

Private Facility File Format

Queensland Hospital Admitted Patient Data Collection (QHAPDC)

2018 – 2019 Collection Year

V1.0

Private Facility File Format 2018 – 2019 v1.0

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Contents

Private Facility File Format 2018-2019 Collection Year.....	4
Introduction.....	4
Private Facility File Format.....	5
Header file.....	5
Patient File.....	8
Admission File.....	11
Activity File.....	16
Activity Details if Activity Code = A (Account Class Variation).....	17
Activity Details if Activity Code = L (Leave Episode).....	17
Activity Details if Activity Code = W (Ward/Unit Transfer).....	18
Activity Details if Activity Code = C (Contract Status).....	18
Activity Details if Activity Code = Q (Qualification Status).....	18
Activity Details if Activity Code = S (Sub and Non-Acute Items).....	19
Activity Details if Activity Code = T (Nursing Home Type).....	22
Activity Details if Activity Code = B (Mother's Patient Identifier of Baby Born in Hospital).....	22
Morbidity File.....	23
Mental Health File.....	25
Sub and Non-Acute Patient (SNAP) File.....	27
Palliative Care File.....	31
Department of Veterans' Affairs File.....	32
Private Validation Rules.....	33
Patient details records.....	33
Admission details records.....	35
Activity details records.....	38
Activity Code = A.....	38
Activity Code = L.....	38
Activity Code = W.....	39
Activity Code = C.....	39
Activity Code = Q.....	40
Activity Code = S.....	40
Activity Code = T.....	41
Activity Code = B.....	41
Morbidity details records.....	42
Mental Health details records.....	43
Sub and Non-Acute Patient details records.....	45
Palliative Care details records.....	47
Department of Veterans' Affairs details records.....	48
Private Processing Rules.....	49
RECORD IDENTIFIER = N.....	49
Patient File.....	49
Admission File.....	49
Activity File.....	49
Morbidity File.....	49
Mental Health File.....	49

Sub and Non-Acute Patient File.....	50
Palliative Care File.....	50
Department of Veterans' Affairs File	50
RECORD IDENTIFIER = A.....	51
Patient File	51
Admission File	51
Activity File	51
Morbidity File	51
Mental Health File.....	51
Sub and Non-acute Patient File	51
Palliative Care File.....	51
Department of Veterans' Affairs File	51
RECORD IDENTIFIER = D.....	52
Patient File	52
Admission File	52
Activity File	52
Morbidity File	52
Mental Health File.....	52
Sub and Non-Acute Patient File.....	52
Palliative Care File.....	52
Department of Veterans' Affairs File	52

Private Facility File Format 2018-2019 Collection Year

Introduction

This document specifies the file format for the electronic submission of data by private facilities to the Statistical Services Branch (SSB), Queensland Department of Health for the Queensland Hospital Admitted Patient Data Collection.

A record must be provided for each admitted patient, including all newborn babies, separated from any facility permitted to admit patients. Separated is an inclusive term meaning discharged, died, transferred or statistically separated.

All boarders and posthumous organ procurement donors are also included in the scope of the Collection.

SSB is able to electronically process amendments if the facility's patient record system is capable of supplying amendment and deletion records. These records have a record identifier of 'A' or 'D' as detailed in the following file format. Please inform your SSB contact prior to your facility commencing the reporting of any amendments and deletion records electronically.

There are 9 files specified in this document: Header, Patient, Admission, Activity, Morbidity, Mental Health, Sub and Non-Acute Patient, Palliative Care and Department of Veterans' Affairs.

The following is our standard when naming the files:

ffffctyyctyynn.filetype

ffff	five-digit facility number (zero filled from the left)
ctyycty	collection year to which the data relates
ynn	data extract number for collection year
filetype	HDR for the Header File
	PAT for the Patient File
	ADM for the Admission File
	ACT for the Activity File
	MOR for the Morbidity File
	MEN for the Mental Health File
	SNP for the Sub and Non-Acute Patient File
	PAL for the Palliative Care file
	DVA for the Department of Veterans' Affairs File

The 4th admission file for ABC Hospital (facility number 99999) for collection year 2018-2019 would be named:

9999920182019004.ADM

Data for multiple months or for a partial month can be supplied in the one extract file. The data extract number for a collection year must begin at '001' and be contiguous throughout the collection year.

Private Facility File Format

Header file

The header file contains an extraction details record (the facility and period for which data has been extracted, and the date the extraction took place) and file details records (the number and type of records on each file).

The extraction details record is the first record on the Header File. There should be only one extraction details record in the Header File.

For each file extracted, there must be a file details record on the Header File.

EXTRACTION DETAILS RECORD			
Record Identifier	1 char	E = Extraction details	
Facility Number	5 num	Must be a valid facility number	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
Extract Date	8 date	Date data extracted	ctyymmdd

FILE DETAILS RECORD			
Record Identifier	1 char	F = File details	
File Type	3 char	PAT = Patient ADM = Admission ACT = Activity MOR = Morbidity MEN = Mental Health SNP = Sub and Non-Acute Patient PAL = Palliative Care DVA = Department of Veterans' Affairs	
Record Type	1 char	N = New	
Number of Records	5 num	Number of new records	Right adjusted and zero filled from left; zero if null
Record Type	1 char	A = Amendment	
Number of Records	5 num	Number of amendment records	Right adjusted and zero filled from left; zero if null
Record Type	1 char	D = Deletion	

FILE DETAILS RECORD			
Number of Records	5 num	Number of deletion records	Right adjusted and zero filled from left; zero if null
Filler	8	Blank	

An example of a header file is:

```

E99999201807012018073120180820
FPATN00420A00020D00000
FADMN00420A00124D00001
FACTN00080A00000D00010
FMORN01000A00000D00005
FMENN00020A00000D00001
FSNPN00010A00002D00001
FPALN00008A00001D00002
FDVAN00003A00001D00001

```

The details provided by the above example are:

Extraction details

```

Facility 99999 –      ABC Private Facility
Extraction period   1 July 2018 to 31 July 2018
Extraction date     20 August 2018

```

File details

Patient file

```

420      New records
20       Amendments
0        Deletions

```

Admission details

```

420      New records
124     Amendments
1        Deletions

```

Activity

```

80      New records
0       Amendments
10      Deletions

```

Morbidity details

```

1000    New records
0       Amendments
5       Deletions

```

Mental Health details

```

20      New records
0       Amendments
1       Deletions

```

Sub and Non-Acute Patient file details

```

10      New records
2       Amendments
1       Deletions

```

Palliative Care details

```

8       New records

```

- 1 Amendments
- 2 Deletions

Department of Veterans' Affairs details

- 3 New records
- 1 Amendments
- 1 Deletions

Patient File

The header record is the first record on the file. There is only one header record, followed by the patient details records.

HEADER RECORD			
Facility Number	5 num	Must be the same as the facility number in the corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type PAT = Patient	
Number of Records	5 num	Total number of records in the file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify the version of the software used	Left adjusted, blank if null
Filler	234	Blank	

PATIENT DETAILS RECORDS			
Record Identifier	1 char	N = New A = Amendment	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by the facility	Right adjusted and zero filled from left
Family Name	24 char	First 24 characters of the patients surname	Left adjusted
First Given name	15 char	First 15 characters of the patients first given name	Left adjusted, blank if null
Second Given name	15 char	First 15 characters of second given name of patient	Left adjusted, blank if null
Address of Usual Residence	40 char	Number and street of usual residential address of patient Note: Post office box numbers, property names (with no other details, eg include access road name with the property name), or mail service numbers should NOT be recorded.	Blank if null

PATIENT DETAILS RECORDS			
Location of Usual Residence	40 char	Location associated with the permanent address	
Postcode of Usual Residence	4 num	Australian postcode associated with the permanent address. Supplementary codes as below (note that for Australian External Territory addresses, the actual postcode should be used). 9301 = Papua New Guinea 9302 = New Zealand 9399 = Overseas other (not PNG or NZ) 9799 = At sea 9989 = No fixed address 0989 = Not stated or unknown	
State of Usual Residence	1 num	State associated with the permanent address (note that for Australian External Territory addresses, the actual state id should be used). 0 = Overseas 1 = New South Wales 2 = Victoria 3 = Queensland 4 = South Australia 5 = Western Australia 6 = Tasmania 7 = Northern Territory 8 = Australian Capital Territory 9 = Not stated/Unknown/No fixed address/At sea	
Filler	4	Blank	
Sex	1 num	1 = Male 2 = Female 3 = Other	
Date of Birth	8 date	Full date of birth of the patient Where dd is unknown use 15 Where mm is unknown use 06 Where yy is unknown estimate year	ctyymmdd
Estimated Date of Birth Indicator	1 char	A flag to indicate whether any component of a reported date of birth is estimated. 1 = Estimated	Blank if null
Marital Status	1 num	1 = Never married 2 = Married (registered and de facto) 3 = Widowed 4 = Divorced 5 = Separated 9 = Not stated/unknown	

PATIENT DETAILS RECORDS			
Country of Birth	4 num	Country of birth of patient	Right adjusted and zero filled from left
Indigenous Status	1 num	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/unknown	
Filler	2	Currently not required	
Occupation	4	Currently not required	Blank if null
Employment Status	1	Currently not required	Blank if null
Medicare Eligibility	1 num	1 = Eligible 2 = Not eligible 9 = Not stated/unknown	
Medicare Number	11 num	Medicare number of the patient The eleventh digit is the number that precedes the patient's name on the card (the sub numerate). If a sub numerate cannot be supplied, the eleventh digit of the Medicare number should be provided as zero.	Blank if not available or if null
Australian South Sea Islander Status	1 char	Denotes whether the patient is of Australian South Sea Islander origin 1 = Yes 2 = No 9 = Not stated/unknown	
Contact for Feedback Indicator	1 char	Currently not required	Blank if null
Telephone Number – Home	20 char	Currently not required	Blank if null
Telephone Number – Mobile	20 char	Currently not required	Blank if null
Telephone Number – Business or Work	20 char	Currently not required	Blank if null

Admission File

The header record is the first record on the file. There is only one header record, followed by the admission details records.

HEADER RECORD			
Facility Number	5 num	Must be the same as the facility number in the corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctymmdd ctymmdd
File Type	3 char	Abbreviation to identify file type ADM = Admission	
Number of Records	5 num	Total number of records in the file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify the version of the software used	Left adjusted, blank if null
Filler	133	Blank	

ADMISSION DETAILS RECORDS			
Record Identifier	1 char	N = New A = Amendment D = Deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by the facility	Right adjusted and zero filled from left
Admission Date	8 date	Date of admission to the facility	ctymmdd
Admission Time	4 num	Time of admission to the facility (0000 to 2359)	hhmm (24 hour clock)
Account Class	12 char	Currently not required	Blank if null
Chargeable Status	1 num	1 = Public 2 = Private shared 3 = Private single	

ADMISSION DETAILS RECORDS			
Care Type	2 num	01 = Acute 20 = Rehabilitation 30 = Palliative 05 = Newborn 09 = Geriatric evaluation and management 10 = Psychogeriatric 11 = Maintenance 12 = Mental health 06 = Other care 07 = Organ procurement 08 = Boarder	Right adjusted, zero filled from left
Compensable Status	1 num	1 = Workers' Compensation Queensland 2 = Workers' Compensation (Other) 6 = Motor Vehicle (QLD) 7 = Motor Vehicle (Other) 3 = Compensable third party 4 = Other compensable 5 = Department of Veterans' Affairs 9 = Department of Defence 8 = None of the above	
Band	2 char	Classification to categorise same day procedures into the Commonwealth Bands. 1A = Band 1A 1B = Band 1B 2 = Band 2 3 = Band 3 4 = Band 4	Left adjusted, blank if null.
Source of Referral/Transfer	2 num	01 = Private medical practitioner (excl. Psychiatrist) 02 = Emergency dept – this hospital 03 = Outpatient dept – this hospital 23 = Residential aged care service 06 = Episode change 09 = Born in hospital 15 = Private psychiatrist 16 = Correctional facility 17 = Law enforcement agency 18 = Community service 19 = Routine readmission not requiring referral 14 = Other health care establishment 20 = Organ procurement 21 = Boarder 24 = Admitted patient transferred from another hospital 25 = Non-admitted patient referred from other hospital 29 = Other 31 = Residential mental health care facility	Right adjusted, zero filled from left

ADMISSION DETAILS RECORDS			
Transferring from Facility	5 num	Facility number from which the patient was transferred or referred Provide facility code if Source of Referral/Transfer is 16, 23, 24 or 25, 31	Right adjusted and zero filled from left; blank if null
Hospital Insurance	1 num	7 = Hospital insurance 8 = No hospital insurance 9 = Not stated/unknown	
Separation Date	8 date	Date of separation from the facility	Ctyymmdd
Separation Time	4 num	Time of separation from the facility (0000 to 2359)	hhmm (24 hour clock)
Mode of Separation	2 num	01 = Home/usual residence 16 = Transferred to another hospital 15 = Residential aged care service 05 = Died in hospital 06 = Episode change 07 = Discharged at own risk 09 = Non return from leave 12 = Correctional facility 04 = Other health care establishment 13 = Organ procurement 14 = Boarder 19 = Other 17 = Medi-Hotel 31 = Residential mental health care facility	Right adjusted and zero filled from left
Transferring to Facility	5 num	Facility number to which the patient was transferred Provide facility code if Mode of Separation is 12, 15 or 16, 31	Right adjusted and zero filled from left, blank if null
DRG	5	Currently not required	Blank if null
MDC	3	Currently not required	Blank if null
Baby Admission Weight	4 num	Admission weight in grams for neonates who are under 29 days or weigh less than 2500 grams at time of admission.	Right adjusted and zero filled from left, blank if null
Admission Ward	6 char	Code to describe the admitting ward	Left adjusted
Admission Unit	4 char	Code to describe admitting unit	Blank if null
Standard Unit Code	4 char	Standard code to describe the treating doctor speciality/unit	Left adjusted
Treating Doctor at Admission	6 char	Code to identify the treating doctor at the admission of the episode of care	Left adjusted, blank if null

ADMISSION DETAILS RECORDS			
Planned Same Day	1 char	Y = Yes, planned to be separated from the hospital on the same day N = No, planned to stay at least one night	
Elective Patient Status	1 char	1 = Emergency admission 2 = Elective admission 3 = Not assigned	
Qualification Status	1 char	A = Acute U = Unqualified	Blank if null
Standard Ward Code	4 char	Denotes whether the ward is assigned to a Designated SNAP Unit SNAP = Designated SNAP Unit	Blank if null
Contract Role	1 char	A = Hospital A (contracting hospital) B = Hospital B (contracted hospital) Identifies whether the hospital is 'Hospital A' – the purchaser of hospital care (contracting hospital) or 'Hospital B' - the provider of an admitted or non-admitted service (contracted hospital)	Blank if null
Contract Type	1 char	1 = B 2 = ABA 3 = AB 4 = (A)B 5 = BA Describes the contract arrangement between the contracting hospital ('Hospital A') and the contracted hospital ('Hospital B')	Blank if null
Funding Source	2 char	Expected principal source of funds for the episode. 01 = Health service budget (not covered elsewhere) 02 = Private health insurance 03 = Self-funded 04 = Workers' compensation 05 = Motor vehicle third party personal claim 06 = Other compensation (e.g. Public liability, common law and medical negligence) 07 = Department of Veterans' Affairs 08 = Department of Defence 09 = Correctional facility 10 = Other hospital or public authority (contracted care) 11 = Health service budget (due to eligibility for Reciprocal Health Care) 12 = Other funding source 13 = Health service budget (no charge raised due	Right adjusted and zero filled from left

ADMISSION DETAILS RECORDS			
		to hospital decision) 99 = Not known	
Incident Date	8 date	Currently not required	ctyymmdd Blank if null
Incident Date Flag	1 char	Currently not required	Blank if null
Workcover Queensland (Q-Comp) Consent	1 char	Currently not required	Blank if null
Motor Accident Insurance Commission (MAIC) Consent	1 char	Currently not required	Blank if null
Department of Veterans' Affairs (DVA) Consent	1 char	Currently not required	Blank if null
Department of Defence Consent	1 char	Currently not required	Blank if null
Preferred Language	4 num	Currently not required	Blank if null
Interpreter Required	1 num	Currently not required	Blank if null
Religion	4 num	Currently not required	Blank if null
QAS Patient Identification Number (eARF Number)	12 num	QAS patient identification number provided by the QAS team when delivering a patient to this facility.	Left adjusted, blank if null
Purchaser/Provider Identifier	5 num	The identifier of the 'other' facility or purchaser involved in the contracted care. Record the Facility ID of the other hospital if contract type = 2, 3, 4, 5 Record the ID of the jurisdiction, HHS or other external purchaser that has purchased the public contracted hospital care if contract type = 1 and contract role = B (Hospital B).	Right adjusted and zero filled from left; blank if null
Filler	6	Blank	
Length of Stay in an Intensive Care Unit	7 num	The total amount of time spent by an admitted patient in an approved intensive care unit (Adult Intensive Care Unit - ICU6 or Children's Intensive Care Service Level 6 - CIC6) Format HHHHMM H = Hours, M = Minutes	Right adjusted and zero filled from left; blank if null
Duration of continuous ventilatory support	7 num	The total amount of time an admitted patient has spent on continuous ventilatory support (ie invasive ventilation) Format HHHHMM H = Hours, M = Minutes	Right adjusted and zero filled from left; blank if null

Activity File

The header record is the first record on the file. There is only one header record, followed by the activity details records.

HEADER RECORD			
Facility Number	5 num	Must be the same as the facility number in the corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type ACT = Activity	
Number of Records	5 num	Total number of records in the file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify the version of the software used	Left adjusted, blank if null
Filler	25	Blank	

ACTIVITY DETAILS RECORDS			
Record Identifier	1 char	N = New D = Deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by the facility	Right adjusted and zero filled from left
Activity Code	1 char	A = Account class variation L = Leave episode W = Ward/unit transfer C = Contract status Q = Qualification status S = Sub and non-acute items T = Nursing home type B = Mother's patient identifier of baby born in hospital	
Activity Details		See below for record details	

Activity Details if Activity Code = A (Account Class Variation)

Account Class	12 char	Currently not required	Left adjusted, blank if null
Filler	2	Blank	
Chargeable Status	1 num	1 = Public 2 = Private shared 3 = Private single	
Compensable Status	1 num	1 = Workers' Compensation Queensland 2 = Workers' Compensation (Other) 6 = Motor Vehicle (Qld) 7 = Motor Vehicle (Other) 3 = Compensable Third Party 4 = Other Compensable 5 = Department of Veterans' Affairs 9 = Department of Defence 8 = None of the above	
Filler	2	Blank	
Date of Change	8 date	Date that change to account class occurred	ctymmdd
Time of Change	4 num	Currently not required	Blank if null

Activity Details if Activity Code = L (Leave Episode)

Date of Starting Leave	8 date	Date the patient went on leave	ctymmdd
Time of Starting Leave	4 num	Time the patient started leave	hhmm (24 hour clock)
Date Returned from Leave	8 date	Date the patient returned from leave	ctymmdd
Time Returned from leave	4 num	Time the patient returned from leave	hhmm (24 hour clock)
Filler	6	Blank	

Activity Details if Activity Code = W (Ward/Unit Transfer)

Ward	6 char	Ward that the patient was transferred to	
Unit	4 char	Unit that the patient was transferred to	Blank if null
Standard Unit Code	4 char	Standard unit that the patient was transferred to	
Date of Transfer	8 date	Date the patient transferred	ctyymmdd
Time of Transfer	4 num	Time the patient transferred	hhmm (24 hour clock)
Standard Ward Code	4 char	Denotes whether the ward is assigned to a Designated SNAP unit SNAP = Designated SNAP Unit	Blank if null

Activity Details if Activity Code = C (Contract Status)

Date Transferred for Contract	8 date	Date the patient transferred for a contract service	ctyymmdd
Date returned from Contract	8 date	Date the patient returned from a contract service	ctyymmdd
Facility Contracted to	5 num	Facility number for the facility performing the contracted service	
Filler	9	Blank	

Activity Details if Activity Code = Q (Qualification Status)

Qualification Status	1 char	A = Acute U = Unqualified	
Date of Change	8 date	Date that the change of qualification status occurred	ctyymmdd
Time of Change	4 num	Currently not required	Blank if null
Filler	17	Blank	

All changes of qualification status must be provided. If more than one change of qualification status occurs on a single day, then the final qualification status for that day should be provided.

Activity Details if Activity Code = S (Sub and Non-Acute Items)

SNAP information is required for all sub and non-acute patients with a public chargeable status.

SNAP Episode Number	3 num	The unique SNAP episode number	Right adjusted, zero filled from left
ADL Type	3 char	<p>Measure of physical, psychosocial, vocational and cognitive functions of an individual with a disability</p> <p>FIM = Functional Independence Measure (FIM) HON = Health of the Nation Outcomes Scale 65+ (HoNOS 65+) RUG = Resource Utilisation Groups-Activities of Daily Living (RUG-ADL) SMM = Standardised Mini-Mental State Examination (SMME)</p>	
ADL Subtype	3 char	<p>For patients assigned a Psychogeriatric care type: ADL Type = HON and record scores for 12 ADL Subtypes and a Total ADL Subtype:</p> <p>BEH = Behavioural disturbance NAS = Non-accidental self-injury DDU = Problem drinking or drug use CGP = Cognitive problems PID = Problems related to physical illness or disability HAD = Problems associated with hallucinations and delusions DPS = Problems with depressive symptoms OMB = Other mental and behavioural problems SSR = Problems with social or supportive relationships ADL = Problems with activities of daily living LVC = Overall problems with living conditions WLQ = Problems with work and leisure activities and the quality of the daytime environment. TOT = Total</p> <p>The FIM tool has a cognitive and a motor sub-scale.</p> <p>For patients assigned a Rehabilitation or Geriatric Evaluation and Management care type: ADL Type = FIM and record scores for the 13 Motor ADL Subtypes, 5 Cognitive ADL Subtypes and a Total Cognitive and a Total Motor ADL Subtype:</p> <p>EAT = Eating GRM = Grooming BTH = Bathing DRU = Dressing upper body</p>	

		<p>DRL = Dressing lower body TLT = Toileting BDR = Bladder management BWL = Bowel management TBC = Transfer (bed/chair/wheelchair) TTL = Transfer (toileting) TBS = Transfer (bath/shower) LWW = Locomotion (walk/wheelchair) LST = Locomotion (stairs) CMP = Comprehension EXP = Expression SOC = Social interaction PRS = Problem solving MEM = Memory MOT = Motor (total) COG = Cognitive (total)</p> <p>The RUG tool requires the collection of the total RUG score when assigning to a Maintenance or Palliative care type.</p> <p>ADL Type = RUG and record 1 ADL Subtype: TOT = Total</p> <p>Reporting of Standardised Mini-Mental State Examination scores is optional for patients assigned a Geriatric Evaluation and Management care type and not required for any other sub and non-acute care type. ADL Type = SMM and record scores for the 12 ADL Subtypes and a Total ADL Subtype:</p> <p>ORT = Orientation - time ORP = Orientation - place MIM = Memory - immediate LAT = Language/attention MSH = Memory - short LMW = Language memory – long (wristwatch) LMP = Language memory – long (pencil) LAV = Language/abstract thinking/verbal fluency LNG = Language LAC = Language/attention/comprehension ACD = Attention/comprehension/follow commands/constructional (diagram) ACP = Attention/comprehension/construction/follow commands (paper) TOT = Total</p>	
ADL Score	3 num	<p>Numerical rating from the ADL tool used as a measurement of different components of functional ability</p> <p>Where ADL Type is FIM and ADL Subtype is; ▪ EAT score must be between 1 and 7 or 999 ▪ GRM score must be between 1 and 7 or 999</p>	Right adjusted, zero filled from left

		<ul style="list-style-type: none"> ▪ BTH score must be between 1 and 7 or 999 ▪ DRU score must be between 1 and 7 or 999 ▪ DRL score must be between 1 and 7 or 999 ▪ TLT score must be between 1 and 7 or 999 ▪ BDR score must be between 1 and 7 or 999 ▪ BWL score must be between 1 and 7 or 999 ▪ TBC score must be between 1 and 7 or 999 ▪ TTL score must be between 1 and 7 or 999 ▪ TBS score must be between 1 and 7 or 999 ▪ LWW score must be between 1 and 7 or 999 ▪ LST score must be between 1 and 7 or 999 ▪ CMP score must be between 1 and 7 or 999 ▪ EXP score must be between 1 and 7 or 999 ▪ SOC score must be between 1 and 7 or 999 ▪ PRS score must be between 1 and 7 or 999 ▪ MEM score must be between 1 and 7 or 999 ▪ COG score must be between 5 and 35 or 999 ▪ MOT score must be between 13 and 91 or 999 <p>Where ADL Type is HON and ADL Subtype is;</p> <ul style="list-style-type: none"> ▪ BEH score must be between 0 and 4 or 999 ▪ NAS score must be between 0 and 4 or 999 ▪ DDU score must be between 0 and 4 or 999 ▪ CGP score must be between 0 and 4 or 999 ▪ PID score must be between 0 and 4 or 999 ▪ HAD score must be between 0 and 4 or 999 ▪ DPS score must be between 0 and 4 or 999 ▪ OMB score must be between 0 and 4 or 999 ▪ SSR score must be between 0 and 4 or 999 ▪ ADL score must be between 0 and 4 or 999 ▪ LVC score must be between 0 and 4 or 999 ▪ WLQ score must be between 0 and 4 or 999 ▪ TOT score must be between 0 and 48 or 999 <p>Where ADL Type is SMM and ADL Subtype is;</p> <ul style="list-style-type: none"> ▪ ORT score must be between 0 and 5 or 999 ▪ ORP score must be between 0 and 5 or 999 ▪ MIM score must be between 0 and 3 or 999 ▪ LAT score must be between 0 and 5 or 999 ▪ MSH score must be between 0 and 3 or 999 ▪ LMW score must be between 0 and 1 or 999 ▪ LMP score must be between 0 and 1 or 999 ▪ LAV score must be between 0 and 1 or 999 ▪ LNG score must be between 0 and 1 or 999 ▪ LAC score must be between 0 and 1 or 999 ▪ ACD score must be between 0 and 1 or 999 ▪ ACP score must be between 0 and 3 or 999 ▪ TOT score must be between 0 and 30 or 999 <p>Where ADL Type is RUG and ADL Subtype is;</p> <ul style="list-style-type: none"> ▪ TOT score must be between 4 and 18 or 999 	
ADL Date	8 date	Date the ADL score was recorded	ctyymmdd
ADL Time	4 num	Not currently required	Blank if null

Phase Type	2 num	A distinct period or stage of illness relating to palliative care patients. For example, when SNAP Type = PAL record one phase type: 01 = Stable 02 = Unstable 03 = Deteriorating 04 = Terminal Care	Blank if null Must not be null if SNAP Type = PAL
Filler	4	Blank	
<p><i>ADL scores for each SNAP episode are to be supplied. Do not provide more than one set of scores on the same date for the same ADL Type and ADL Subtype.</i></p> <p><i>For all SNAP episodes:</i></p> <ul style="list-style-type: none"> <i>An ADL score of 999 is valid when an assessment has not been undertaken.</i> 			

Activity Details if Activity Code = T (Nursing Home Type)

Nursing Home Type Flag	3 char	NHT = Nursing Home Flag	Not valid for patients with a care type of: 01 – Acute 05 – Newborn 07 – Organ Procurement 08 - Boarder
Date Commenced NHT Care	8 date	Date when the patient commenced Nursing Home Type care	ctyyymmdd
Date Ceased NHT Care	8 date	Date when the patient ceased Nursing Home Type care	ctyyymmdd
Filler	11	Blank	

Activity Details if Activity Code = B (Mother's Patient Identifier of Baby Born in Hospital)

Mother's Patient Identifier	8 char	Mother's Patient Identifier of baby born in the hospital	Right adjusted and zero filled from left
Filler	22	Blank	

Morbidity File

The header record is the first record on the file. There is only one header record, followed by the morbidity details records.

HEADER RECORD			
Facility Number	5 num	Must be the same as the facility number in the corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type MOR = Morbidity	
Number of Records	5 num	Total number of records in the file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify the version of the software used	Left adjusted, blank if null
Filler	66	Blank	

MORBIDITY DETAILS RECORDS			
Record Identifier	1 char	N = New D = Deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
Diagnosis Code Identifier	3 char	PD = Principal diagnosis OD = Other diagnosis EX = External cause code PR = Procedure M = Morphology	Left adjusted
ICD-10-AM Code (10th edition)	7 char	Code assigned from The International Statistical Classification of Diseases and Related Health Problems, 10 th Revision, Australian Modification, 10th edition	Left adjusted

MORBIDITY DETAILS RECORDS			
Diagnosis Text	50 char	Textual description of diseases and procedures are optional	Left adjusted, blank if null
Date of Procedure	8 date	Date that the procedure was performed. The date must be provided if the procedure is within the following block ranges: 1 to 1059 1062 to 1821 1825 to 1866 1869 to 1892 1894 to 1912 1920 to 2016	ctymmdd, blank if null
Contract Flag	1 num	Recorded by Hospital A when a patient receives an admitted or non-admitted contracted service from the contracted hospital (Hospital B) 1 = Contracted admitted procedure 2 = Contracted non-admitted procedure	Blank if null
Diagnosis Onset Type (Condition present on admission indicator)	1 char	An indicator for each diagnosis to indicate the onset and/or significance of the diagnosis to the episode of care. 1 = Condition present on admission to the episode of admitted patient care 2 = Condition arises during the current episode of admitted patient care 9 = Condition onset unknown/uncertain	Blank if null
Most Resource Intensive Condition Flag	1 char	Currently not required	Blank if null
Other Co-Morbidity of Interest Flag	1 char	Currently not required	Blank if null

Mental Health File

A record is to be provided on the mental health details file for each episode of care where the standard unit code (either at admission to the episode or through a unit transfer during the episode) is in the range PYAA to PYZZ.

No record is to be provided if there were no standard unit codes in this range during the episode of care.

The header record is the first record on the file. There is only one header record, followed by the mental health details records.

HEADER RECORD			
Facility Number	5 num	Must be the same as the facility number in the corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctymmdd ctymmdd
File Type	3 char	Abbreviation to identify file type MEN = Mental health	
Number of Records	5 num	Total number of records in the file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify the version of the software used	Left adjusted, blank if null
Filler	2	Blank	

MENTAL HEALTH DETAILS RECORDS			
Record Identifier	1 char	N = New, A = Amendment D = Deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left

MENTAL HEALTH DETAILS RECORDS			
Type of Usual Accommodation	1 char	1 = House or flat 2 = Independent unit as part of a retirement village or similar 3 = Hostel or hostel type accommodation 4 = Psychiatric hospital 5 = Acute hospital 7 = Other accommodation 8 = No usual residence 6 = Residential mental health care facility	
Employment Status	1 char	1 = Child not at school 2 = Student 3 = Employed 4 = Unemployed 5 = Home duties 6 = Pensioner 8 = Other	
Pension Status	1 char	1 = Aged pension 2 = Repatriation pension 3 = Invalid pension 4 = Unemployment benefit 5 = Sickness benefit 7 = Other 8 = No pension/benefit	
First Admission For Psychiatric Treatment	1 char	1 = No previous admission for psychiatric treatment 2 = Previous admission for psychiatric treatment	
Referral to Further Care	2 char	01 = Not referred 02 = Private psychiatrist 03 = Other private medical practitioner 04 = Mental health/alcohol and drug facility - admitted patient 05 = Mental health/alcohol and drug facility - non-admitted patient 06 = Acute hospital - admitted patient 07 = Acute hospital - non-admitted patient 08 = Community health program 09 = General Practitioner 10 = Residential mental health care facility 29 = Other 98 = Not Applicable	Right adjusted and zero filled from left
Mental Health Legal Status Indicator	1 char	1 = Involuntary patient for any part of the episode 2 = Voluntary patient for all of the episode	
Previous Specialised Non-Admitted Treatment	1 char	1 = Patient has no previous non-admitted service contacts for psychiatric treatment 2 = Patient has previous non-admitted service contacts for psychiatric treatment	

Sub and Non-Acute Patient (SNAP) File

SNAP information is required for all sub and non-acute patients with a public chargeable status.

A record for each SNAP type is to be provided on the sub and non-acute patient details file for each episode of care where the care type is sub-acute or non-acute (ie Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care, Psychogeriatric Care or Maintenance Care)

No record is to be provided if the care type is mental health, acute, newborn, boarder, organ procurement or other care.

The header record is the first record on the file. There is only one header record, followed by the sub and non-acute patient details records.

HEADER RECORD			
Facility Number	5 num	Must be the same as the facility number in the corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctymmdd ctymmdd
File Type	3 char	Abbreviation to identify file type SNP = Sub and Non-acute Patient	
Number of Records	5 num	Total number of records in the file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify the version of the software used	Left adjusted, blank if null
Filler	31	Blank	

SUB AND NON-ACUTE PATIENT DETAILS RECORDS			
Record Identifier	1 char	N = New A = Amendment D = Deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted, zero filled from left
SNAP Episode Number	3 num	The unique SNAP episode number	Right adjusted, zero filled from

SUB AND NON-ACUTE PATIENT DETAILS RECORDS			
			left
SNAP Type	3 char	<p>Classification of a patient's care type based on characteristics of the person, the primary treatment goal and evidence.</p> <p>PAL = Palliative care RCD = Rehabilitation – congenital deformities ROI = Rehabilitation - other disabling impairments RST = Rehabilitation – stroke RBD = Rehabilitation – brain dysfunction RNE = Rehabilitation – neurological RSC = Rehabilitation - spinal cord dysfunction RAL = Rehabilitation – amputation of limb RPS = Rehabilitation - pain syndromes ROF = Rehabilitation – orthopaedic conditions, fractures ROR = Rehabilitation – orthopaedic conditions, replacement ROA = Rehabilitation – orthopaedic, all other RCA = Rehabilitation – cardiac RMT = Rehabilitation - major multiple trauma RPU = Rehabilitation – pulmonary RDE = Rehabilitation – debility (reconditioning) RDD = Rehabilitation – developmental disabilities RBU = Rehabilitation – burns RAR = Rehabilitation – arthritis GEM = Geriatric evaluation and management care MRE = Maintenance – respite MNH = Maintenance - nursing home type MCO = Maintenance - convalescent care MOT = Maintenance – other PSG = Psychogeriatric care</p>	
AN-SNAP Group Classification	3 num	Currently not required	Blank if null
SNAP Episode Start Date	8 date	The start date of each SNAP episode	ctyymmdd
SNAP Episode End Date	8 date	The end date of each SNAP episode	ctyymmdd
Multidisciplinary Care Plan Flag	1 char	<p>There is documented evidence of an agreed multidisciplinary care plan.</p> <p>Y = Yes N = No U = Unknown</p>	<p>Required for patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type. Blank if null</p>

SUB AND NON-ACUTE PATIENT DETAILS RECORDS			
Multidisciplinary Care Plan Date	8 date	The date of the establishment of the multidisciplinary care plan	Ctyymmdd Required for patients with a Rehabilitation , Geriatric Evaluation and Management , Psychogeriatric or Palliative SNAP Type and Multidisciplinary Care Plan Flag = 'Y' Blank if null
Proposed Principal Referral Service	3 num	<p>The principal type of service proposed for a patient post discharge. Only one proposed service can be provided. If there is more than one proposed service, provide the principal service.</p> <p>001 = No service is required 101 = Community/home based rehabilitation 102 = Community/home based palliative 103 = Community/home based geriatric evaluation and management 111 = Community/home based – nursing/domiciliary 104 = Community/home based respite 105 = Community/home based psychogeriatric 106 = Home and community care 107 = Community aged care package, extended aged care in the home 108 = Flexible care package 109 = Transition care program (includes intermittent care service) 110 = Outreach Service 198 = Community/home based – other 201 = Hospital based (admitted) – rehabilitation 202 = Hospital based (admitted) – maintenance 203 = Hospital based (admitted) – palliative 204 = Hospital based (admitted) – geriatric evaluation and management 205 = Hospital based (admitted) – respite 206 = Hospital based (admitted) – psychogeriatric 207 = Hospital based (admitted) – acute 208 = Hospital based – non-admitted services 298 = Hospital based – other 998 = Other service 999 = Not stated/unknown service</p>	Required for patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type. Blank if null
Primary Impairment Type	7 char	The impairment which is the primary reason for admission to the episode.	Left adjusted, Blank if null. Only required for patients with

SUB AND NON-ACUTE PATIENT DETAILS RECORDS			
			a rehabilitation SNAP type
Clinical Assessment Only Indicator	1 num	Currently not required	Blank if null

For Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care, Psychogeriatric Care SNAP Episodes

- *At least one set of mandatory ADL scores must be provided for each SNAP episode.*
- *There can only be one SNAP episode within a single sub-acute episode of care.*
- *The start date of the SNAP episode must be the same as the start date of the episode of care.*
- *The end date of the SNAP episode must be the same as the end date of the episode of care.*

For Maintenance SNAP Episodes

- *At least one set of mandatory ADL scores must be provided for each SNAP episode.*
- *There must be at least one SNAP episode within a single non-acute episode of care.*
- *If there is more than one SNAP episode then these must be contiguous.*
- *The start date of the first SNAP episode must be the same as the start date of the episode of care.*
- *The end date of the last SNAP episode must be the same as the end date of the episode of care.*

Palliative Care File

A record is to be provided on the palliative care details file for each episode of care where the care type is: 30 = Palliative care

No record is to be provided if the care type is NOT 30.

The header record is the first record on the file. There is only one header record, followed by the palliative care details records.

HEADER RECORD			
Facility Number	5 num	Must be the same as the facility number in the corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type PAL = Palliative Care	
Number of Records	5 num	Total number of records in the file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify the version of the software used	Left adjusted, blank if null

PALLIATIVE CARE DETAILS RECORDS			
Record Identifier	1 char	N = New A = Amendment D = Deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions, etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (e.g. Unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
First Admission For Palliative Care Treatment	1 char	1 = No previous admission for palliative care treatment 2 = Previous admission for Palliative care treatment	
Previous Specialised Non-Admitted Palliative Care Treatment	1 char	1 = Patient has no previous non-admitted service contacts for Palliative care treatment 2 = Patient has previous non-admitted service contacts for Palliative care treatment	
Filler	4	Blank	

Department of Veterans' Affairs File

A record is to be provided on the Department of Veterans' Affairs patient details file where the charges for the episode of care are met by the Department of Veterans' Affairs.

A record is not to be provided if the charges for the episode of care are not met by the Department of Veterans' Affairs.

The header record is the first record on the file. There is only one header record, followed by the Department of Veterans' Affairs details records.

HEADER RECORD			
Facility Number	5 num	Must be the same as the facility number in the corresponding header file	Right adjusted and zero filled from left
Extract Period	16 date	From date To date	ctyymmdd ctyymmdd
File Type	3 char	Abbreviation to identify file type DVA = Department of Veterans' Affairs	
Number of Records	5 num	Total number of records in the file	Right adjusted and zero filled from left; zero if null
Extraction Software Identifier	10 char	Code to identify the version of the software used	Left adjusted, blank if null
Filler	5	Blank	

DEPARTMENT OF VETERANS' AFFAIRS DETAILS RECORDS			
Record Identifier	1 char	N = New A = Amendment D = Deletion	
Unique Number	12 char	A number unique within the facility to identify each admission. This number is not to be reused, regardless of deletions etc.	Right adjusted and zero filled from left
Patient Identifier	8 char	Unique number to identify the patient within the facility (eg. unit record number)	Right adjusted and zero filled from left
Admission Number	12 char	Admission number allocated by facility	Right adjusted and zero filled from left
DVA File Number	10 char	The patient's Department of Veterans' Affairs identification number	Left adjusted and space filled from the right
DVA Card Type	1 char	Denotes whether the patient is a gold or white card holder G = Gold W = White	

Private Validation Rules

These validation rules apply only to New (N), Amendment (A) and Delete (D) records.

Patient details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by facility Must not be null Must not be zero Must be unique for each admission within facility
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within facility
Family Name	Must not be null
Patient First name	No validation
Patient Second name	No validation
Address of Usual Residence	No validation
Location (Suburb/town) of Usual Residence	Must not be null Validated against Locality Data Set parts with the Postcode and Locality of Usual Residence
Postcode of Usual Residence	Must not be null Validated against Locality Data Set parts with the Postcode and Locality of Usual Residence
State of Usual Residence	Must not be null Validated against a list of State codes
Sex	Must not be null Validated against a list of valid sex codes
Date of Birth	Must not be null Must be a valid date Must not be in the future (ie. past current date) Must not be after the admission date Must not be more than 124 years prior to admission date

Data Item	Guidelines
Estimated Date of Birth Indicator	Can be null Validated against a list of estimated date of birth indicator codes
Marital Status	Must not be null Validated against a list of marital status codes
Country of Birth	Must not be null Validated against country codes
Indigenous Status	Must not be null Validated against a list of indigenous status codes
Occupation	Currently not required, no validation
Employment Status	Currently not required, no validation
Medicare Eligibility	Must not be null Validated against a list of Medicare eligibility codes
Medicare Number	Must be a valid Medicare number, if not null 11 digit Medicare number required The eleventh digit is the number that precedes the patient's name on the card (the sub numerate). If a sub numerate cannot be supplied, the eleventh digit of the Medicare number should be provided as zero
Australian South Sea Islander Status	Must not be null Must be 1, 2 or 9
Contact for Feedback Indicator	Currently not required, no validation
Telephone Number – Home	Currently not required, no validation
Telephone Number – Mobile	Currently not required, no validation
Telephone Number – Business or Work	Currently not required, no validation

Admission details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within the facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility
Admission Date	Must not be null Must be a valid date Must not be in the future (i.e. past current date) Must not be before the birth date of the patient Must be before or on the separation date
Time of Admission	Must not be null Must be a valid time Must be before the separation time, if admitted the same day as separated
Account Class	Not currently required, no validation
Chargeable Status	Validated against a list of chargeable status codes Must not be null
Care Type	Validated against a list of type of episode codes Must not be null
Compensable Status	Validated against a list of compensable status codes Must not be null
Band	Validated against a list of band codes, if not null Must be a same day patient
Source of Referral/Transfer	Validated against a list of source of referral/transfer codes Must not be null
Transferring from Facility	Must not be null if source of referral/transfer is 16, 23, 24 or 25 Only applicable if source of referral/transfer is 16, 23, 24 or 25 Must be a valid facility number

Data Item	Guidelines
Hospital Insurance	Validated against list of hospital insurance codes Must not be null
Separation Date	Must not be null Must be a valid date Must not be in the future (ie. past current date) Must be on or after the admission date
Separation Time	Must not be null Must be a valid time Must be after admission time
Mode of Separation	Must not be null Validated against a list of mode of separation codes
Transferring to Facility	Must not be null if mode of separation is 12, 15 or 16 Only applicable if mode of separation is 12, 15 or 16 Must be a valid facility number
DRG	Not currently required, no validation
MDC	Not currently required, no validation
Baby Admission Weight	Must not be null if patient age is under 29 days, or admission weight is less than 2500 grams
Admission Ward	Must not be null No validation
Admission Unit	No validation
Standard Unit Code	Must not be null Must be a valid standard unit code
Treating Doctor at admission	No validation
Planned Same Day	Must be Y or N
Elective Patient Status	Must not be null Must be a valid elective patient status code
Qualification Status	Can be null Validated against a list of qualification status codes
Standard Ward Code	Can be null Must be a valid standard ward code
Contract Role	Can be null Must be a valid contract role code
Contract Type	Can be null Must be a valid contract type code

Data Item	Guidelines
Funding Source	Must not be null Validated against a list of funding source codes If Funding Source = 10 then contract role and contract type cannot be null
Incident Date	Not currently required, no validation
Incident Date Flag	Not currently required, no validation
WorkCover Queensland (Q-Comp) Consent	Not currently required, no validation
Motor Accident Insurance Commission (MAIC) Consent	Not currently required, no validation
Department of Veterans' Affairs (DVA) Consent	Not currently required, no validation
Department of Defence Consent	Not currently required, no validation
Interpreter Required	Not currently required, no validation
Religion	Not currently required, no validation
QAS Patient Identification Number (eARF Number)	Can be null Validated against source of referral/transfer
Purchaser/Provider Identifier	Must be a valid establishment number Must not be null if contract role = A or B and contract type = 2, 3, 4 or 5 Must not be null if contract role = B and Contract Type = 1 and chargeable status is public
Length of Stay in an Intensive Care Unit	Must not be null if treatment was provided in an ICU Level 6 or CIC Service Level 6
Duration of Continuous Ventilatory Support	Must not be null if the patient received continuous ventilatory support

Activity details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within the facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility
Activity Code	Must be a valid code (A, L, W, C, Q, S, T, B)

Activity Code = A

Data Item	Guidelines
Account Class Code	Currently not required, no validation
Chargeable Status	Validated against a list of chargeable status codes
Compensable Status	Validated against a list of compensable status codes
Date of Change	Valid date format Must not be null Must not be before the admission date Must not be after the separation date
Time of Change	Not currently required, no validation

Activity Code = L

Data Item	Guidelines
Date of Starting Leave	Must be a valid date Must not be null Must not be before the admission date Must not be after the separation date Must not fall within any other leave periods Same day and overnight leave are required
Time of Starting Leave	Must be a valid time Must not be null Same day and overnight leave are required
Date Returned from Leave	Must be a valid date

	Must not be null Must be after the date of starting leave Must not be after the separation date Must not fall within any other leave periods Same day and overnight leave are required
Time Returned from Leave	Must be a valid time Must not be null Same day and overnight leave are required

Activity Code = W

Data Item	Guidelines
Ward	Must not be null No validation
Unit	No validation
Standard Unit Code	Must be valid standard unit code Must not be null
Date of Transfer	Must be a valid date Must not be in the future Must not be before the admission date Must not be within any leave periods Must not be after the separation date Must not be null
Time of Transfer	Must be a valid time Must not be null
Standard Ward Code	Can be null Must be a valid standard ward code of 'SNAP'

Activity Code = C

Data Item	Guidelines
Date Transferred for Contract	Must be a valid date Must not be within any leave periods Must not be before the admission date Must not be after the separation date Must not be in future Must not be null Must not be after date returned from contract
Date Returned from Contract	Must be a valid date Must not be within any leave periods Must not be before the admission date Must not be after the separation date Must not be in future Must not be null Must not be before the date transferred for contract

Facility Contracted to	Must not be null if there is a date transferred for contract Must be a valid facility number
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Activity Code = Q

Data Item	Guidelines
Qualification Status	Must not be null Validated against list of qualification status codes
Date of Change	Must be a valid date Must not be before the admission date Must not be after the separation date Must not be in the future Must not be null
Time of Change	Not currently required, no validation

Activity Code = S

SNAP information is required for all sub and non-acute patients with a public chargeable status.

Data Item	Guidelines
SNAP Episode Number	Must not be null Must not be zero
ADL Type	Must not be null Validated against a list of ADL type codes
ADL Subtype	Must not be null Validated against a list of ADL subtype codes
ADL Score	Must not be null Validated against a list of ADL scores ADL scores for each SNAP episode are to be supplied. Do not provide more than one set of scores on the same date for the same ADL Type and ADL Subtype. For all SNAP episodes: An ADL score of 999 is valid when an assessment has not been undertaken.
ADL Date	Must be a valid date Must not be before the admission date Must not be after the separation date Must not be in future Must not be null
ADL Time	Not currently collected, no validation
Phase Type	Can be null Must not be null if SNAP type = PAL Validated against list of phase type codes

Activity Code = T

Data Item	Guidelines
Nursing Home Type Flag	<p>Must not be null</p> <p>Must be a valid Nursing Home Flag code</p> <p>Not valid for patients with a care type of:</p> <p>01 – Acute</p> <p>05 – Newborn</p> <p>07 – Organ Procurement</p> <p>08 – Boarder</p>
Date Commenced NHT Care	<p>Must be a valid date</p> <p>Must not be before the admission date</p> <p>Must not be after the separation date</p> <p>Must not be in the future</p> <p>Must not be null</p> <p>Must be before the date ceased NHT care</p> <p>Must not fall within any other NHT periods</p> <p>Same day and overnight NHT periods are required</p>
Date Ceased NHT Care	<p>Must be a valid date</p> <p>Must not be before the admission date</p> <p>Must not be after separation date</p> <p>Must not be in the future</p> <p>Must not be null</p> <p>Must be after the date commenced NHT care</p> <p>Must not fall within any other NHT periods</p> <p>Same day and overnight NHT periods are required</p>

Activity Code = B

Data Item	Guidelines
Mother's Patient Identifier	<p>Must not be zero</p> <p>Must be unique for each patient within the facility</p> <p>Must not be null for Source of Referral/Transfer = 09</p>

Morbidity details records

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within the facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility
Diagnosis Code Identifier	Must not be null Validated against list of diagnosis code types Every separation must have one and only one PD Cannot have an OD, EX, PR or M without a PD
ICD-10-AM Code (10th edition)	Must not be null Please refer to Queensland Hospital Admitted Patient Data Collection guidelines for the sequencing of ICD-10-AM codes.
Diagnosis Text	Text is optional, as ICD-10-AM codes must be supplied.
Date of Procedure	Must be a valid date Must not be in the future Must not be null for procedures with block codes between: 1 to 1059 1062 to 1821 1825 to 1866 1869 to 1892 1894 to 1912 1920 to 2016
Contract Flag	Validated against a list of contract flag codes
Diagnosis Onset Type (Condition present on admission indicator)	Validated against a list of Diagnosis Onset Type codes Must not be null if Diagnosis Code Identifier = PD,OD, EX or M
Most Resource Intensive Condition Flag	Not currently required, no validation
Other Co-Morbidity of Interest Flag	Not currently required, no validation

Mental Health details records

A record is to be provided on the mental health details file for each episode of care where the standard unit code (either at admission to the episode or through a unit transfer during the episode) is in the range PYAA to PYZZ.

No record is to be provided if there were no standard unit codes in this range during the episode of care.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by a facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within the facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility
Type of Usual Accommodation	Must not be null Validated against the type of usual accommodation codes
Employment Status	Must not be null Validated against the employment status codes If 1 then age must be < 18 If 3, 4, or 6 then age must be > 14
Pension Status	Must not be null Validated against pension status codes If 1 then age must be > 59 if female and > 64 if male If 2 to 5 then age must be between 14 and 65
First Admission For Psychiatric Treatment	Must not be null Validated against the previous specialised non-admitted treatment codes
Referral To Further Care	Must not be null Validated against referral to further care codes
Mental Health Legal Status Indicator	Must not be null Validated against legal status indicator codes

Previous Specialised Non-admitted Treatment	Must not be null Validated against previous specialised non-admitted treatment codes
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Sub and Non-Acute Patient details records

SNAP information is required for all sub and non-acute patients with a public chargeable status.

A record for each SNAP type is to be provided on the sub and non-acute patient details file for each episode of care where the care type is sub-acute or non-acute (ie Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care, Psychogeriatric Care or Maintenance Care)

No record is to be provided if the care type is mental health, acute, newborn, boarder, organ procurement or other care.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within the facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility
SNAP Episode Number	Must not be null Must not be zero
SNAP Type	Must not be null Validated against a list of SNAP type codes For Palliative care only PAL is valid For Rehabilitation care only RCD, ROI, RST, RBD, RNE, RSC, RAL, RPS, ROF, ROR, ROA, RCA, RMT, RPU, RDE, RDD, RBU, RAR are valid For Geriatric Evaluation and Management care only GEM is valid For Maintenance care only MRE, MNH, MCO, MOT are valid For Psychogeriatric care only PSG is valid
AN-SNAP Group Classification	Not currently required, no validation

Data Item	Guidelines
SNAP Episode Start Date	Must not be null Must be a valid date Must not be in the future (i.e. past current date) Must not be before the birth date of the patient Must be on or after the admission date Must be before or on the separation date
SNAP Episode End Date	Must not be null Must be a valid date Must not be in the future (ie. past current date) Must be on or after the admission date Must be before or on the separation date
Multidisciplinary Care Plan Flag	Must be a valid value Must not be null if SNAP Type is Rehabilitation, Geriatric Evaluation and Management, Palliative or Psychogeriatric
Multidisciplinary Care Plan Date	Must be a valid date Must not be in the future (ie. past current date) Must be before or on the separation date Can be null
Proposed Principal Referral Service	Must not be null if SNAP Type is Rehabilitation, Geriatric Evaluation and Management, Palliative or Psychogeriatric Validated against the list of proposed principal referral service codes
Primary Impairment Type	Must not be null if SNAP Type is rehabilitation Validated against the list of Primary Impairment Type codes
Clinical Assessment Only Indicator	Not currently required, no validation

For Maintenance Care SNAP Episodes

- At least one set of mandatory ADL scores must be provided for each SNAP episode.
- There must be at least one SNAP episode within a single non-acute episode of care.
- If there is more than one SNAP episode then these must be contiguous.
- The start date of the first SNAP episode must be the same as the start date of the episode of care.
- The end date of the last SNAP episode must be the same as the end date of the episode of care.

For Rehabilitation Care, Geriatric Evaluation and Management Care, Palliative Care and Psychogeriatric Care SNAP Episodes

- At least one set of mandatory ADL scores must be provided for each SNAP episode.
- There can only be one SNAP episode within a single sub-acute episode of care.
- The start date of the SNAP episode must be the same as the start date of the episode of care.
- The end date of the SNAP episode must be the same as the end date of the episode of care.

Palliative Care details records

A record is to be provided on the palliative care details file for each episode of care where the care type is: 30 = Palliative care

No record is to be provided if the care type is NOT 30.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within the facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility
First Admission For Palliative Care Treatment	Must not be null Validated against the first admission for palliative care treatment codes
Previous Specialised Non-Admitted Palliative Care Treatment	Must not be null Validated against the previous specialised non-admitted palliative care treatment codes

Department of Veterans' Affairs details records

A record is to be provided on the Department of Veterans' Affairs patient details file where the charges for the episode of care are met by the Department of Veterans' Affairs.

A record is not to be provided if the charges for the episode of care are not met by the Department of Veterans' Affairs.

Data Item	Guidelines
Record Identifier	Must be a valid value Must not be null
Unique Number	Must not be used more than once by the facility Must not be null Must not be zero Must be unique for each admission within the facility All records related to each admission must have the same unique number of that admission
Patient Identifier	Must not be null Must not be zero Must be unique for each patient within the facility
Admission Number	Must not be null Must not be zero Must be unique for each admission of a particular patient within the facility
DVA File Number	Must not be null
DVA Card Type	Must not be null Must be a valid Card Type code

Private Processing Rules

RECORD IDENTIFIER = N

Description:

Patient separated in the extract period or patient separated prior to the extract period but not previously submitted (late insertion).

Patient File

- A corresponding record must exist in the admission file.

Admission File

- Admission record must not already exist.
- A corresponding record must exist in the patient file.
- Patient must be separated in the extract period or patient separated prior to extract period but not previously submitted (late insertion).
- Late insertions for the current financial year can be received up to and including the extraction for July data of the next financial year (due in early September).

Activity File

- A corresponding record must exist in the admission file and in the patient file.
- All activities must occur within the admission and separation dates.
 - Account Class Variations
 - Must not already exist.
 - Leave
 - Must not already exist.
 - Leave period must not overlap with any other leave periods for admission.
 - Ward Transfer
 - Must not already exist for admission.
 - Contract Status
 - Must not already exist for admission.
 - Qualification Status
 - Must not already exist for admission.
 - Sub and Non-acute Patient Items
 - Must not already exist for admission.
 - Nursing Home Type Patient Items
 - Must not already exist for admission.
 - Patient Identifier of mother of baby born in hospital
 - Must not already exist for admission.

Morbidity File

- A corresponding record must exist in the admission file and in the patient file.
- The ICD-10-AM code must not already exist for this admission except for procedure, morphology and external cause codes.

Mental Health File

- A corresponding record must exist in the admission file and in the patient file.

- Must not already exist for admission.
- Must exist if any standard unit code in the activity or admission file is in the range PYAA to PYZZ.

Sub and Non-Acute Patient File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Palliative Care File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

Department of Veterans' Affairs File

- A corresponding record must exist in the admission file and in the patient file.
- Must not already exist for admission.

RECORD IDENTIFIER = A

Description:

Amendment to records submitted prior to the extract period. Amendment records for the current financial year can be received up to and including the extraction of July data of the next financial year (due in early September).

Patient File

- Patient record must exist.

Admission File

- Admission record must exist

Activity File

- Cannot be amended, must instead be deleted and re-created.

Morbidity File

- Cannot be amended, must instead be deleted and re-created.

Mental Health File

- Mental Health record must exist.

Sub and Non-acute Patient File

- Sub and Non-acute Patient record must exist.

Palliative Care File

- Palliative Care record must exist.

Department of Veterans' Affairs File

- Department of Veterans' Affairs record must exist.

RECORD IDENTIFIER = D

Description:

Deletion of any record previously sent. Deletion records for the current financial year can be received up to and including the extraction of July data of the next financial year (due in early September).

Patient File

- Deletion is not applicable to patient records.

Admission File

- The admission record must exist.

Activity File

- Only the one record matching the previously submitted record exactly will be deleted.
 - Account Class Variations
 - The record must exist.
 - Leave
 - The record must exist.
 - Ward Transfer
 - The record must exist.
 - Contract Status
 - The record must exist.
 - Qualification Status
 - The record must exist.
 - Sub and Non-acute Items
 - The record must exist.
 - Nursing Home Type Patient Items
 - The record must exist.
 - Patient Identifier of mother of baby born in hospital
 - The record must exist.

Morbidity File

- All morbidity records in relation to that admission will be deleted.
- The morbidity record must exist.

Mental Health File

- Mental Health record must exist.

Sub and Non-Acute Patient File

- Sub and Non-acute Patient record must exist.

Palliative Care File

- Palliative Care record must exist.

Department of Veterans' Affairs File

- Department of Veterans' Affairs record must exist.