Private Facility File Format

Queensland Hospital Admitted Patient Data Collection (QHAPDC) 2022-2023 v1.0

Queensland Government

Private Facility File Format 2022–2023 v1.0

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An electronic version of this document is available at http://qheps.health.qld.gov.au/hsu/datacollections.htm

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Private Facility File Format 2022-2023 Collection Year

Introduction

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

A record must be provided for each admitted patient, including newborn babies, separated from facilities 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 QHAPDC.

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:

fffffctyyctyynnn.filetype

fffff	five-digit facility number (zero filled from the left)	
ctyyctyy	collection year to which the data relates	
nnn	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 1st admission file for ABC Hospital (facility number 99999) for collection year 2022-2023 would be named:

9999920222023001.ADM

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

E999992022070120220731202208 20
FPATN00420A00020D00000
FADMN00420A00124D00001
FACTN00080A00000D00010
FMORN01000A00000D00005
FMENN00020A00000D00001
FSNPN00010A00002D00001
FPALN00008A00001D00002
FDVAN00003A00001D00001

The details provided by the above example are:

Extraction details

Facility	99999 – ABC Private Hospital
Extraction period	1 July 2022 to 31 July 2022
Extraction date	20 August 2022

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
Location of Usual Residence	40 char	Location associated with the permanent address	

PATIENT DETAILS RECORDS			
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	

PATIENT DETAILS RECORDS			
		5 = Separated 9 = Not stated/unknown	
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	CTYYMMDD CTYYMMDD
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	CTYYMMDD
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 05 = Newborn 06 = Other care 07 = Organ procurement-posthumous 08 = Boarder 09 = Geriatric evaluation and management 10 = Psychogeriatric 11 = Maintenance 12 = Mental health 20 = Rehabilitation 30 = Palliative	Right adjusted, zero filled from left
Compensable Status	1 num	1 = Workers' Compensation Queensland 2 = Workers' Compensation (Other) 3 = Compensable third party 4 = Other compensable 5 = Department of Veterans' Affairs 6 = Motor Vehicle (QLD) 7 = Motor Vehicle (Other) 8 = None of the above 9 = Department of Defence	
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 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	Right adjusted, zero filled from left

ADMISSION DETAILS RECORDS			
		14 = Other health care establishment 20 = Organ procurement 21 = Boarder 23 = Residential aged care service 24 = Admitted patient transferred from another hospital 25 = Non-admitted patient referred from other hospital 29 = Other 30 = Planned Emergency 31 = Residential mental health care facility 32 = Change of reference period	
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, 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 04 = Other health care establishment 05 = Died in hospital 06 = Episode change 07 = Discharged at own risk 09 = Non return from leave 12 = Correctional facility 13 = Organ procurement 14 = Boarder 16 = Transferred to another hospital 17 = Medi-Hotel 19 = Other 21 = Residential aged care service, which is not the usual place of residence 22 = Residential aged care service, which is the usual place of residence 31 = Residential mental health care facility	Right adjusted and zero filled from left

ADMISSION DETAILS RECORDS			
Transferring to Facility	5 num	Facility number to which the patient was transferred Provide facility code if Mode of Separation is 12, 16, 21 or 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
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

ADMISSION DETAILS RECORDS			
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 to hospital decision) 99 = Not known	Right adjusted and zero filled from left
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

ADMISSION DETAILS RECORDS			
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 HHHHHMM 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 HHHHHMM 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) 3 = Compensable Third Party 4 = Other Compensable 5 = Department of Veterans' Affairs 6 = Motor Vehicle (Qld) 7 = Motor Vehicle (Other) 8 = None of the above 9 = Department of Defence	
Filler	2	Blank	
Date of Change	8 date	Date that change to account class occurred	CTYYMMDD
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	CTYYMMDD
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	CTYYMMDD
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	Measure of physical, psychosocial, vocational and cognitive functions of an individual with a disability 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)	

ADL Subtype	3 char	For patients assigned a Psychogeriatric care type: ADL Type = HON and record scores for 12 ADL Subtypes and a Total ADL Subtype: 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 The FIM tool has a cognitive and a motor sub-scale. 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: EAT = Eating GRM = Grooming BTH = Bathing DRU = Dressing upper body 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) The RUG tool requires the collection of the total RUG score when assigning to a Maintenance or Palliative care type. ADL Type = RUG and record 1 ADL Subtype: TOT = Total 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: 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	

ADL Score	3 num	Numerical rating from the ADL tool used as a measurement of different components of functional ability 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 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 Where ADL Type is HON and ADL Subtype is; 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	Right adjusted, zero filled from left

		TOT score must be between 0 and 48 or 999 Where ADL Type is SMM and ADL Subtype is; 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 Where ADL Type is RUG and ADL Subtype is; 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	
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.*			

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-posthumous 08 - Boarder
Date Commenced NHT Care	8 date	Date when the patient commenced Nursing Home Type care	CTYYMMDD
Date Ceased NHT Care	8 date	Date when the patient ceased Nursing Home Type care	CTYYMMDD
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 EX = External cause code M = Morphology OD = Other diagnosis PR = Procedure	Left adjusted
ICD-10-AM /ACHI Code (12th Edition)	**7 char**	**Code assigned from The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification, 12th Edition and The Australian Classification of Health Interventions, 12th Edition**	**Left adjusted**
Diagnosis Text	50 char	Textual description of diseases and procedures are optional	Left adjusted, blank if null

MORBIDITY DETAILS RECORDS			
Date of Intervention	**8 date**	**Date that the intervention was performed.** **The date must be provided if the intervention is within the following block ranges:** **1 to 1059** **1062 to 1821** **1825 to 1866** **1869 to 1892** **1894 to 1912** **1920 to 2016**	**CTYYMMDD, 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 onset flag)	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 care 2 = Condition arises during the current episode of 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	CTYYMMDD CTYYMMDD
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
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	

MENTAL HEALTH DETAILS RECORDS			
		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	

MENTAL HEALTH DETAILS RECORDS			
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 Details 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-posthumous 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	CTYYMMDD CTYYMMDD
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 left

SUB AND NON-ACUTE PATIENT DETAILS RECORDS			
SNAP Type	3 char	Classification of a patient's care type based on characteristics of the person, the primary treatment goal and evidence. 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	
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

SUB AND NON-ACUTE PATIENT DETAILS RECORDS			
Multidisciplinary Care Plan Flag	1 char	There is documented evidence of an agreed multidisciplinary care plan. Y = Yes N = No U = Unknown	Required for patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type. Blank if null
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	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. 001 = No service is required 101 = Community/home based rehabilitation 102 = Community/home based palliative 103 = Community/home based geriatric evaluation and management 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 111 = Community/home based – nursing/domiciliary 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	Required for patients with a Rehabilitation, Geriatric Evaluation and Management, Psychogeriatric or Palliative SNAP Type. Blank if null

SUB AND NON-ACUTE PATIENT DETAILS RECORDS			
		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	
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 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	

PALLIATIVE CARE DETAILS RECORDS			
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	

DEPARTMENT OF VETERANS' AFFAIRS DETAILS RECORDS			
		W = White	

Private Validation Rules

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
Estimated Date of Birth Indicator	Can be null Validated against a list of estimated date of birth indicator codes

Data Item	Guidelines
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, 25 or 31 Only applicable if source of referral/transfer is 16, 23, 24, 25 or 31 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, if separated the same day
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, 16, 21 or 31 Only applicable if mode of separation is 12, 16, 21 or 31 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

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	Must not be null Must be a valid Nursing Home Flag code Not valid for patients with a care type of: 01 – Acute 05 – Newborn 07 – Organ Procurement-posthumous 08 – Boarder

Data Item	Guidelines
Date Commenced NHT Care	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 Must be before the date ceased NHT care Must not fall within any other NHT periods Same day and overnight NHT periods are required
Date Ceased NHT Care	Must be a valid date Must not be before the admission date Must not be after separation date Must not be in the future Must not be null Must be after the date commenced NHT care Must not fall within any other NHT periods Same day and overnight NHT periods are required

Activity Code = B

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

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 Cannot have a PD, OD, EX, M following a PR
ICD-10-AM /ACHI Code (12th edition)	**Must not be null** **Please refer to Queensland Hospital Admitted Patient Data Collection manual for the sequencing of ICD-10-AM/ACHI codes.**
Diagnosis Text	Text is optional, as ICD-10-AM/ACHI codes must be supplied.
Date of Intervention	**Must be a valid date** **Must not be in the future** **Must not be null for interventions 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 onset flag)	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 admissions for psychiatric 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

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 (i.e. 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-posthumous 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 (i.e. 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 (i.e. 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

1. 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 the 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 August data of the next financial year (due in early October).

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
  - 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.

  Nursing Home Type Patient Items
  - Must not already exist for admission.

  Sub and Non-acute 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

- 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

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

Department of Veterans' Affairs

- 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 August data of the next financial year (due in early October).

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 patient 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 August data of the next financial year (due in early October).

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

  Nursing Home Type Patient Items
  - The record must exist

  Sub and Non-acute 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.