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient referral for further health care
Data element concept:	Patient's separation from service - Type of health care referred to

Value domain

Class:	Code
Type:	Number
Format:	NN
Length:	2
Values:	01 (Not referred) 02 (Private medical specialist: Excluding psychiatrist) 03 (Other private health practitioner) 04 (Outpatient / Emergency department: Acute hospital) 05 (Community mental health service) 06 (Other community health service) 07 (Hospital at home / Rehab at home) 08 (Disability SA) 10 (Healthcare @ Home) 11 (Residential mental health service) 12 (Transition to Residential Aged Care (TRAC)) 13 (Transition care package) 14 (Other residential health service) 15 (Private medical specialist: Psychiatrist) 16 (Drug and alcohol inpatient facility) 17 (Drug and alcohol non-inpatient facility) 18 (Outpatient / Emergency Department: Psychiatric hospital) 20: NDIS home support 21: NDIS short-term accommodation 22: NDIS long-term accommodation 23: NDIS residential aged care: Usual place of res 24: NDIS residential aged care: Not usual place of res 25: NDIS other 99 (Other / Unknown)

Obligation

Class:	Mandatory

Dependency:	None

Collection

Referral for further health care must be formally organised at the discharging hospital. This item is only used when the patient leaves the in-patient care of a hospital.

Transfers and intention to re-admit to health facilities are not considered a referral for further health care.

01 (Not referred)

If on discharge, there has been no arrangement made for further health care for continuing care/treatment of a condition which relates to the current admission.

Includes:

- Transfers to another hospital, including transfers to Glenside and specialised mental health wards in acute hospitals.
- Transfers to social welfare agencies like Meals on Wheels or the Central Mission are considered social services.

02 (Private medical specialist: excluding psychiatrist)

Patients referred for further care to a private medical specialist or general practitioner. Includes patients who are referred back to their private specialist for a post-surgery follow-up appointment.

03 (Other private health practitioner)

Includes referrals to allied health professionals, psychologists, social workers, other health professionals such as a chiropractor, physiotherapist, dentist, dietician or homeopath.

04 (Outpatient / Emergency Department: Acute hospital)

Patients referred to any hospital outpatient/emergency department for further care. This includes patients who are referred back to an outpatient department or emergency service for removal of stitches, dressings of wounds and removal of plaster, for example.

05 (Community mental health service)

Includes referrals to all South Australian Mental Health Service, GROW, COPE and similar self-help groups, northern and southern CAMHS.

06 (Other community health service)

Patients referred for further care to a community health service. For example, visits by the community welfare nurse, domiciliary care or RDNS.

07 (Hospital at home / Rehab at home)

Patients referred to a qualified Hospital at Home or Rehab at Home program.

See Hospital At Home, page 204.

08 (Disability SA)

Patients referred to Disability SA in order to provide additional resources to support transition of patients with a disability into the community.

10 (Healthcare @ Home)

Patients referred to Healthcare @ Home in order to provide a rapid, short term response to either avoid a presentation to an Emergency Department or an admission to a metropolitan public hospital and/or support a safe and timely discharge from a metropolitan public hospital.

See Healthcare @ Home, page 203.

11 (Residential Mental Health Service)

Patients transferred to a Residential Mental Health Care service such as a Community Rehabilitation Centre (CRC) or an Intermediate Care. Should be used in conjunction with:

- [Nature Of Separation] of 4 (Other health care accommodation).

12 (Transition to Residential Aged Care (TRAC))

The Transition to Residential Aged Care pilot is a State funded initiative that runs across metropolitan Adelaide and aims to support the safe and timely transition of older people who are medically stable and waiting a residential care placement but remain in acute care due to a range of complex circumstances.

13 (Transition care package)

Community Transitional Care Program (TCP) or a Residential TCP and other aged care services. The TCP program is primarily focused on reducing the transition of people from acute hospitals directly into residential aged care. It does this by providing services and supports that allow people at risk during such transitions to return home instead.

14 (Other residential health service)

Other residential health service that is not adequately described by any other code in this value domain

15 (Private medical specialist: psychiatrist)

Other residential health service that is not adequately described by any other code in this value domain.

16 (Drug and alcohol inpatient facility)

For patients referred to any specialist drug & alcohol inpatient facility.

17 (Drug and alcohol non-inpatient facility)

For patients referred to non-inpatient facilities including such services operating on Glenside Health Services campus as well as community-based services.

18 (Outpatient / Emergency Department: Psychiatric hospital)

For referrals to an Outpatient clinic or an ED care of a psychiatric hospital (i.e. Glenside).

20 (NDIS Home support, equipment, modification)

Patient discharged with home support, equipment or modification.

21 (NDIS short term accommodation, not usual place of residence)

Patient discharged to short term accommodation which is not their usual place of residence.

22 (NDIS long term accommodation, usual place of residence)

Patient discharged to long term accommodation which is their usual place of residence

23 (NDIS residential aged care, usual place of residence)

Patient discharged to residential aged care which is their usual place of residence.

24 (NDIS residential aged care, not usual place of residence)

Patient discharged to residential aged care which is not their usual place of residence.

25 (NDIS other)

Patient discharged to other NDIS accommodation providing medical/nursing care not specified in other Nature of Separation categories.

99 (Other / Unknown)

If, on discharge, arrangements not covered in the above categories, have been made for further care/treatment of a condition that relates to the current condition.

Data Quality Checks

- 2720: [Referral For Further Health Care] of (07) REQUIRES [Nature Of Separation] of (A)
- 2730: [Episode Of Care] of (7) NOT COMPATIBLE WITH [Referral For Further Health Care] of (07)
- 2750: [Episode Of Care] of (5, 6, 7, 8, or L) NOT COMPATIBLE WITH [Referral For Further Health Care] of (07) and [Nature Of Separation] of (A)
- 4013: [Referral For Health Care] of (21 or 24) NOT COMPATIBLE WITH [Nature of Separation] of (1, or 3)
- 4230: [Referral For Further Health Care] not (01, 02, 03, 04, 05, 06, 07, 11, 13, 14, 15, 16, 17, 18, 20, 21, 22, 23, 24, 25, or 99)
- 4240: [Nature Of Separation] of (2, 5, 6, 7, or E), and [Referral For Further Health Care] not (01)

[Religious Affiliation]

Identification

Technical name:	Religious affiliation, code NNNN
APC data item:	106
SAHMR identifier:	None
Registration status:	SA Health, Standard 01/09/2016
Definition:	The patient's professed religious affiliation
Data element concept:	Person – religious affiliation

Value domain

Class:	Code
Type:	Number
Format:	NNNN
Length:	4
Values:	Reference file

Obligation

Class:	Optional
Dependency:	None

Collection

It is essential that where this question is asked, it be clearly marked as optional. The following question is recommended.

Q: What is your religion? (Answering this question is optional)

Reference file:

- **Admitted Activity Reference Table - Religious Group** available from:
  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Data Quality Checks

- None

[Research Items]

Identification

Technical name:	Research items, A/N code
APC data item:	108
SAHMR identifier:	None
Registration status:	SA Health, Standard 17/10/2018
Definition:	The public hospital research activities cluster identified in the patient record
Data element concept:	Public hospital service research activities cluster – research items

Value domain

Class:	Code
Type:	String
Format:	XXXXXXXXXX
Length:	10
Values:	Free text

Obligation

Class:	
Dependency:	

Collection

The public hospital service research activities cluster comprises three data elements that provide information on the number of full-time equivalent research directorate staff, number of peer reviewed articles published, and number of approved research projects.

Research refers to the activities undertaken in a public health service where the primary objective is the advancement of knowledge that ultimately aims to improve consumer and patient health outcomes and/or health system performance. The activity must be undertaken in a structured and ethical way, be formally approved by a research governance or ethics body, and have potential for application outside of the health service in which the activity is undertaken.

For activity based funding purposes, the definition of research relates to the public health service's contribution to maintain research capability, excluding the costs of research activities that are funded from a source other than the state or territory provided in kinds.

Data Quality Checks

- None

[RUG-ADL]

Identification

Technical name:	Resource utilisation group – Activities of daily living score code AN [NNNNR]
APC data item:	104
SAHMR identifier:	SA1588
Registration status:	SA Health, Standard 03/08/2015
Definition:	The patient's Resource Utilisation Group: Activities of Daily Living score (RUG-ADL)
Data element concept:	Patient – level of functional independence score

Value domain

Class:	Code
Type:	String
Format:	NNNNA
Length:	5
Values:	Per RUG-ADL reference data

Obligation

Class:	Conditional
Dependency:	Mandatory for: • [Episode Of Care] = 2 (Maintenance care)

Collection

RUG-ADL score is a mandatory data element for separations where the episode of care is 2 (Maintenance care).

The user enters a four digit code that represents the four scores of the RUG-ADL followed by the alpha character R in order:

- Bed mobility
- Toileting
- Transfers
- Eating
- R

The code should be entered as either:

- [RUG-ADL]: 2131R
- [Additional Diagnosis]: 2131R

The code:

- Without decimal points
- Include end alpha character

- Left justify, blank fill
- If required, submit with [Condition Onset Flag] of 9 (Not reported).

RUG-ADL score is to be captured each and every time a patient begins a maintenance care episode except for end of quarter administrative discharges and readmissions. One RUG-ADL score is required for each maintenance care episode.

RUG-ADL is required national for activity based funding of maintenance (non-acute) care episodes. Failure to submit the code will impact national funding.

Data Quality Checks

- 2751: [Episode Of Care] of (2), and [Source Of Referral] not (E) REQUIRES [RUG-ADL]

[Separation Date]

Identification

Technical name:	Patient's separation from service - date of event, DDMMYYYY
APC data item:	43
SAHMR identifier:	SA1085
Registration status:	SA Health, Standard 24/04/2013
Definition:	The date the episode of care ended
Data element concept:	Patient's separation from service - Date of event

Value domain

Class:	Date/Time
Type:	Date
Format:	DDMMYYYY
Length:	8
Values:	Free text

Obligation

Class:	Mandatory
Dependency:	None

Collection

See Dates and Times, page 195.

See Formal Admission and Formal Separation, page 202.

Data Quality Checks

- 1341: [Separation Date] & [Separation Time] is between [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] of another record in database
- 1351: [Admission Date] & [Admission Time] is between [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] of another record in database
- 1361: [Admission Date] & [Admission Time] < [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] > [Separation Date] & [Separation Time] of another record in database
- 2002: [Date Of First Operating Theatre Procedure] > [Separation Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033), and [Procedure Location Indicator] of (1)
- 2004: [Time Of First Operating Theatre Procedure] > [Separation Time] where [Date Of First Operating Theatre Procedure] = [Separation Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2190: [Leave From Date] & [Leave From Time] < [Admission Date] & [Admission Time], or [Leave From Date] & [Leave From Time] > [Separation Date] & [Separation Time]

- 2200: [Leave To Date] & [Leave To Time] < [Admission Date] & [Admission Time], or [Leave To Date] & [Leave To Time] > [Separation Date] & [Separation Time]
- 2240: [Admission Date] = [Separation Date], and [Admission Time] > [Separation Time]
- 2256: Length Of Stay > (9 days) NOT COMPATIBLE WITH [Episode Of Care] of (5)
- 2260: [Hours In ICU] > Length of stay in hours
- 2270: [Hours On Mechanical Ventilation] > Length of stay in hours
- 2340: [Admission Type] of (1), and Length of stay of (> 35 days), and [Funding Source] not (01, 02, 03, 07, or 08) REQUIRES [Status Change Type] of (2, or 3)
- 2695: [Episode Of Care] of (2), [Separation Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Separation Time] of (2358) REQUIRES [Nature Of Separation] of (E)
- 2700: [Episode Of Care] of (2), [Separation Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Nature Of Separation] of (E) REQUIRES [Separation Time] of (2358)
- 2705: [Episode Of Care] of (2), and [Nature Of Separation] of (E) REQUIRES [Separation Date] of (YYYY0331, YYYY0630, YYYY0930, or YYYY1231)
- 2753: Non-emergency selected same day scope procedures where no general anaesthetic is administered are INVALID inpatient admissions; REPLACE inpatient admission with an outpatient occasion of service
- 2764: [Date Of Transfer To Discharge Lounge] > [Separation Date]
- 2766: [Time Of Transfer To Discharge Lounge] > [Separation Time] where [Date Of Transfer To Discharge Lounge] = [Separation Date]
- 4000: Principal [Procedure] may be INVALID for same day inpatient episodes (may violate Technical Bulletins 28 or 29); CONSIDER replacing inpatient record with outpatient record
- 4066: [Principal Diagnosis] or [Additional Diagnosis] of (Z511 or Z2921) INVALID WITH [Admission Date] <>[Separation Date]
- 4075: [Additional Diagnosis] of (Z511 or Z2921) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4085: [Principal Diagnosis] of (Z510) NOT COMPATIBLE WITH [Admission Date] ≠ [Separation Date]
- 4095: [Additional Diagnosis] of (Z510) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4105: [Additional Diagnosis] of (Z491, or Z492) and not (Z530-Z539) SHOULD BE [Principal Diagnosis] when Length of stay = 1 day
- 4115: [Principal Diagnosis] of (Z491, or Z492) NOT COMPATIBLE WITH Length of stay of (> 1 day)
- 4160: Length of Stay of (> 92 days), and [Admission Type] in (2, or 3)
- 4170: Length of stay of (> 1 day), and [Hospital Number] in system reference table where [Day Hospital] of (1)
- 4175: Length of stay of (> 9999 days)
- 4203: [Principal Diagnosis] of (Z5181), and [Additional Diagnosis] not (Z530-Z539) REQUIRES [Admission Date] = [Separation Date]
- 4204: [Additional Diagnosis] of (Z5181), and [Additional Diagnosis] not (Z530-Z539) SHOULD BE [Principal Diagnosis] when [Admission Date] = [Separation Date]
- 4390: [Patient Category] not (1, 2, or 4), and [Admission Date] ≠ [Separation Date]

- 4390A: [Patient Category] not (1, 2, or 4), and [Admission Date] = [Separation Date]
- 4580: [Contracted Service Admission Date] is an invalid date, [Contracted Service Admission Date] < [Admission Date], or [Contracted Service Admission Date] > [Separation Date]
- 4710: Length of stay of (> 1 year)

[Separation Time]

Identification

Technical name:	Patient's separation from service - time, hhmm
APC data item:	70
SAHMR identifier:	SA1087
Registration status:	SA Health, Standard 24/04/2013
Definition:	The time the episode of care ended
Data element concept:	Patient's separation from service - Time of first event

Value domain

Class:	Date/Time
Type:	Time
Format:	hhmm
Length:	4
Values:	Free text

Obligation

Class:	Mandatory
Dependency:	None

Collection

See Dates and Times, page 195.

See Formal Admission and Formal Separation, page 202.

Data Quality Checks

- 1341: [Separation Date] & [Separation Time] is between [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] of another record in database
- 1351: [Admission Date] & [Admission Time] is between [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] of another record in database
- 1361: [Admission Date] & [Admission Time] < [Admission Date] & [Admission Time], and [Separation Date] & [Separation Time] > [Separation Date] & [Separation Time] of another record in database
- 2004: [Time Of First Operating Theatre Procedure] > [Separation Time] where [Date Of First Operating Theatre Procedure] = [Separation Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2190: [Leave From Date] & [Leave From Time] < [Admission Date] & [Admission Time], or [Leave From Date] & [Leave From Time] > [Separation Date] & [Separation Time]
- 2200: [Leave To Date] & [Leave To Time] < [Admission Date] & [Admission Time], or [Leave To Date] & [Leave To Time] > [Separation Date] & [Separation Time]
- 2240: [Admission Date] = [Separation Date], and [Admission Time] > [Separation Time]

- 2260: [Hours In ICU] > Length of stay in hours
- 2270: [Hours On Mechanical Ventilation] > Length of stay in hours
- 2695: [Episode Of Care] of (2), [Separation Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Separation Time] of (2358) REQUIRES [Nature Of Separation] of (E)
- 2700: [Episode Of Care] of (2), [Separation Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Nature Of Separation] of (E) REQUIRES [Separation Time] of (2358)
- 2766: [Time Of Transfer To Discharge Lounge] > [Separation Time] where [Date Of Transfer To Discharge Lounge] = [Separation Date]
- 4000: Principal [Procedure] may be INVALID for same day inpatient episodes (may violate Technical Bulletins 28 or 29); CONSIDER replacing inpatient record with outpatient record

[Sex]

Identification

Technical name:	Patient - sex, code N
APC data item:	8
SAHMR identifier:	SA1116
Registration status:	SA Health, Standard 24/04/2013
Definition:	Identify if the patient has male or female sex characteristics
Data element concept:	Patient - Sex

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (Male) 2 (Female) 3 (Another term)

Obligation

Class:	Mandatory
Dependency:	None

Collection

Sex refers to the biological differences between males and females.

See Sex and Gender, page 232.

1 (Male)

Patient presents with male sex characteristics such as chromosomes, hormones and reproductive organs, or reports their sex as male at time of collection.

2 (Female)

Patient presents with female sex characteristics such as chromosomes, hormones and reproductive organs, or reports their sex as female at time of collection.

3 (Another term)

Patient presents with neither discernible male or female sex characteristics, or reports their sex as another term at time of collection.

Data Quality Checks

- 4081: [Sex] not (1, 2, or 3)
- 4505: [Sex] of (3) NOT COMPATIBLE WITH Age at admission of (> 90 days)

- 4506: [Sex] changed since last admission record
- 4800: [Sex] from patient record NOT COMPATIBLE WITH [Sex] in system reference table with [Sex Flag] of (1) for [Principal Diagnosis] or [Additional Diagnosis]
- 4820: [Sex] from patient record NOT COMPATIBLE WITH, [Sex] in system reference table with [Sex Flag] of (1) for [Procedure]

[Source Of Referral]

Identification

Technical name:	Patient admission - source of referral, code X
APC data item:	16
SAHMR identifier:	SA1080
Registration status:	SA Health, Standard 24/04/2013
Definition:	Source of the patient referral
Data element concept:	Patient admission - Source of referral

Value domain

Class:	Code
Type:	String
Format:	X
Length:	1
Values:	0 (Admit from leave) 1 (Other private medical practice: Excluding psychiatrist) 2 (Residential aged care facility) 3 (Community health service) 4 (Inter-Hospital transfer) 5 (Outpatient department) 6 (Casualty / Emergency) 7 (Contracted service) 8 (Other) 9 (Unknown) A (Administrative admission) E (End of quarter reporting) L (Law enforcement agency) P (Private psychiatric practice) R (Residential mental health service) V (Virtual Care Service – to TQEH only) X (Retrieval)

Obligation

Class:	Mandatory
Dependency:	None

Collection

0 (Admit from leave)

Those patients who were discharged on short term leave, i.e. less than 72 hours, but who did not return until after a period greater than 72 hours.

1 (Other private medical practice: excluding psychiatrist)

Patients referred to the hospital for admission by their medical practitioner, GP or specialist.

2 (Residential aged care facility)

Patients admitted to hospital directly from a residential aged care facility.

3 (Community health service)

Patients admitted to hospital from a community health service.

4 (Inter-Hospital transfer)

Patients admitted to and transferred from another hospital.

5 (Outpatient department)

Patients admitted from the outpatient department of the same hospital.

6 (Casualty / Emergency)

Patients admitted to hospital from the Accident & Emergency or Casualty department of the same hospital.

7 (Contracted service)

Patients admitted for treatment under a contracted agreement from a supplying hospital. This value is only used by destination hospitals.

8 (Other)

Any patient admitted to hospital through other avenues not listed in this data item. Includes:

- Transfers of non-admitted patients (e.g. from Accident & Emergency, Casualty, or Outpatient department of a different hospital).
- Newborns born during the reported episode.

9 (Unknown)

There should be minimal incidents of cases where the Source of Referral is unknown.

A (Administrative admission)

Used for an Administrative change between [Episode Of Care] types; not a formal separation.

See Administrative Separation and Administrative Admissions, page 186.

E (End of quarter reporting)

Used for End of quarter reporting purposes; not a formal separation.

See End of Quarter Reporting, page 200.

L (Law enforcement agency)

Includes police and correctional services officers.

P (Private psychiatric practice)

Excludes Rights of Private Practice clinics within hospital Outpatient Departments but includes a pure Private Practice that is located in a hospital or GP Plus Centre/Superclinic.

R Residential mental health service

To be used for referrals (transfers) from: Intermediate Care Centres (ICCs), Community Rehabilitation Centres (CRCs) and 24-hour staffed NGO-managed services (Burnside HASP, Catherine House ASP, Crisis Respite Facilities).

V (Virtual Care Service – to TQEH only)

Admission pathway and workflow in Sunrise EMR for patients referred to TQEH by the Virtual Care Service

X (Retrieval)

A specialist team used to transport a seriously ill or injured patient.

See Retrieval, page 229.

Data Quality Checks

- 2611: [Source of Referral] of (7) REQUIRES [Funding Source] of (12) or (14)
- 2696: [Episode Of Care] of (2), [Admission Date] (YYYY0331, YYYY0630, YYYY0930, or YYYY1231), and [Admission Time] of (2359) REQUIRES [Nature Of Separation] of (E)
- 2710: [Episode Of Care] of (2), [Source Of Referral] of (E), and [Admission Date] of (YYYY0331, YYYY0630, YYYY0930, or YYYY1231) REQUIRES [Admission Time] of (2359)
- 2715: [Episode Of Care] of (2), and [Source Of Referral] of (E) REQUIRES [Admission Date] of (YYYY0331, YYYY0630, YYYY0930, or YYYY1231)
- 2751: [Episode Of Care] of (2), and [Source Of Referral] not (E) REQUIRES [RUG-ADL]
- 2772: [Funding Source] of (12) or (14) REQUIRES [Admission Election] of (1) AND [Hospital Insurance] of (2) AND [Source of Referral] of (7)
- 4001: [Source Of Referral] of (A, or E), and [Admission Category] not (4)
- 4002: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (Z491), and [Admission Category] not (4)
- 4003: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (Z511 or Z2921) and [Admission Category not (4)
- 4004: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (Z510) and not (Z491, or Z511), and [Admission Category] not (4)
- 4006: [Source Of Referral] not (A, or E), [Principal Diagnosis] of (O80, or O840) and not (Z491, Z510, or Z511), AND [Admission Category] not (4)
- 4007: [Source Of Referral] not (A, or E), [Principal Diagnosis] not (O80, O840, Z491, Z510, or Z511), [Episode Of Care] of (5), and [Admission Category] not (4)
- 4008: [Source Of Referral] not (4, A, E, or X), [Principal Diagnosis] not (O80, O840, Z491, Z510, or Z511), [Episode Of Care] not (5), [Admission Date] = [Date Of Birth], and [Admission Category] not (4)
- 4030: [Source of Referral] not (0, 1, 2, 3, 4, 5, 6, 7, 8, 9, A, E, L, P, R, V, or X)
- 4165: [Hospital Number] of (0001-0500), [Episode Of Care] of (5, or 6), [Date Of Birth] = [Admission Date], and [Source Of Referral] not (4, X) REQUIRES [Principal Diagnosis] or [Additional Diagnosis] of (Z380-Z388)
- 4300: [Hospital Transferred From] is not blank and [Source Of Referral] not (4, or X)

- 4310: [Hospital Transfer From] is blank and [Source Of Referral] of (4)
- 4561: [Source Of Referral] not (7) and [Contracted Service Hospital Number] not in system reference table, [Contract Hospital Patient Unit Record Number] of (0000000000), or [Contracted Service Admission Date] is not a valid date
- 4740: [Source Of Referral] of (E) or [Nature Of Separation] of (E) NOT COMPATIBLE WITH [Hospital Number] of (≥ 4000 and ≤ 4999)
- 4824: [Episode Of Care] of (7) NOT COMPATIBLE WITH [Source Of Referral] not (A) and [Principal Diagnosis] of (Z519)
- 4930: [Contracted Service Hospital Number] ≠ 0000, [Contracted Service Patient Unit Record Number] ≠ 0000000000, or [Contracted Service Admission Date] ≠ 00000000 REQUIRES [Procedure Location Indicator] of (2)

[Statistical Local Area]

Identification

Technical name:	Patient - home SLA, code NNNN
APC data item:	7
SAHMR identifier:	SA1102
Registration status:	SA Health, Standard 24/04/2013
Definition:	The Statistical Local Area of the patient's home address
Data element concept:	Patient - Home SLA

Value domain

Class:	Code
Type:	Number
Format:	NNNN
Length:	4
Values:	Reference file

Obligation

Class:	Mandatory
Dependency:	None

Collection

The Admitted Patient Care data set does not store:

- Patient name
- Patient address

[Postcode] and [Statistical Local Area] are used to classify patients into demographic regions.

See Locality, page 215.

Data Quality Checks

- None

Reference file

- **Admitted Activity Reference Table - Locality** available from:
  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

[Status Change Effective Date]

Identification

Technical name:	Patient status - date of change event, DDMMYYYY
APC data item:	24, 27, 30
SAHMR identifier:	SA1083
Registration status:	SA Health, Standard 24/04/2013
Definition:	The effective date from when patient changed their [Admission Election] or [Admission Type]
Data element concept:	Patient status - Date of change event

Value domain

Class:	Date/Time
Type:	Date
Format:	DDMMYYYY
Length:	8
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Status change

Collection

See Dates and Times, page 195.

See Status Change, page 233.

Related Data Items

[Status Change Election]. Refer also to [Admission Election].

[Status Change Type]. Refer also to [Admission Type].

Data Quality Checks

- 4470: [Status Change Effective Date] of invalid format
- 4480: [Status Change Type] of (1, 2, or 3), [Status Change Effective Date] is valid date, and [Status Change Election] of blank
- 4490: [Status Change Election] of (1, or 2), and [Status Change Effective Date] is valid date, and [Status Change type]
- 4500: [Status Change Election] of (1, or 2), [Status change Type] of (1, 2, or 3), and [Status Change Effective Date] of blank

- 4992: [Episode Of Care] not (2, 3, 4, 8, 9, J, K, or L) NOT COMPATIBLE WITH [Admission Type] or [Status Change Type] of (3), or [Status Change Date 1], [Status Change Date 2], or [Status Change Date 3] < [Admission Date]

[Status Change Election]

Identification

Technical name:	Patient status - admission election status change, code N
APC data item:	22, 25, 28
SAHMR identifier:	SA1082
Registration status:	SA Health, Standard 24/04/2013
Definition:	The change to the patient's [Admission Election]
Data element concept:	Patient status - Admission election (care type) (change)

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	0 (None) 1 (Hospital) 2 (Private)

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Status change

Collection

See Status Change, page 233.

For Value Domain and Collection attributes, see [Admission Election], page 33.

Data Quality Checks

- 2585: [Admission Election] or [Status Change Election] not (2) NOT COMPATIBLE WITH [Funding Source] of (04, 05, 09, or 10) for [Hospital Number] of (≥ 0049 and ≤ 0250)
- 4450: [Status Change Election] not (0, 1, or 2)
- 4474: [Status Change Election] same as [Admission Election], or [Status Change Type] same as [Admission Type]
- 4480: [Status Change Type] of (1, 2, or 3), [Status Change Effective Date] is valid date, and [Status Change Election] of blank
- 4490: [Status Change Election] of (1, or 2), and [Status Change Effective Date] is valid date, and [Status Change type]
- 4500: [Status Change Election] of (1, or 2), [Status change Type] of (1, 2, or 3), and [Status Change Effective Date] of blank

[Status Change Type]

Identification

Technical name:	Patient status - stay type status change, code N
APC data item:	23, 26, 29
SAHMR identifier:	SA1084
Registration status:	SA Health, Standard 24/04/2013
Definition:	The date the patient changed their [Admission Type]
Data element concept:	Patient status - Stay type (Change)

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	0 (None) 1 (Ordinary) 2 (Long stay: Acute) 3 (Long stay: Maintenance care)

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Status change

Collection

See Status Change, page 233.

For Value Domain and Collection attributes, see [Admission Type], page 38.

Data Quality Checks

- 2340: [Admission Type] of (1), and Length of stay of (> 35 days), and [Funding Source] not (01, 02, 03, 07, or 08) REQUIRES [Status Change Type] of (2, or 3)
- 2342: [Episode Of Care] of (2, or J) NOT COMPATIBLE WITH [Admission Type] or [Status Change Type] of (2)
- 4460: [Status Change Type] not (0, 1, 2, or 3)
- 4474: [Status Change Election] same as [Admission Election], or [Status Change Type] same as [Admission Type]
- 4480: [Status Change Type] of (1, 2, or 3), [Status Change Effective Date] is valid date, and [Status Change Election] of blank
- 4490: [Status Change Election] of (1, or 2), and [Status Change Effective Date] is valid date, and [Status Change type]

- 4500: [Status Change Election] of (1, or 2), [Status change Type] of (1, 2, or 3), and [Status Change Effective Date] of blank
- 4992: [Episode Of Care] not (2, 3, 4, 8, 9, J, K, or L) NOT COMPATIBLE WITH [Admission Type] or [Status Change Type] of (3), or [Status Change Date 1], [Status Change Date 2], or [Status Change Date 3] < [Admission Date]

[Suburb / Locality]

Identification

Technical name:	Patient - home suburb/locality, identifier X[20]
APC data item:	5
SAHMR identifier:	SA1103
Registration status:	SA Health, Standard 24/04/2013
Definition:	The suburb / locality of the patient's home address
Data element concept:	Patient - Home suburb/locality

Value domain

Class:	Code
Type:	String
Format:	XXXXXXXXXXXXXXXXXXX
Length:	20
Values:	Free text

Obligation

Class:	Mandatory
Dependency:	None

Collection

See Locality, page 215.

Data Quality Checks

- 2612: [Funding Source] (04) REQUIRES Statistical Area Level 2 not BLANK; check [Suburb / Locality] and/or [Postcode]
- 4015: [Suburb / Locality] and [Postcode] combination not in system reference table

Reference file

- **Admitted Activity Reference Table - Locality** available from:

  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

[Time Of First Operating Theatre Procedure]

Identification

Technical name:	Operating theatre procedure - time first performed, hhmm
APC data item:	81
SAHMR identifier:	SA1069
Registration status:	SA Health, Standard 24/04/2013
Definition:	The time of the patient’s first operating theatre procedure
Data element concept:	Operating theatre procedure - Time first performed

Value domain

Class:	Date/Time
Type:	Time
Format:	hhmm
Length:	4
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for hospitals: • Flinders Medical Centre • Lyell McEwin Health Service • Modbury Hospital • Noarlunga Community Hospital • Repatriation General Hospital • Royal Adelaide Hospital • The Queen Elizabeth Hospital • Women's & Children's Hospital

Collection

Enter the time of the first operating theatre procedure.

See Dates and Times, page 195.

See First Operating Theatre Procedure, page 201.

Data Quality Checks

- 2003: [Time Of First Operating Theatre Procedure] < [Admission Time] where [Date Of First Operating Theatre Procedure] = [Admission Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)

- 2004: [Time Of First Operating Theatre Procedure] > [Separation Time] where [Date Of First Operating Theatre Procedure] = [Separation Date] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2005: [Date Of First Operating Theatre Procedure] REQUIRES [Time Of First Operating Theatre Procedure] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)
- 2006: [Time Of First Operating Theatre Procedure] REQUIRES [Date Of First Operating Theatre Procedure] for [Hospital Number] of (0003, 0005, 0014, 0018, 0019, 0027, 0030, or 0033)

[Time Of Transfer To Discharge Lounge]

Identification

Technical name:	Episode of care - transfer to discharge lounge, time hhmm
APC data item:	53
SAHMR identifier:	SA1011
Registration status:	SA Health, Standard 24/04/2013
Definition:	The time the patient was transferred to the discharge lounge
Data element concept:	Admitted Activity

Value domain

Class:	Date/Time
Type:	Time
Format:	hhmm
Length:	4
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for hospitals: • Flinders Medical Centre • Lyell McEwin Health Service • Modbury Hospital • Noarlunga Community Hospital • Repatriation General Hospital • Royal Adelaide Hospital • The Queen Elizabeth Hospital • Women's & Children's Hospital

Collection

Enter the time of the transfer to discharge lounge.

See Dates and Times, page 195.

See Transfer to Discharge Lounge, page 235.

Data Quality Checks

- 2760: [Time Of Transfer To Discharge Lounge] format is INVALID
- 2761: [Date Of Transfer To Discharge Lounge] REQUIRES [Time of Transfer To Discharge Lounge]

- 2762: [Time of Transfer To Discharge Lounge] REQUIRES [Date of Transfer To Discharge Lounge]
- 2765: [Time Of Transfer To Discharge Lounge] < [Admission Time] where [Date Of Transfer To Discharge Lounge] = [Admission Date]
- 2766: [Time Of Transfer To Discharge Lounge] > [Separation Time] where [Date Of Transfer To Discharge Lounge] = [Separation Date]

[Type Of Usual Accommodation]

Identification

Technical name:	Patient - type of usual accommodation, code N
APC data item:	90
SAHMR identifier:	SA1117
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient's usual type of accommodation
Data element concept:	Patient - Accommodation type

Value domain

Class:	Code
Type:	Number
Format:	N
Length:	1
Values:	1 (House, flat or other private residence) 2 (Independent unit as part of retirement village or similar) 4 (Psychiatric hospital) 5 (Homeless: Boarding / Rooming house) 6 (Other accommodation) 7 (Homeless: No usual residence) 8 (Homeless: Shelter / Refuge) 9 (Unknown) A (Specialised alcohol/other drug treatment residence) B (Boarding / Rooming house: Not homeless) C (Residential aged care service) D (Domestic scale supported living facility) H (Hostel or hostel type accommodation) M (Specialised mental health community based: Residential) N (Prison) O (Other supported accommodation) R (Remand) S (Shelter / Refuge: Not homeless persons shelter) Y (YTC)

Obligation

Class:	Mandatory
Dependency:	None

Collection

"Usual" is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to admission to institutional health care or first contact with a community service setting. If a person stays in a particular place of accommodation for four or more days a week

over the period, that place of accommodation would be the person's type of usual accommodation. In practice, receiving an answer to questioning about a person's usual accommodation setting may be difficult to achieve. The place the person perceives as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.

1 (House, flat or other private residence)

People who usually reside in a private residence (e.g. house, flat, unit, caravan, boat, including private and public rented homes).Includes caravans and boats used as a private residence.

2 (Independent unit as part of retirement village or similar)

Includes independent units in a retirement village. Implies that the resident does not require full time care.

4 (Psychiatric hospital)

People who reside long term in a psychiatric health care facility

5 (Homeless: Boarding / Rooming house)

People in marginal accommodation, who live in single rooms in private boarding or rooming houses, without their own bathroom, kitchen or security of tenure, on a medium or long term basis.

6 (Other accommodation)

Other accommodation not elsewhere classified under the other domains. Includes: hotel/motel, specialised mental health community based residential support, shelter/refuge (other than homeless shelter or refuge).

7 (Homeless: No usual residence)

People without conventional or usual accommodation, such as people living on the streets, sleeping in parks, squats, cars or makeshift dwellings for temporary shelter.

8 (Homeless: Shelter / Refuge)

People who move frequently between various forms of temporary shelter e.g. friends, emergency accommodation, hostels and boarding houses.

9 (Unknown)

Details of type of usual accommodation is not stated or unknown.

A (Specialised alcohol/other drug treatment residence)

Includes alcohol/other drug treatment units in psychiatric hospitals.

B (Boarding / Rooming house: Not homeless)

Boarding / Rooming houses do not require tenancy agreements; they may be single or shared rooms.

C (Residential aged care service)

Includes nursing home beds in acute care hospitals

D (Domestic scale supported living facility)

(e.g. group home for people with disability): Domestic-scale supported living facilities include group homes for people with disability, cluster apartments where a support worker lives on-site, community

residential apartments (except mental health), congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care.

H (Hostel or hostel type accommodation)

Includes youth hostels.

M (Specialised mental health community based: residential)

Specialised mental health community-based residential support services are defined as community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.

N (Prison)

Includes Prisons but not including Remand centres and/or Youth Training centres.

O (Other supported accommodation)

Includes other supported accommodation facilities such as hostels for people with disability, aged people and residential services/facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.

R (Remand centre)

Includes Remand centres but not including Prisons and/or Youth Training centres.

S (Shelter / Refuge: Not homeless persons shelter)

A shelter facility which is not a homeless persons shelter.

Y (YTC)

Includes Youth Training centres (YTC) but not including Prisons and/or Remand centres.

Data Quality Checks

- 4780: [Type Of Usual Accommodation] not (1, 2, 3, 4, 5,6, 7, 8, A, B, C, D, H, M, N,O, P, R, S or Y), and [Hospital Number] < 4000

[Veteran Card Number]

Identification

Technical name:	Patient—DVA card number, identifier X(9)
APC data item:	69
SAHMR identifier:	SA1098
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient's Department of Veteran Affairs card number.
Data element concept:	Patient—DVA card number, identifier X(9)

Value domain

Class:	Identifier
Type:	String
Format:	XXXXXXXXX
Length:	9
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Veteran

Collection

9-character identifier for the Veteran.

Data Quality Checks

- 2280: [Veteran Card Type] of (G, W, or N) or [Funding Source] = (04), and [Veteran Card Number] is blank, or invalid format
- 2290: [Veteran Card Number] War Code INVALID for [Hospital Number] of (< 4000)
- 2296: [Funding Source] of (04) REQUIRES [Veteran Card Number] and [Veteran Card Type]
- 4530: [Veteran Card Type] of blank, and [Veteran Card Number] is valid
- 4540: [Veteran Card Type] not (G, W or N), and [Veteran Card Number] is valid

[Veteran Card Type]

Identification

Technical name:	Patient - DVA card type, code A
APC data item:	31
SAHMR identifier:	SA433
Registration status:	SA Health, Standard 01/07/1996
Definition:	The patient's Department of Veteran Affairs card type
Data element concept:	Patient - DVA card type, code A

Value domain

Class:	Code
Type:	String
Format:	A
Length:	1
Values:	G (Gold: DVA Health Card - For all conditions) N (Not available) W (White: DVA Health Card - For specific conditions)

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Veteran

Collection

Type of card used by the veteran.

G (Gold: DVA Health Card - For all conditions)

Eligible Veterans with a [Veterans Card Type] of G (Gold) are covered for all conditions.

N (Not available)

Enter N (Not available) for a patient who claims to be an eligible Veteran, but whose card cannot be sighted before discharge.

W (White: DVA Health Card - For specific conditions)

Eligible Veterans with a [Veterans Card Type] of W (White) are covered for specific conditions, treatment from medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA have arrangements

Data Quality Checks

- 2280: [Veteran Card Type] of (G, W, or N) or [Funding Source] = (04), and [Veteran Card Number] is blank, or invalid format

- 2296: [Funding Source] of (04) REQUIRES [Veteran Card Number] and [Veteran Card Type]
- 4530: [Veteran Card Type] of blank, and [Veteran Card Number] is valid
- 4540: [Veteran Card Type] not (G, W or N), and [Veteran Card Number] is valid

[Ward On Admission]

Identification

Technical name:	Patient admission - Ward on admission, code X[10]
APC data item:	54
SAHMR identifier:	SA1008
Registration status:	SA Health, Standard 24/04/2013
Definition:	The ward where the patient was first admitted
Data element concept:	Patient Admission - Ward name

Value domain

Class:	Code
Type:	String
Format:	NNNNNNNNNN
Length:	10
Values:	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Public hospitals

Collection and usage

One of the key purposes of capturing Ward on Admission is to assist in the accurate identification and monitoring the effectiveness of the Acute Medical Units through a range of performance indicators.

Data Quality Checks

- None

[Ward On Discharge]

Identification

Technical name:	Patient admission - Ward on admission, code X[10]
APC data item:	66
SAHMR identifier:	SA1089
Registration status:	SA Health, Standard 24/04/2013
Definition:	The ward where the patient last separated
Data element concept:	Patient's separation from service - Ward name

Value domain

Class:	Code
Type:	String
Format:	NNNNNNNNNN
Length:	10
Values	Free text

Obligation

Class:	Conditional
Dependency:	Mandatory for: • Public hospitals

Collection and usage

One of the key purposes of capturing Ward on Discharge is to assist in the identification inpatient activity through designated, specialist mental health beds.

Data Quality Checks

- None

APPENDICES

Constructs

Administrative Separation and Administrative Admissions

An Administrative Admission follows an Administrative Separation. It occurs when the Episode Of Care changes within the one hospital stay. An Administration Admission is recorded as taking place 1 minute after an Administrative Separation.

For example, a patient transitioning from Acute to Maintenance care at 17:30 on 15-Aug-2019 requires the following:

- At separation:
  - [Episode Of Care]: 1
  - [Nature Of Separation]: A
  - [Separation Date]: 15082019
  - [Separation Time]: 1730
- At admission:
  - [Admission Date]: 15082019
  - [Admission Time]: 1731
  - [Episode Of Care]: 2
  - [Source Of Referral]: A

Admission Types

An admission may be one of the following types:

- **Formal Admission**: see Formal Admission and Formal Separation, page 202.
- **Administrative Admission**: see Administrative Separation and Administrative Admissions, page 186.
- **End of Quarter (EOQ) Admission**: see End of Quarter Reporting, page 200.

Admitted Patient

An admitted patient is a patient who undergoes a hospital admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home e.g. for [Episode Of Care] = 7 (Hospital in the home / Rehab in the home).

The patient may be admitted if one or more of the following apply:

- Patient's condition requires clinical management and/or facilities not available in their usual residential environment;
- Patient requires observation in order to be assessed or diagnosed;
- Patient requires at least daily assessment of their medication needs;
- Patient requires a procedure(s) that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available (e.g. cardiac catheterisation);
- Legal requirement for admission (e.g. under child protection legislation);
- Patient is undergoing posthumous organ procurement

Boarder

A Boarder is any person who receives food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. Hospital boarders are not admitted to the hospital and are therefore not part of the Admitted Patient Care data set. However, a hospital may register a boarder. Boarders include:

- Parents or relatives of an admitted child who are provided with accommodation to be near the child during the period of care.
- Healthy newborn babies who are more than 9 days old who do not require clinical care (within the classification of Acute Care) and are with their mother:
    - Who is an admitted patient of the hospital.
    - Who has been transferred from another hospital.

Exclusions

- Babies in hospital at age 9 days of less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

Compensable

Compensable patients admitted to a metropolitan or country hospital can be admitted as either:

- At admission:
    - [Admission Election]: 1 (Hospital)
    - [Admission Election]: 2 (Private)

Certification of a compensable patient as a compensable private patient cannot be overridden by the patient wishing to be classified as a compensable hospital patient.

However, if the patient's status reverts to non-compensable the patient is classified as private, if the patient has private health insurance and elects to be admitted under their private hospital cover.

In addition, the following is required:

- At admission:
    - [Funding Source]: either:
        - 01 (Compensable: MVA)
        - 02 (Compensable: WC)
        - 03 (Compensable: Other)

Component Care and Contracted Care

Component care and Contract care allow hospitals to leverage the specialisation of other hospitals, such as where specialised technology prohibits the service being widely available. For example, hospitals are able to provide a comprehensive service by making arrangements with hospitals that have particular equipment or offer a particular service.

In both the following scenarios, the duty of care remains with the originating hospital.

Component Care

An admitted patient at a public hospital may be admitted to another public hospital for a period of less than 24 hours for a component of their overall episode of care. The intent is for the patient to return to the hospital (and frequently a bed is held for that patient). There may be more than one component of care instance during the overall episode of care but each time the intent is for the patient to return to the originating hospital within 24 hours.

If a patient is admitted at Hospital A and sent to Hospital B for an admitted contracted service or component of care, they cannot be on leave from hospital A.

Component care:

- Formal agreement between two hospitals: No
- Agreement with private hospital: No
- Admitted services: Yes
- Intended length of stay: ≤ 24 hours

Contract Care

Contracted hospital care is provided to a patient under a formal agreement between a contracting hospital (or external purchaser) and a provider of an admitted or non-admitted service (contracted hospital).

Contract care:

- Formal agreement between two hospitals: Yes
- Agreement with private hospital: Yes
- Admitted services: Yes
- Intended length of stay: any time

Reference file

- Contracted Care Data Protocol - 2019-2020 v2.0 Objective ID A2277681
- SA Health Intranet link - Contracted Care Data Protocol

Example: Electroconvulsive Therapy (ECT)

Patient 0000001234 is admitted as a public patient to an originating hospital 0020 at 10:30 on 01-Jul-2019. During their hospitalisation, the patient is diagnosed with paranoid schizophrenia is sent as patient 0000005678 to contracting hospital 0300 on 6 different occasions (July 2, 6, 11, 16, 21, and 26) for ECT under General Anaesthetic. The patient is discharged from the originating hospital on 16:00 on 31-Jul-2019.

Originating hospital requires:

- One Episode of Care

Contracting hospital requires:

- Six Episodes of Care

Stage 1: Admission at originating hospital 0020

Admit the patient per standard processes, e.g.:

- [Admission Date]: 01-Jul-2019
- [Admission Time] : 10:30
- [Patient Unit Record Number] : 0000001234
- [Source Of Referral]: 6 (Casualty/Emergency)
- [Funding Source]: 11 (Medicare)
- [Admission Election]: 1 (Hospital)

Stage 2: Treatment at originating hospital 0020

Diagnose and treat the patient per standard processes, e.g.:

- [Principal Diagnosis]: F200 (Paranoid schizophrenia)
- [Additional Diagnosis]: as appropriate
- Procedures at originating hospital:
    - [Procedures]: as appropriate
    - [Procedure Location Indicator]: 1 (This hospital)
- [Contracted Service Hospital Number]: 0300
- [Contracted Patient Unit Record Number]: 0000005678
- [Contracted Service Admission Date]: 02-Jul-2019

Note: [Contracted Service Admission Date] is overwritten six times during the patients Episode of Care to reflect the latest (current) date the patient is transferred to the contracting hospital.

Stage 3: Admission to contracting hospital 0300

Admit the patient per standard processes, e.g.:

- [Admission Date]: 02-Jul-2019
- [Admission Time]: as appropriate
- [Patient Unit Record Number]: 0000005678
- [Source Of Referral]: 7 (Contracted service)
- [Funding Source]: 12 (Other Hosp or Public Authority)
- [Admission Election] = 1 (Hospital)

Stage 4: Treatment at contracting hospital 0300

Diagnose and treat the patient per standard processes, e.g.:

- Procedures at contracting hospital:
    - [Procedures]:
        - 1 of 1422400 (Electroconvulsive Rx unsp lat unsp u/b)
        - 1 of 9251499 (General anaesthesia, ASA 99)
    - [Procedure Location Indicator]: 1 (This hospital)

Stage 5: Separation from contracting hospital 0300

Patient leaves contracting hospital and returns originating hospital:

- [Nature Of Separation]: 4 (Other health care accommodation)
- [Separation Date]: 02-Jul-2019
- [Separation Time]: as appropriate

Stage 6: Return to originating hospital 0020

Continue to treat the patient per standard processes, e.g.:

- Procedures at contracting hospital:
    - [Procedures]:
        - 6 of 1422400 (Electroconvulsive Rx unsp lat unsp u/b)
        - 6 of 9251499 (General anaesthesia, ASA 99)
    - [Procedure Location Indicator]: 2 (Other hospital)
- Further procedures at originating hospital:
    - [Procedures]: as appropriate
    - [Procedure Location Indicator]: 1 (This hospital)

Stage 7: Separation from originating hospital 0020

Patient leaves originating hospital:

- [Nature Of Separation]: 1 (Home)
- [Separation Date]: 31-Jul-2019
- [Separation Time]: 16:00

Dates and Times

Dates

Enter dates with leading a zero where appropriate (e.g. the first day of a month is entered as “01” instead of “1”).

Example

A date of 06-Aug-2019 is entered as

- 06082019

The following data elements are in scope for dates:

- [Admission Date]
- [Contracted Service Admission Date]
- [Date Of Birth]
- [Date Of First Operating Theatre Procedure]
- [Date Of Transfer To Discharge Lounge]
- [Leave To Date]
- [Leave From Date]
- [Separation Date]
- [Status Change Effective Date]

Times

Enter time with a leading zero where appropriate (e.g. a time between five and six o’clock is entered as “05” instead of “5”).

Example

A time of 05:05 is entered as:

- 0505

The following data elements are in scope for times:

- [Admission Time]
- [Leave To Time]
- [Leave From Time]
- [Separation Time]
- [Time Of First Operating Theatre Procedure]
- [Time Of Transfer To Discharge Lounge]

Date Of Birth

Two data elements are required to record Date of Birth:

- At admission:
    - [Date Of Birth]
    - [Date Of Birth Accuracy Flag]

[Date Of Birth]

[Date Of Birth] is the date (only) when the patient was born.

[Date Of Birth Accuracy Flag]

[Date Of Birth Accuracy Flag] is the extent to which the [Date Of Birth] is known to be accurate.

Example

If the Date of Birth is known to be accurate (e.g. to 05-Jul-1946):

- At admission:
    - [Date Of Birth]: 05071946
    - [Date Of Birth Accuracy Flag]: 1 (Accurate)

If the Date of Birth is unknown, then use a default (i.e. 01-Jul-1900):

- At admission:
    - [Date Of Birth]: 01071890
    - [Date Of Birth Accuracy Flag]: 2

Defence

An admitted defence patient requires:

- At admission:
    - [Admission Election]: 2 (Private)
    - [Funding Source]: 05 (Defence)

Diagnosis and Procedure Codes

ICD-10-AM (12th Edition) diagnosis codes must be recorded in the following format:

- Without decimal points
- Include lead alpha characters
- Record codes in sequence order
- Left justify, blank fill
- Where there is no 4th digit, but a 5th digit is required use "0" as a filler

Nine data elements are required to record diagnosis and procedure codes:

- [Principal Diagnosis]
- [Additional Diagnosis]
- [Condition Onset Flag]
- [Activity When Injured]
- [External Cause]
- [Place Of Occurrence]
- First [Procedure]
- Additional [Procedure]
- [Procedure Location Indicator]

[Activity When Injured] is sequenced in [Additional Diagnosis] before [Place Of Occurrence].

Example

Diagnosis codes for:

- [Principal Diagnosis]: G4060 (Gr mal sez unsp w / wo pet mal wo IE)
- [Activity When Injured]: U738 (Other specified activity)
- [Place Of Occurrence]: Y9218 (Plo oth spec residential institution)
- [External Cause]: X58 (Exposure to other specified factors)
- [Additional Diagnosis]:
    - S0005 (Superficial injury of scalp contusion)
    - E871 (Hypo-osmolality and hyponatraemia)
    - R11 (Nausea and vomiting)
    - R13 (Dysphagia)
    - G819 (Hemiplegia unspecified)
    - U794 (Disorder of intellectual development)

Are entered as:

- [Principal Diagnosis]: G4060
- [Additional Diagnosis]: S0005E871 R11 R13 G819 U794
- [Activity When Injured]: U738
- [Place Of Occurrence]: Y9218
- [External Cause]: X58

Procedure codes for:

- First [Procedure]: 9555005 (Allied health intervtn, speech pathology)
- Additional [Procedure]:
    - 9555003 (Allied health intervtn, physiotherapy)
    - 9555002 (AH intervention, occupational therapy)
    - 9555009 (Allied health intervention, pharmacy)
    - 9602700 (Prescribed/self-selected medicatn assess)

Are entered as:

- First [Procedure]: 9555005
- Additional [Procedure]: 955500395550029555009960270O

End of Quarter Reporting

An End of Quarter Admission follows an End of Quarter Separation. It is an administrative process by which a hospital reports an admission for a patient who was an inpatient at the beginning of a quarter.

An End of Quarter Admission is recorded as taking place 1 minute after an End of Quarter Separation.

Example

A patient with an [Episode Of Care] of Maintenance Care who is in hospital as at 00:00 on 30-Sep-2019 requires the following:

- At separation:
    - [Episode Of Care]: 2 (Maintenance Care)
    - [Nature Of Separation]: E (End of quarter reporting)
    - [Separation Date]: 30092019
    - [Separation Time]: 2358
- At admission (to new hospital):
    - [Admission Date]: 30092019
    - [Admission Time]: 2359
    - [Episode Of Care]: 2 (Maintenance Care)
    - [Source Of Referral]: E (End of quarter reporting)

Patients on leave at the end of quarter are also discharged for reporting purposes. For example, a patient on leave as at 30-Sep-2019 requires the following:

- Separation record:
    - [Leave To Date]: 30092019
    - [Leave To Time]: 2358
    - [Separation Date]: 30092019
    - [Separation Time]: 2358
    - [Nature Of Separation]: E (End of quarter reporting)
- Admission record:
    - [Leave To Date]: 30092019
    - [Leave To Time]: 2359
    - [Admission Date]: 30092019
    - [Admission Time]: 2359
    - [Source Of Referral]: E (End of quarter reporting)

Exclusions

End of Quarter Admission and End of Quarter Separation are not used by:

- Sunrise EMR public hospitals
- Private hospitals

First Operating Theatre Procedure

Two data elements are required to record First Operating Theatre Procedure:

- [Date Of First Operating Theatre Procedure]
- [Time Of First Operating Theatre Procedure]

[Date Of First Operating Theatre Procedure]

[Date Of First Operating Theatre Procedure] is the date (only) of the first operating theatre procedure performed.

[Time Of First Operating Theatre Procedure]

[Time Of First Operating Theatre Procedure] is the time (only) of the first operating theatre procedure performed.

Example

A first operating theatre procedure which took place at 18:30 on 06-Mar-2019 would be entered as:

- [Date Of First Operating Theatre Procedure]: 06032019
- [Time Of First Operating Theatre Procedure]: 1830

[Admission Date] same as [Date Of First Operating Theatre Procedure] facilitates derivation of the Day of Surgery Admission (DOSA) Indicator.

Formal Admission and Formal Separation

A Formal Admission is the process by which a hospital records the commencement of treatment and/or care and accommodation of a patient. When formally admitted, a patient is classified as same-day or overnight stay.

A Formal Separation is a separation when the treatment and/or care, and the accommodation of the patient are complete. Includes:

- Discharges to return home.
- Transfers to other hospitals, nursing homes and other forms of congregate living.
- Deaths of persons who were in-patients at the time of death.
- Patients who discharge themselves against medical advice

Date

Enter the full date of separation using the day, month and year and leading zeros where necessary.

For example, if a patient was discharged on 15-Aug-2019, the date would be entered as follows:

- [Separation Date]: 15082019

For patients who die in hospital, [Separation Date] is date of death.

Time

Any time submitted as 2400 will have the following action taken:

- Separation Time will be changed to 0000; and
- Separation Date will be incremented by 1.

For patients who die in hospital, [Separation Time] is time of death.

Example

Record submitted for 24:00 30-Sep-2019:

- At separation:
    - [Separation Time]: 2400
    - [Separation Date]: 30092019

Record is changed to 00:00 01-Oct-2019:

- At separation:
    - [Separation Time]: 0000
    - [Separation Date]: 01102019

Healthcare @ Home

Healthcare @ Home is contracted to or provided by a community-based organisation and is a specifically funded program. It is separate and distinct from Hospital At Home.

Hospital At Home

Hospital At Home allows for a hospital to provide care for the patient in their home instead of at the hospital.

When a patient starts a Hospital at Home episode without having been a formally admitted in-patient (e.g. on to the Hospital at Home episode through Emergency or Outpatients) use the appropriate [Source Of Referral], e.g. 6 (Casualty / Emergency).

When a patient starts a Hospital at Home episode after an in-patient episode, an administrative discharge is required and commencement of an administrative admission for the Hospital at Home episode:

Example

A patient is discharged from hospital at 15:30 21-Jul-2019 to Hospital At Home, and is readmitted to hospital at 09:00 25-Jul-2019, following a presentation to an Emergency Department.

- At separation:
    - [Nature Of Separation]: A (Administrative discharge)
    - [Referral For Further Health Care]: 07 (Hospital at home / Rehab at home)
    - [Separation Date]: 21072019
    - [Separation Time]: 1530
- At admission (to home):
    - [Admission Date]: 21072019
    - [Admission Time]: 1531
    - [Episode Of Care]: 7 (Hospital at home / Rehab at home)
    - [Source Of Referral]: A (Administrative admission)
- At separation (from home):
    - [Nature Of Separation]: 1 (Home)
    - [Referral For Further Health Care]: 01 (Not referred)
    - [Separation Date]: 25072019
    - [Separation Time]: 0859
- At readmission (to hospital):
    - [Admission Date]: 25072019
    - [Admission Time]: 0900
    - [Episode Of Care]: 1 (Acute)
    - [Source Of Referral]: 6 (Casualty / Emergency)

A patient is discharged from hospital at 15:30 21-Jul-2019 to Hospital At Home, and subsequently dies at home at 09:00 25-Jul-2019.

- At separation:
    - [Nature Of Separation]: A (Administrative discharge)
    - [Referral For Further Health Care]: 07 (Hospital at home / Rehab at home)
    - [Separation Date]: 21072019
    - [Separation Time]: 1530

- At admission (to home):
    - [Admission Date]: 20172019
    - [Admission Time]: 1531
    - [Episode Of Care]: 7 (Hospital at home / Rehab at home)
    - [Source Of Referral]: A (Administrative admission)
- At separation (from home):
    - [Nature Of Separation]: 6 (Died: autopsy)
    - [Referral For Further Health Care]: 01 (Not referred)
    - [Separation Date]: 25072019
    - [Separation Time]: 0900

Where a patient is admitted to Hospital At Home and needs to return to the hospital for same day elective surgery, pharmacotherapy or renal dialysis treatment:

- there is no need to discharge and readmit between H@H and the same day admission
- the same day treatment is recorded as part of the H@H episode
- if attending a different hospital for same day treatment, component of care or contracted care should be used to record this treatment as part of the H@H episode.

Exclusion

[Episode Of Care] of 7 (Hospital at home / Rehab at home) may not have:

- [Nature Of Separation] of E (End of quarter reporting)
- [Source Of Referral] of E (End of quarter reporting)

Reference

SA Health Intranet link Hospital in the Home (HITH) Data Protocol

Hospital Insurance

[Admission Election] and [Hospital Insurance] are independent.

Valid scenarios showing the relationship between [Admission Election] and [Hospital Insurance] include are shown below.

Example

A patient who elects to be admitted as a public hospital patient, with private health (hospital) insurance:

- At admission:
    - [Admission Election]: 1 (Hospital)
    - [Funding Source]: 11 (Medicare)
    - [Hospital Insurance]: 1 (Hospital insurance)
    - [Medicare Number]
    - [Medicare Number IRN]

A patient who elects to be admitted as a public hospital patient, without private health (hospital) insurance, or has private health (extras) insurance:

- At admission:
    - [Admission Election]: 1 (Hospital)
    - [Funding Source]: 11 (Medicare)
    - [Hospital Insurance]: 2 (No hospital insurance)
    - [Medicare Number]
    - [Medicare Number IRN]

A patient who elects to be admitted as a private hospital patient, with private health (hospital) insurance:

- At admission:
    - [Admission Election]: 2 (Private)
    - [Funding Source]: 09 (Private health)
    - [Hospital Insurance]: 1 (Hospital insurance)
    - [Medicare Number]
    - [Medicare Number IRN]

However, the following scenario is not valid: A patient who elects to be admitted as a private hospital patient, without private health (hospital) insurance, or has private health (extras) insurance:

- At admission:
    - [Admission Election]: 2 (Private)
    - [Funding Source]: 11 (Medicare)
    - [Hospital Insurance]: 2 (No hospital insurance)
    - [Medicare Number]
    - [Medicare Number IRN]

Hospital Number

Public hospitals have three digit codes and require a leading zero.

The number should be entered as follows:

- [Hospital Number]: 0106

Private hospitals, including day surgery facilities, have four digit codes beginning with a ‘4’, and should be entered as follows:

- [Hospital Number]: 4313

The following data elements are in scope for Hospital number:

- [Contract Service Hospital Number]
- [Hospital Number]
- [Hospital Transferred From]
- [Hospital Transferred To]

Reference file

- **Admitted Activity Reference Table – Admitted Patient Care Hospital Codes** listing available from:

  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Hours

Round up or down the total hours:

- If 0-29 min round down to 0 hour
- If 30-59 min round up to 1 hour

Example

A patient spent 18.5 hours in a location, if appropriate, the information is entered with leading zeros as follows:

- Hours: 0019

The following data elements are in scope for Hours:

- [Hours In ICU]
- [Hours On Mechanical Ventilation]

Hours in Intensive Care Unit

Hours in ICU includes the following:

- Paediatric Intensive Care Unit

Hours in ICU excludes the following:

- Coronary care
- High dependency
- Neonate Intensive Care Unit (NICU)

Hours On Mechanical Ventilation

In general, duration is calculated from the procedure times:

- **Start**: (endotracheal) intubation
- **End**: (endotracheal) extubation

If a patient is intubated prior to admission, duration is calculated from:

- **Start**: [Admission Time]
- **End**: (endotracheal) extubation

However, if a patient is transferred (discharged) while intubated, the duration would end at the time of transfer (discharge).

If a patient begins on (endotracheal) intubation and subsequently has a tracheostomy performed for mechanical ventilation, duration:

- **Start**: (endotracheal) intubation
- **End**: mechanical ventilation is turned off (after the weaning period)

If a patient has received a tracheostomy prior to admission and is on mechanical ventilation at the time of admission, duration:

- **Start**: [Admission Time]
- **End**: mechanical ventilation is turned off (after the weaning period)

However, if a patient is transferred (discharged) while still on mechanical ventilation via tracheostomy, the duration would end at the time of the transfer (discharge).

Indigenous Status

This data element should always be asked regardless of the patient's appearance.

When requesting information on Indigenous Status the following question structure is recommended: [Are you] [Is the person] [is (name)] of Aboriginal or Torres Strait Islander origin?

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander
- Yes, Both Aboriginal and Torres Strait Islander

This question is recommended for self-enumerated or interview-based collection. It can also be used in circumstances where a close relative, friend or another member of the household is answering on behalf of the subject.

When someone is not present, the person answering for them should be in a position to do so i.e. this person must know the person about whom the question is being asked well and feel confident to provide accurate information about them. However, it is strongly recommended that this question be asked directly wherever possible.

In circumstances where it is impossible to ask the person directly, such as in the case of death, the question should be asked of a close relative or friend, and only if a relative or friend is not available should the undertaker or other such person answer.

The classification for Indigenous Status has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. Based on the response for this data element, the broad classifications are:

- Indigenous
    - 1 (Aboriginal but not Torres Strait Islander origin)
    - 2 (Torres Strait Islander but not Aboriginal origin)
    - 3 (Both Aboriginal and Torres Strait Islander origin)
- Non-Indigenous
    - 4 (Neither Aboriginal nor Torres Strait Islander origin)

Inter-Hospital Transfer

A hospital transfer requires separation from one hospital for the patient to be transferred to another.

- Hospital Transfer: Down
- Hospital Transfer: Up

In these cases, the duty of care is transferred to the destination hospital; there is no expectation that the patient returns to the originating hospital. Thus, the patient requires:

- At separation:
    - [Hospital Transfer To]
- At admission (to new hospital):
    - [Hospital Transfer From]

Inter-Hospital transfer does not need to be made in an ambulance; family or friends may drive the patient between hospitals. However, transfer must be undertaken within 24 hours, and no overnight stay elsewhere is permitted.

Hospital Transfer: Down

Patient transferred to another hospital for the purpose of receiving a reduced level of care relative to that just received.

Example

A patient is transferred to a hospital close to home for convalescence, after receiving specialist burns care in a teaching hospital.

In addition to hospital transfer fields, the following is required:

- At separation:
    - [Nature Of Separation]: 7 (Other hospital: Down transfer)
- At admission (to new hospital):
    - [Source Of Referral]: 4 (Inter-Hospital transfer)

Hospital Transfer: Up

Patient transferred to another hospital for the purpose of receiving an equivalent or increased level of care relative to that just received.

Example

A newborn transferred to another hospital to receive specialist neonatal care after undergoing stabilisation.

A patient transferred from a country hospital to a metropolitan hospital for rehabilitation.

In addition to hospital transfer fields, the following is required:

- At separation:
    - [Nature Of Separation]: 2 (Other hospital: Up transfer)
- At admission (to new hospital):
    - [Source Of Referral]: 4 (Inter-Hospital transfer)

Exclusions

Patients discharged to a residential aged care facility is not an inter-hospital transfer. This scenario requires:

- [Hospital Transferred To]: blank
- [Nature Of Separation]: 3 (Residential aged care facility).

Reference file

Admitted Activity Reference Table – Admitted Patient Care Hospital Codes listing available from: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Live Birth

A Live Birth is a complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

Locality

Three data elements are used with respect to locality:

- [Postcode]
- [Statistical Local Area]
- [Suburb / Locality]

[Postcode]

Apart from the postcode of the patient's residential address, one other postcode is valid:

- [Postcode]: 0999 for:
    - Babies for Adoption
    - Overseas
    - Unconscious patients
    - No Fixed Abode
    - Not Known

[Statistical Local Area]

The obsolete construct Statistical Local Area is expected to be replaced by the current construct Statistical Area Level 2 in 2021 or 2022.

Enter the statistical local area codes using leading zeros where necessary:

- [Statistical Local Area]: 4620
- [Statistical Local Area]: 0070

While Statistical Local Area is in use, note the above exception values in [Postcode].

[Suburb / Locality]

The suburb of the patient's usual residence. If the patient is from interstate, enter the patient's usual (permanent) address and not their holiday (temporary) address.

Reference file

- **Admitted Activity Reference Table - Locality** available from:

  https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Medicare Number

Two data elements are required to record Medicare Number:

- At admission:
    - [Medicare Number]
    - [Medicare Number IRN]

[Medicare Number]

[Medicare Number] is a ten-digit number which comprises:

- Eight digits
- A check digit (one digit)
- An issue number (one digit)

Note: the first digit of the Medicare card number should be in the range 2 to 6.

There are three broad categories of [Medicare Number].

- NNNNNNNNNN: A valid Medicare number (refer Medicare Number Check Digit Calculation below)
- 0000000009: Ineligible for Medicare
- 0000000000: Eligible but number unavailable

Up to date information on Medicare eligibility is available from the Department of Human Services:

https://www.humanservices.gov.au/individuals/services/medicare/medicare-card/eligibility/who-can-get-it

[Medicare Number IRN]

[Medicare Number IRN] is a one-digit number:

- 1-9: An individual reference number representing each family member on the Medicare card

Example

A Medicare-eligible patient with a Medicare Number of 4961991871 who is the second individual reference number on the card is recorded as:

- [Medicare Number]: 4961991871
- [Medicare Number IRN]: 2

A patient who is eligible for Medicare, but is not yet registered, is recorded as:

- [Medicare Number]: 0000000000
- [Medicare Number IRN]: 0

A patient who is ineligible for Medicare is recorded as:

- [Medicare Number]: 0000000009
- [Medicare Number IRN]: 0

A patient who is registered, but after considerable attempts the hospital is unable to obtain the Medicare number, is recorded as:

- [Medicare Number]: 0000000000
- [Medicare Number IRN]: 0

Medicare Number Check Digit Calculation

1. Calculate the sum of:
    - [(digit 1) + (digit 2 * 3) + (digit 3 * 7) + (digit 4 * 9) + (digit 5) + (digit 6 * 3) + (digit 7 * 7) + (digit 8 * 9)] where digit 1 is the first digit of the Medicare card number and digit 8 is the eighth digit of the Medicare card number.
    - Example: for Medicare card number '2123 45670 1', digit 1 is 2 and digit 8 is 7.
2. Divide the calculated sum by 10.
3. The check digit is the remainder.
    - Example: For Medicare card number 2123 4567.
    - (2) + (1 * 3) + (2 * 7) + (3 * 9) + (4) + (5 * 3) + (6 * 7) + (7 * 9) = 170
    - Divide 170 by 10. The remainder is 0.
    - The check digit for this Medicare number is 0

Newborns

Newborn care is initiated when the patient is born in hospital or is 9 days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated.

There are two types of newborn:

- Unqualified newborn
- Qualified newborn

Unqualified newborn

An unqualified newborn is:

- A single live birth or the first live born infant in a multiple birth, whose mother is currently an admitted patient
- Not admitted to an intensive care facility in a hospital at an approved hospital

Unqualified newborns are not counted under the Medicare Agreement and are not eligible for health insurance benefit purposes. This is because the funding for unqualified newborns is already included in the funding for the mother's inpatient stay.

If an unqualified newborn remains in hospital after day 9 to receive acute care, then change [Episode Of Care]:

- From: 5 (Unqualified newborn)
- To: 1 (Acute)

Alternatively, if after day 9, the newborn is not receiving acute care, then the newborn should be discharged and recorded as a boarder:

- [Patient Category]: 3 (Boarder)

Qualified newborn

A qualified newborn is:

- The second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient; or
- Admitted to an intensive care unit in an approved hospital
- Remains in hospital without its mother

If a qualified newborn remains in hospital after day 9, a change of care type is not required. A qualified newborn is considered to be receiving acute care and therefore a change in care type unnecessary. Note: this rule applies also to twin 2.

It is important to note that stillbirths are not reported to the APC data collection.

Example

The final Episode of Care for newborns must contain all [Diagnosis] and [Procedure] codes used in all Episodes of Care. For example, a newborn had three Episodes of Care from 05:36 12-Aug-2019 to 18:45 16-Aug-2019.

First Episode Of Care:

- [Admission Date]: 0536
- [Admission Time]: 12082019

- [Episode Of Care]: 5 (Unqualified newborn)
- [Diagnosis]:
    - [Principal Diagnosis]: Z382 (Singleton unsp as to place of birth)
    - [Condition Onset Flag] for [Principal Diagnosis]: 2 (Not during care)
    - [Additional Diagnosis]: none
    - [Condition Onset Flag] for [Additional Diagnosis]: none
- [Procedure]:
    - First [Procedure]: none
    - [Procedure Location Indicator] for First [Procedure]: none
    - Additional [Procedure]: none
    - [Procedure Location Indicator] for Additional [Procedure]: none
- Nature Of Separation]: A (Administrative discharge)
- [Separation Date]: 0559
- [Separation Time]: 12082019
- [Source Of Referral]: 8 (Other)

Second Episode Of Care:

- [Admission Date]: 0600
- [Admission Time]: 12082019
- [Episode Of Care]: 6 (Qualified newborn)
- [Diagnosis]:
    - [Principal Diagnosis]: Z382 (Singleton unsp as to place of birth)
    - [Condition Onset Flag] for [Principal Diagnosis]: 2 (Not during care)
    - [Additional Diagnosis]: none
    - [Condition Onset Flag] for [Additional Diagnosis]: none
- [Procedure]:
    - First [Procedure]: none
    - [Procedure Location Indicator] for First [Procedure]: none
    - Additional [Procedure]: none
    - [Procedure Location Indicator] for Additional [Procedure]: none
- [Nature Of Separation]: A (Administrative discharge)
- [Separation Date]: 1746
- [Separation Time]: 14082019
- [Source Of Referral]: A (Administrative admission)

Third Episode Of Care:

- [Admission Date]: 1747
- [Admission Time]: 14082019
- [Episode Of Care]: 5 (Unqualified newborn)
- [Diagnosis]:
    - [Principal Diagnosis]: P252 (Pneumomediastinum in perinatal period)

    - [Condition Onset Flag] for [Principal Diagnosis]: 2 (Not during care)
    - [Additional Diagnosis]:
        - P925 (Neonatal difficulty in feeding at breast)
        - Z0371 (Obs newb for suspect infectious cond)
        - Z292 (Other prophylactic pharmacotherapy)
        - Z380 (Singleton born in hospital)
    - [Condition Onset Flag] for [Additional Diagnosis]:
        - 1 (During care)
        - 2 (Not during care)
        - 2 (Not during care)
        - 2 (Not during care
- [Procedure]:
    - First [Procedure]: 9204400 (Other oxygen enrichment)
    - [Procedure Location Indicator] for First [Procedure]: 1 (This hospital)
    - Additional [Procedure]:
        - 9619902 (IV admin of pharmac agent anti-infective)
        - 9619919 (IV admin of pharmac agt oth & unsp agent)
    - [Procedure Location Indicator] for Additional [Procedure]: 1 (This hospital)
- [Nature Of Separation]: 1 (Home)
- [Separation Date]: 1845
- [Separation Time]: 16082019
- [Source Of Referral]: A (Administrative admission)

Outpatient Services

Some services are classified as outpatient services. However, if the Doctor believes the patient requires admission to hospital, based on individual need, then the patient can be admitted as a same day patient.

Overnight Stay

Includes:

- A patient who, following a clinical decision, receives hospital treatment for a minimum of one night (i.e. who is admitted to and separated from the hospital on different dates).
- Treatment provided to an intended same-day patient who is subsequently classified as an overnight stay patient is regarded as part of the overnight episode.
- Patients who leave of their own accord, die, or are transferred on their first day in hospital.

Excludes:

- Persons who are not sick (e.g. Healthy mothers accompanying sick children). See Boarder, page 189.

Patient number

Enter patient numbers with leading zeros where appropriate (e.g. pad the number with leading zeros to make it a 10-character number).

Thus, a patient number of 537859 is entered as: 0000537859.

The following data elements are in scope for patient numbers:

- [Contracted Service Patient Unit Record Number]
- [Patient Unit Record Number]

Periods of Leave

Four data elements are used when a patient undertakes a period of leave:

- During treatment:
    - [Leave From Date]
    - [Leave From Time]
    - [Leave To Date]
    - [Leave To Time]

[Leave From Date]

[Leave From Date] is the date (only) when the patient begins a period of leave.

[Leave From Time]

[Leave From Time] is the time (only) when the patient begins a period of leave.

[Leave To Date]

[Leave To Date] is the date (only) when the patient ends a period of leave.

[Leave To Time]

[Leave To Time] is the time (only) when the patient ends a period of leave.

A patient can have numerous periods of leave within the one episode of care. Periods of leave must be reported in chronological order.

Periods of leave ≥ 5 hours must be reported to the Admitted Patient Care data set.

Only four periods of leave can be reported for an episode of admitted patient care. If more than four periods of leave were taken during an episode, then it is acceptable to enter the total of all subsequent leave hours in the fourth period of leave data element fields.

A period of leave of < 5 hours should be captured on the patient record; however, that period of leave does not need to be reported to the Admitted Patient Care data set. The time of departure and return to the ward must be documented in the health record along with the reason for leave being taken, particularly if the patient is attending another health service or medical appointment.

A patient qualifies for a period of leave if they meet the following criteria:

- Is not discharged; remains under the responsibility of the primary hospital while on leave
- Does not exceed seven consecutive days (except for patients with [Legal Status]: 3 (Involuntary))
- Intends to return to hospital after leave
- Requires an absence from their hospital to undertake an outpatient service at another hospital

No charges are generated while a patient is on a period of leave.

No accrual for Long Stay is made while a patient is on a period of leave.

If a patient notifies their intent not to return to hospital, then the patient is discharged as at the time notified:

- [Leave To Date]: Date of notification not return from leave
- [Leave To Time]: Time at which notification not return from leave
- [Separation Date]: Date of notification not return from leave
- [Separation Time]: Time at which notification not return from leave
- [Nature Of Separation]: 0 (Discharge on leave)

If that patient is subsequently admitted to hospital with a condition related to their previous admission:

- [Source Of Referral]: 0 (Admit from leave)

Example

A period of leave of one day (10:00 04-Mar-2019 to 09:00 05-Mar-2019) would be entered as:

- [Leave From Date]: 04032019
- [Leave From Time]: 1000
- [Leave To Date]: 05032019
- [Leave To Time]: 0900

A period of weekend leave (from 18:30 06-Mar-2019 to 08:15 09-Mar-2019) would be entered as:

- [Leave From Date]: 06032019
- [Leave From Time]: 1830
- [Leave To Date]: 09032019
- [Leave To Time]: 0815

A patient who had the following periods of leave:

	Leave from Date	Leave from time	Leave to Date	Leave to Time	Length (hours)
1	01-Dec-2018	10:00	02-Dec-2018	10:00	24
2	05-Dec-2018	14:00	06-Dec-2018	12:00	46
3	08-Dec-2018	18:00	10-Dec-2018	18:00	48
4	15-Dec-2018	13:00	17-Dec-2018	09:00	44
5	25-Dec-2018	11:00	27-Dec-2018	11:00	48
6	31-Dec-2018	09:00	02-Jan-2019	09:00	48
7	04-Jan-2019	14:00	06-Jan-2019	14:00	48
8	10-Jan-2019	10:00	11-Jan-2019	15:00	29

These periods of leave would be recorded in the Admitted Patient Care data set as follows.

First period of leave:

- [Leave From Date]: 01122018
- [Leave From Time]: 1000
- [Leave To Date]: 02122018
- [Leave To Time]: 1000

Second period of leave:

- [Leave From Date]: 05122018
- [Leave From Time]: 1400
- [Leave To Date]: 06122018
- [Leave To Time]: 1200

Third period of leave:

- [Leave From Date]: 08122018
- [Leave From Time]: 1800
- [Leave To Date]: 10122018
- [Leave To Time]: 1800

Fourth period of leave:

- [Leave From Date]: 15122018
- [Leave From Time]: 1300
- [Leave To Date]: 24122018
- [Leave To Time]: 1400

Note the fourth period of leave represents the total 9 days (217 hours) of leave the patient took between 15-Dec-2018 and 11-Jan-2019.

Reciprocal Health Care Agreements (RCHA)

As at May 2018, Australia has Reciprocal Health Care Agreements (RCHA) with 11 countries:

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

Up to date information on overseas patient's eligibility is available from the Department of Human Services:

https://www.humanservices.gov.au/individuals/services/medicare/reciprocal-health-care-agreements/visitors-australia/medical-care-visitors-australia

Patients admitted under a RCHA require:

- At admission:
    - [Admission Election]: 1 (Hospital)

Residential Aged Care Facility or Hostel

Patient discharged to a residential aged care facility or hostel (which is not the patient's usual residence) providing medical or nursing care.

Exclusions:

- If the residential aged care facility or hostel is their usual place of residence, use [Nature Of Separation] as 1 (Home).
- Youth hostels and backpackers hostels are considered accommodation only hostels and do not provide medical or nursing care. If a patient is discharged to an accommodation only hostel, use [Nature Of Separation] as 1 (Home).

Retrieval

Retrieval involves the transportation of seriously ill or injured patient under the specialist care of a recognised retrieval team. The seriously ill or injured person/s requires specialised monitoring and treatment in transit to the retrieving hospital. A retrieval team is formally recognised by the hospital and usually consists of two staff: a medical officer and a nurse. On some occasions the team may include a second medical officer and/or nurse.

A retrieval admission requires:

- At separation:
    - [Hospital Transferred To]
    - [Nature Of Separation]: X (Retrieval)
- At admission (to new hospital):
    - [Hospital Transferred From]
    - [Source Of Referral]: X (Retrieval)

Same-day Patient

A Same-day Patient is a patient who is admitted and separated on the same calendar day, and who received treatment in one of two categories of procedures. Same-day patients include intended overnight-stay patients who left of their own accord, died or were transferred on their first day in the hospital.

Day Only Type B Bands

Type B classifies procedures into four bands:

- Band 1 is a categorisation of Day Only Patients which includes gastrointestinal endoscopy, certain minor surgical items and non-surgical procedures that do not normally require anaesthetic:
    - (a) is a definitive list of procedures with no flexibility for re-classifications to another band
    - (b) professional attention that embraces all other day only admission to hospital not related to Bands 2, 3, or 4.
- Band 2 is a categorisation of Day Only Patients which includes procedures (other than Band 1) carried out under local anaesthetic with no sedation.
- Band 3 is a categorisation of Day Only Patients which includes procedures (other than Band 1) carried out under general or regional anaesthesia, or intravenous sedation. Theatre time (actual time in theatre) is less than one hour.
- Band 4 is a categorisation of Day Only Patients which includes procedures (other than Band 1) carried out under general or regional anaesthesia, or intravenous sedation. Theatre time (actual time in theatre) is one hour or more.

Day Only Type C Exclusion List

- Day Only Type C professional attention includes those procedures that do NOT normally require hospital treatment.
- The Type C exclusion list is a list of services for which basic table benefits will not normally be paid.

Separation Types

A separation may be one of the following types:

- **Formal Separation**: see Formal Admission and Formal Separation, page 202.
- **Administrative Separation**: see Administrative Separation and Administrative Admissions, page 186.
- **End of Quarter (EOQ) Separation**: see End of Quarter Reporting, page 200.

Sex and Gender

The term 'sex' denotes the biological characteristics of an individual, typically categorised as male or female. However, some individuals may possess both male and female characteristics, neither, or other sexual characteristics. Sex is assigned at birth and is generally considered fixed, though it can change over a person's lifetime through procedures commonly known as sex change, gender reassignment, gender affirmation, transgender reassignment, or sexual reassignment. Throughout this process, which may span a significant duration, sex may be identified as male, female, or other.

'Gender' refers to an individual's identification with masculine or feminine characteristics. It encompasses a person's deeply held internal sense of gender, which may not align exclusively with their assigned sex at birth. Gender identity is subjective and can evolve over time, independent of biological factors.

The distinction between sex and gender lies in their definitions: sex pertains to the physical or biological aspects of the body, while gender relates to the way an individual perceives themselves and is recognised within society. This includes outward social markers like name, appearance, mannerisms, and attire. Sexual orientation, on the other hand, is separate from both sex and gender, focusing on an individual's emotional or sexual attraction to others and is not addressed in the context of collecting sex-related information.

In general, both sex and gender should not be collected in a single collection instrument. The Australian Government Guidelines on the Recognition of Sex and Gender recommends the preferred Australian Government approach of collecting and using gender information, with sex only being collected where there is a legitimate need to know the biological characteristics of the target population. It should be recognised that in some cases an individual may choose to report their gender when sex is being requested.

Organisations should ensure when they collect sex and/or gender information they use the correct terminology for the information they are seeking. Male and female are predominantly associated with the set of biological attributes that define the different types of sexes, while masculine and feminine characteristics are predominantly associated with the set of factors that make up gender. However, it should be recognised that male/female and masculine/feminine are sometimes used interchangeably to refer to sex and/or gender.

Status Change

Status change refers to either a change in:

- [Admission Election]
- [Admission Type]

Three data elements govern status changes:

- [Status Change Effective Date]
- [Status Change Election]
- [Status Change Type]

[Status Change Effective Date]

[Status Change Effective Date] is the date when a status change becomes effective.

[Status Change Election]

[Status Change Election] is the change to/from Public to Private patient.

[Status Change Type]

[Status Change Type] is the change to/from Ordinary to Long stay patient.

A [Status Change Effective Date] requires one more of:

- [Status Change Election]
- [Status Change Type]

A status change can be made if the following criteria are met.

During treatment:

- [Episode Of Care]: either:
    - 1 (Acute)
    - 2 (Maintenance care)
- Length of stay ≥ 35 days
- [Funding Source]: neither:
    - 01 (Compensable: MVA)
    - 02 (Compensable: WC)
    - 03 (Compensable: Other)
    - 08 (Non-Medicare)
    - 07 (Overseas: RHCA)

Example

The following details would be entered if the patient changed from a Private, Ordinary patient to a Hospital, Long Stay: Acute patient on 15-Aug-2019:

- During treatment:
    - [Status Change Election]: 1 (Hospital)
    - [Status Change Type]: 2 (Long stay: Acute)
    - [Status Change Date]: 15082019

Transfers

There are four types of transfers:

- Component care: see Component Care and Contracted Care, page 191.
- Contracted care: see Component Care and Contracted Care, page 191.
- Hospital Transfer: see Inter-Hospital Transfer, Transfer Up page 212.
- Hospital Transfer: see Inter-Hospital Transfer, Transfer Down page 212.

Transfer to Discharge Lounge

Two data elements are required to record Transfer to Discharge Lounge:

- At separation:
    - [Date Of Transfer To Discharge Lounge]
    - [Time Of Transfer To Discharge Lounge]

[Date Of Transfer To Discharge Lounge]

[Date Of Transfer to Discharge Lounge] is the date (only) when the patient is transferred to the discharge lounge.

[Time Of Transfer To Discharge Lounge]

[Time Of Transfer To Discharge Lounge] is the time (only) when the patient is transferred to the discharge lounge.

Example

A transfer to the discharge lounge which took place at 18:30 on 06-Mar-2019 would be entered as:

- [Date Of Transfer To Discharge Lounge]: 06032019
- [Time Of Transfer To Discharge Lounge]: 1830

This information is used to calculate the percentage of overnight stay separations that occur before 11am as a proportion of all overnight stay separations.

The percentage serves as a key performance indicator for hospitals and is reported to the Portfolio Performance Review Committee and the Emergency Access Taskforce as of the Health Performance Agreements between SA Health and the Regions.

Veteran

Two data elements are required to record a veteran patient:

- At admission:
    - [Veteran Card Number]
    - [Veteran Card Type]

In addition, an admitted veteran patient requires:

- At admission:
    - [Admission Election]: 2 (Private)
    - [Funding Source]: either:
        - 01 (Compensable: MVA)
        - 02 (Compensable: WC)
        - 03 (Compensable: Other)
        - 04 (Veteran)
    - [Hospital Insurance]: 2 (No hospital Insurance)

[Veteran Card Number]

[Veteran Card Number] comprises several elements:

- State/Territory code: 1 character
    - N (New South Wales)
    - Q (Queensland)
    - S (South Australia)
    - T (Tasmania)
    - V (Victoria)
    - W (Western Australia)
- War code + identity number: 7 characters
    - If no war code, as is the case with World War 1 veterans, insert a blank and add 6 numeric characters (NNNNNN)
    - If War code is 1 alphabetic character, add 6 numeric characters (ANNNNNN)
    - If War code is 2 alphabetic characters, add 5 numeric characters (AANNNNN)
    - If War code is 3 alphabetic characters, add 4 numeric characters (AAANNNN)
- Segment link: 1 character
    - For Veterans: blank
    - For dependents of veterans: an alphabetic character. The alphabetic code is generated in the order by which the cards are issued. For example A, B, C, D etc.

Note:

- The State/Territory codes are not added to the Admitted Patient Care record

[Veteran Card Number]

[Veteran Card Type] is either:

- G (Gold: DVA Health Card - For all conditions)

- N (Not available)
- W (White: DVA Health Card - For specific conditions)

DOCUMENT CONTROL INFORMATION

Title:	Admitted Patient Care: Data Elements: Reference Manual 2023-2024
Description:	This document describes the data elements used in the Admitted Patient Care data set.
Version	6.0
Version Date	12th March 2024
Document Owner:	Manager Data Governance and Quality Assurance
Contributors:	Chloe Earls, Data Quality Assurance Officer Mark Hall, Manager Information Assembly Dan Atkins, Principal Data Governance and Metedata Officer Anthony Fantasia, A/Manager Data Governance and Quality Assurance
Document Location:	Objective - DATA GOVERNANCE_– Admitted Patient Care - Data Elements - Reference Manual 2023-2024
Objective Id:	A5186520
Document Classification	For Official Use Only-I1-A1