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QUEENSLAND HEALTH

QUEENSLAND HOSPITAL ADMITTED PATIENT DATA COLLECTION *(QHAPDC)*

Manual of instructions and procedures for the completion of patient identification and diagnosis data

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DATA SERVICES UNIT (DSU)

AMENDMENT REGISTER

QUEENSLAND HOSPITAL ADMITTED PATIENT DATA COLLECTION

MANUAL OF INSTRUCTIONS AND PROCEDURES FOR THE COMPLETION OF PATIENT IDENTIFICATION AND DIAGNOSIS DATA

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QHAPDC2			
QHAPDC3			
QHAPDC4			
QHAPDC5			
QHAPDC6			
QHAPDC7			
QHAPDC8			
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QHAPDC21			
QHAPDC22			

Amendment No.	Date of amendment	Date inserted in manual	Signature
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QHAPDC24			
QHAPDC25			
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QHAPDC28			
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GLOSSARY OF TERMS AND ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACS	Australian Coding Standards
AN-DRG	Australian National Diagnosis Related Group
AR-DRG	Australian Refined Diagnosis Related Group
CDHFS	Commonwealth Department of Health and Family Services
CISU	Corporate Information Systems Unit
CTP	Compulsory Third Party
DRG's	Diagnosis Related Groups
DSU	Data Services Unit
DVA	Department of Veterans' Affairs
EAM	Elective Admission Module
HBCIS	Hospital Based Corporate Information System
HQI	Homer Queensland Interface
I&D Form	Identification and Diagnosis Form
ICD-10-AM	International Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ICD-O	International Classification of Diseases - Oncology
ICN	Intensive Care Nursery
LOS	Length of Stay
M	Morphology Code
MAIA	Motor Accident Insurance Act
MDC	Major Diagnostic Category
NCCH	National Centre for Classification in Health
NCR	No carbon required
NHDD	National Health Data Dictionary
NHT	Nursing Home Type
NLI	National Localities Index
NMDS	National Minimum Data Set
NOS	Not Otherwise Specified
QGFMS	Queensland Government Financial Management System
QHAPDC	Queensland Hospital Admitted Patient Data Collection
QHIPS	Queensland Hospital Inpatient Processing System
SCN	Special Care Nursery
SLA	Statistical Local Area
SNAP	Sub-acute and Non-acute Patient Classification
URN	Unit Record Number
WAN	Wide Area Network

1 THE MANUAL: INSTRUCTIONS

1.1 PURPOSE

This manual describes the data items that are collected as part of the Queensland Hospital Admitted Patient Data Collection (QHAPDC). It is intended to be a reference for all hospitals (public and private), Health Service Districts and Corporate Office personnel who are involved in the collection and use of QHAPDC data.

This manual is not intended to be, or replace, the HBCIS system user manual. The latter will often be the main reference for staff at the time of data entry. The QHAPDC manual does not describe the screen layout used in HBCIS.

Amendments to the manual caused by changes in legislation, standards and policies will be required from time to time, and the system for maintaining the manual is described below.

1.2 MAINTENANCE OF THE MANUAL

It is crucial that the information in this manual be updated with the changes forwarded by the Data Services Unit (DSU) from time to time so that the manual remains a relevant and up-to-date reference for contributors to and managers of the collection, and for users of the data. Changes to this manual must be reflected in the HBCIS manual.

1.3 INSTRUCTIONS

In most cases, public hospitals will receive amendments to the manual via **District Health Service Nominees**. These nominees have been appointed by the District Health Service Manager and are confirmed by DSU each year. Private hospitals are also encouraged to designate a person/position responsible for receiving amendments to the manual. Private hospitals that do not have a designated contact will receive amendments via the Medical Record Department.

Note an example of the Amendment Register on page 103 of this section and the actual register at the front of the manual (pages i to ii).

Also note:

- Each amendment will be forwarded from DSU via the District Health Service Nominee for public hospitals and the Medical Record Department or designated contact for private hospitals.

- Each amendment will be numbered and be accompanied by a filing instruction, an example of which is shown on page 102 of this section. It will

contain a brief explanation of what the amendments represent and the reason for them. The instructions should be followed exactly.

Complete the Amendment Register once the changes have been made and make sure the pages removed are not confused with the replacement pages.

EXAMPLE OF AMENDMENT NOTIFICATION

QUEENSLAND HOSPITAL ADMITTED PATIENT DATA COLLECTION

Manual of instructions and procedures for the completion of patient identification and diagnosis data

AMENDMENT NO. QHAPDC 2

Section	Page(s)	Remove	Insert
2	203 to 205	Pages 203 to 205	Pages 203 to 205
3	313 to 315	Nil	Pages 313 to 315

INSTRUCTIONS

1 Turn to page 203 in section 2.
2 Remove pages 203 to 205.
3 Insert new pages 203 to 205.
4 Turn to the end of section 3 and insert pages 313 to 315 (no pages to remove).
5 Complete the Amendment Register contained in section 1 of the Manual, noting that this is amendment no. QHAPDC 2.
6 Make sure you have removed only the pages you were required to remove. Destroy the removed pages.

QUEENSLAND HOSPITAL ADMITTED PATIENT DATA COLLECTION

MANUAL OF INSTRUCTIONS AND PROCEDURES FOR THE COMPLETION OF PATIENT IDENTIFICATION AND DIAGNOSIS DATA

EXAMPLE OF AMENDMENT REGISTER

Amendment No.	Date of amendment	Date inserted in manual	Signature
QHAPDC1			
QHAPDC2			
QHAPDC3			
QHAPDC4			
QHAPDC5			
QHAPDC6			
QHAPDC7			
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QHAPDC9			
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QHAPDC22			

2 INTRODUCTION

Appendix A contains a list of public hospitals which attract funding under the Australian Health Care Agreement between the Commonwealth of Australia and the State of Queensland. These hospitals are required to submit information to Queensland's hospital morbidity collection for admitted patients. Licensed private hospitals are also required to submit information for admitted patients. The data collection is called QHAPDC (Queensland Hospital Admitted Patient Data Collection). The Health Systems Strategy Branch (HSSB) is responsible for informing the DSU of the collection requirements related to the Australian Health Care Agreement.

QHAPDC contains all patients separated (an inclusive term meaning discharged, died, transferred or statistically separated) from within any of the hospitals permitted to admit patients. Since 1 July 1996, QHAPDC contains data from specialist public psychiatric hospitals.

Data submitted to QHAPDC should be timely, accurate and complete, and should reflect the types of patients admitted and the treatment provided.

Data are used for a number of purposes both at hospital and department levels. Traditionally, the common uses for data at department level determined the level of charges by reference to costs per unit of service; monitoring funding arrangements; and negotiating additional funding; for health services planning and resources allocation, and for epidemiologists to study patterns of morbidity (illness) and mortality (death). Hospitals, particularly those with a teaching and research role, want to access data to educate students of medicine, nursing and allied health disciplines. More recently, hospitals have found that the information gained through such collections allows a greater understanding of the workings of the facility and assists in substantiating requests for additional resources from funding sources.

The move to funding public hospitals on the basis of casemix has a direct and important influence on the need for an accurate, complete and timely collection. Data gathered in the process is used to understand the mix of patients that hospitals treat, and the budget setting process relies, in part, on data from QHAPDC.

The system used in public hospitals is known as HBCIS (Hospital Based Corporate Information System). All patient separations and patient days (or occupied bed days) that occur in public hospitals are recorded via direct or indirect access to an operational HBCIS system. All **private** hospitals and those public hospitals without direct access to a HBCIS are referred to in this manual as ***paper*** hospitals.

This manual is directed towards the ***paper*** and ***HBCIS*** hospitals. Where there are differences related to these two types of recording systems, the requirements for HBCIS and forms submission are identified separately.

The following schema is used to distinguish between hospitals with HBCIS and those hospitals **not** on HBCIS:

Example: Non HBCIS hospitals

PAPER HOSPITAL
Source of referral/transfer.

Example: HBCIS hospitals

HBCIS
Admission source code.

It should be noted that where differences occur between HBCIS and Queensland Health's Data Services Unit (DSU) requirements for the collection, HBCIS data are extracted and mapped or grouped to meet the DSU format needs. The software used to achieve compatibility is Homer Queensland Interface (HQI). This extraction software is used to translate data items from hospital systems to the format/descriptions for DSU's own system. Throughout the manual, the codes that HBCIS data are mapped to appear in the HBCIS box. Private hospitals also contribute to QHAPDC and should refer to paper hospital references for an understanding of the definitions of data items that are required by DSU.

2.1 CONFIDENTIALITY

At a broad level, confidentiality applies to information which could reasonably lead to the identification of an individual. Apart from the obvious characteristics (such as name and address), there are other data items which, if seen together, may be sufficient to allow that individual to be identified.

All persons involved in the collection, management and use of patient-related information must ensure that the uses of those data do not "compromise" the privacy of the individual to whom it relates.

There are some circumstances where it is permissible to release information gained in the course of collecting data for this purpose. Hospital personnel should ensure that they are familiar with the circumstances under which this may happen. If there is any doubt, please refer the request to a higher authority.

2.2 BENEFITS OF QHAPDC

QHAPDC has been designed to satisfy the information needs of management and epidemiologists. It is the means by which admitted patient activity can be monitored, evaluated, planned for and researched, thereby allowing improved and objective decision-making.

The benefits of QHAPDC can be described as being:

- To assist hospital management:
  - allocate resources through the provision of casemix data, and
  - monitor average lengths of stay and occupancy rates.
- To assist research into diseases and health related problems by providing clinical and socio-demographic data profiles of patients over a period.
- To provide information for quality assurance and utilisation review.
- To improve the costing of hospital outputs by the identification of different users of various services within the hospital.

2.3 EXAMPLES OF THE USES OF QHAPDC DATA

2.3.1 Management

- Strategic planning - data can identify admission trends for any of the data items collected. Health services provision is therefore more likely to meet the needs of the community.
- Resource allocation - data enable management to examine priorities in hospital resource allocation.
- Performance measurement - managers can measure performance upon the delivery of services.
- Benchmarking - comparison with like facilities.

2.3.2 Administration

- Quality assurance - health care professionals are assisted in the conduct of quality assurance programs.
- Resource requirements - data allows for the examination of resource requirements for individual and specialty groups within a facility.

- Patient management - clinical staff are assisted to develop standard criteria for clinical management of similar groups of patients.

2.3.3 Research

- Epidemiology - QHAPDC collects the mix of socio-demographic data that are invaluable for epidemiologists, either from this system alone, or because data collected are used as the basis for other data collections (such as Cancer Registry and Perinatal Statistics).

- Medical research - QHAPDC gives clinical staff the information which can form the basis for research projects.

- Medical education - in hospitals which have a teaching role for any of the health professions, the data are the basis for retrieval of interesting cases and groups of similar patients for the purpose of clinical education.

2.3.4 Federal Government requirements

Obligations under the Australian Health Care Agreement - the Queensland Government is obliged to ensure that it fulfils its obligations under the Australian Health Care Agreement in relation to the provision of admitted services in recognised hospitals in the state. QHAPDC data are used to substantiate the number of patient days (occupied bed days) for public and private patients in recognised public hospitals and licensed private hospitals, and other key information.

2.4 INFORMATION REQUIRED

A complete record is required for each separation for all admitted overnight (or longer) stay and same day patients. Records on *boarders* (see section 4.10) are also required.

The total number of records submitted for any month should correspond with the number of separations of admitted patients (overnight [or longer] and same day) submitted to the Monthly Activity Collection.

2.5 AUDITS

The importance to both the Federal and State Governments of the data collected by QHAPDC should not be underestimated, and for this reason the potential exists for one or both levels of government to institute audits of information in recognised hospitals. Depending on the purpose and nature of the audit, they are often conducted by agencies which are external to the hospital and focus on the quality of financial, statistical and clinical data. However, audits should occur at many levels, including at the point of coding, data entry, processing, report production and overall monitoring of the health system activity.

Audits should be random (where individual cases are selected randomly) and targeted (where it is suspected or known that errors are likely to have occurred).

Audits might involve:

- Reconciling the number of separations collected by QHAPDC with that submitted to the Monthly Activity Statistical Collection.
- Examining the appropriateness of the admission and classification of public and private same day and overnight (or longer) stay patients within recognised hospitals.
- Monitoring accuracy of the assignment of the Australian National Diagnosis Related Group (AN-DRG) based on appropriate coding of the diagnoses and procedures contained in a patient's record.
- Comparing costs and lengths of stay in similar patients, across and within recognised hospitals, to identify anomalies.
- Assessing the quality of the data items (socio-demographic or ICD-10-AM codes). Although the processing software contains edit checks, it is in the interests of individual hospitals' management, Health Service Districts and DSU to conduct random checks to compare the source data (usually the medical record) and the submitted data.

2.6 CASEMIX

Essentially, casemix is a generic term describing a system which groups patients by predetermined factors into clinically meaningful and resource homogenous groups to describe the output of a hospital. In Australia and overseas, the most common casemix system for measuring inpatient acute care is Diagnosis Related Groups (DRG's).

The initial version of the Australian National Diagnosis Related Group classification (AN-DRG) was closely based on the DRG system developed in America. The Australian version, however, has been adapted to meet local requirements. This system is designed to classify acute inpatient episodes from admission through to discharge. Each DRG can then be related back to its associated inputs. Additionally, other systems have been developed or are under development for patient care episodes other than acute.

The most significant use of casemix in Australian health care reforms is as a basis for understanding, setting and negotiating prices for hospital services. Casemix information is being used as the foundation for funding arrangements, budgeting and performance monitoring at both the Commonwealth and State levels. Furthermore, casemix provides the means to measure hospital output and determine benchmark performance against similar hospitals.

Hospital based information provides the basis upon which to plan services, review care, forecast casemix, measure performance and conduct research. The value of this information directly depends on the care and attention given to the timely provision of accurate data by the hospital.

The Hospital Funding Model is derived from the information received from Queensland hospitals. Consequently, delays or errors in submission of this information may result in errors in determining future activity based payments.

3 GENERAL GUIDELINES

3.1 COVERAGE OF THE COLLECTION

The Queensland Hospital Admitted Patient Data Collection (QHAPDC) covers all admitted patient separations from recognised public and licensed private hospitals, and day surgery units. A separation can be a formal separation (including discharge, transfer or death) or a statistical separation (episode type changes). Departing the hospital on "leave" is not a separation unless the duration of the "leave" was greater than seven days (see Section 3.6.2). Data from each independent recognised/licensed facility must be reported separately.

Specialist public psychiatric hospitals have been required to submit data to QHAPDC since 1 July 1996. Hospitals with psychiatric units and specialist private psychiatric hospitals have submitted data in the past, but are required to also submit mental health data items.

Hospitals which are permitted to admit patients must contribute data to QHAPDC for each admission. These hospitals comprise the list of recognised hospitals, licensed hospitals and public psychiatric hospitals reproduced in Appendix A of this manual. It is understood that whilst all the listed hospitals can admit patients, not all will do so, and some may admit exclusively on a same day basis, and often irregularly.

Figure 3-1 (page 302) depicts patients covered by this collection. Figure 3-2 (page 303) depicts those NOT included in this collection.

3.2 SCOPE

QHAPDC is a monthly collection of unit record data. Public hospitals are required to submit details through their Health Service District either by way of ***Identification and Diagnosis Sheets*** (MR056 (B) - Part One) and ***Patient Activity Forms*** (MR056 (B) - Part Two)) or by electronic means using an approved file format . Private hospitals submit details directly to DSU, either by way of ***Identification and Diagnosis Sheets*** (PHI - Part One) and ***Patient Activity Forms*** (PHI - Part Two) or by electronic means using an approved file format. Only completed months are to be forwarded.

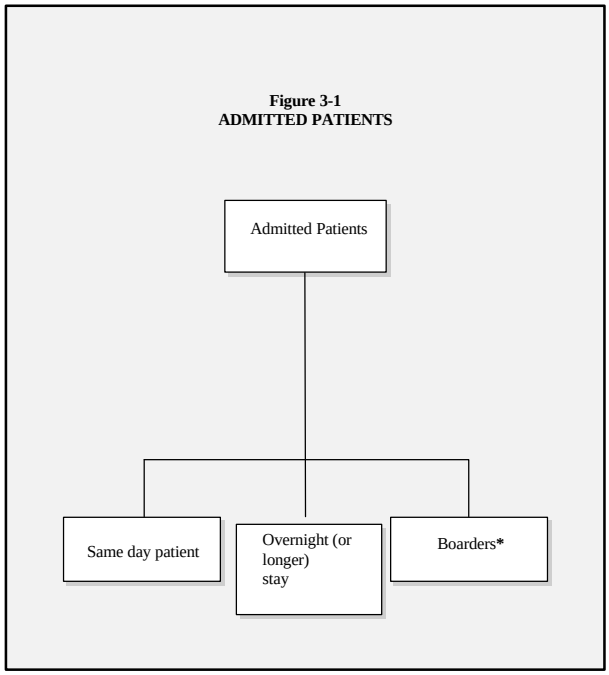
See Appendix B for approved file formats and validation rules for both public and private hospitals and Appendix C for copies of the current paper collection forms for public and private hospitals.

3.3 INSTRUCTION FOR THE COMPLETION OF *IDENTIFICATION AND DIAGNOSIS SHEETS* AND *PATIENT ACTIVITY FORMS*

Paper collection forms are to be typed or completed in ball point pen. Words and figures must be legible and within the confines of the designated field. As the forms are multi-part sets, hospitals must press firmly to obtain a clear copy. The forms have been designed using NCR (no carbon required) paper. Care should be taken to ensure that extraneous imprints are not inadvertently made on the NCR copies. The bottom copy is sent to the DSU.

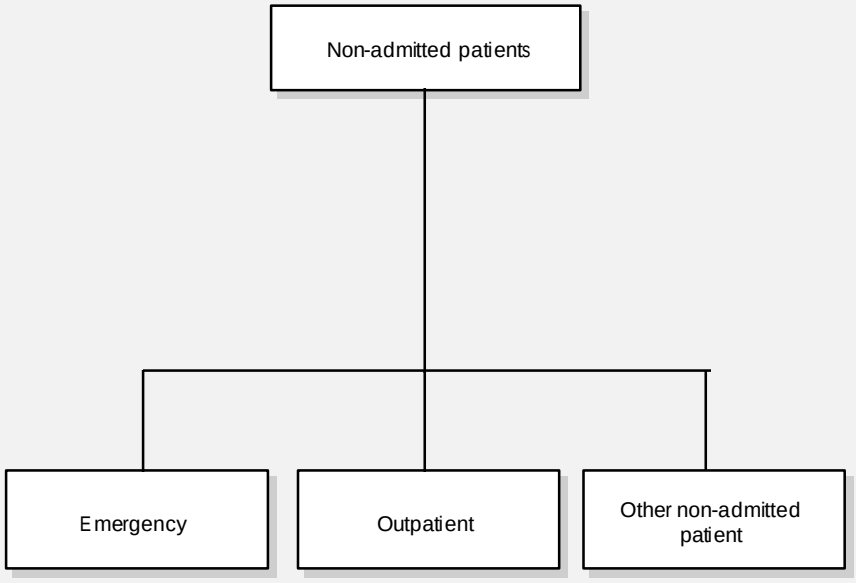
Paper collection forms have not been produced for mental health, elective surgery or SNAP requirements as all hospitals required to submit this data, provide it to DSU electronically.

Figure 3-1
ADMITTED PATIENTS



* All boarders should be registered on hospital systems and provided to DSU

Figure 3-2
NON-ADMITTED PATIENTS

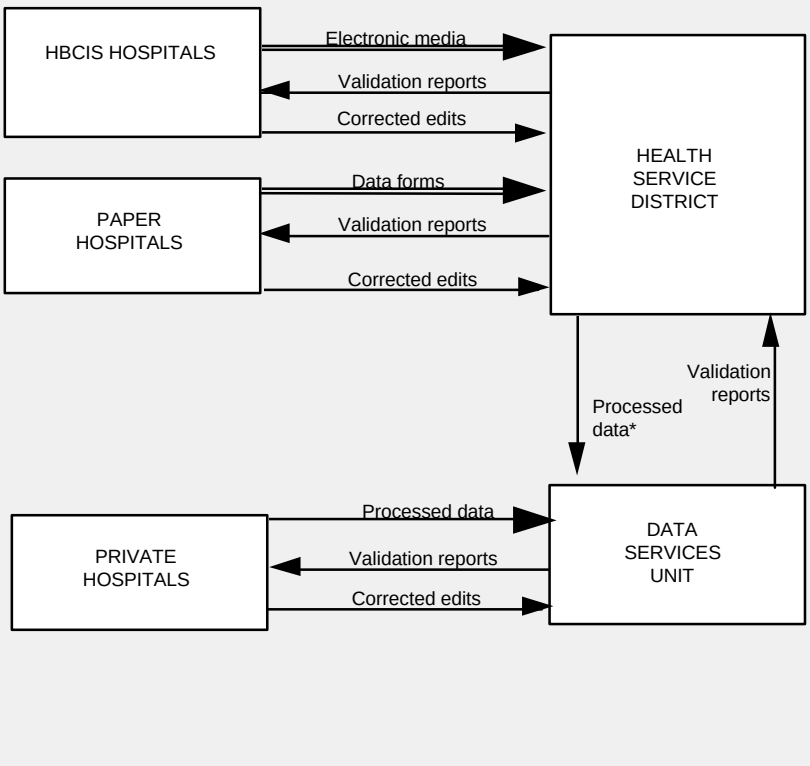


Not to be submitted to QHAPDC

3.4 DATA FLOW

Figure 3-3 is an illustration of the data flow between public hospitals, Health Service Districts, private hospitals and Data Services Unit (DSU).

Figure 3-3
DATA FLOW



* Processed data from HBCIS will be electronic data, which has been edited, coded and grouped.

NB: Although the above diagram suggests that admitted patient data is forwarded to DSU via the Health Service District, this is not common practice. Most hospitals submit their data directly to DSU.

3.4.1 Submission of data

Where public hospitals submit forms, the Health Service District or a nominated hospital given that responsibility, will convert the data into an electronic format suitable for submission to DSU. All data, whether in paper form or electronic media, will be submitted by the hospital to the Health Service District, from where it will be forwarded to DSU by the specified time.

Complete morbidity data are required from hospitals on a monthly basis in the format and media mutually agreed to by DSU and according to the date of separation of the patient. The deadline for submission of data to DSU is five weeks (35 days) after the end of the reference month to which the data refers.

From 1 July 2001 Health Service Districts will have the facility to transfer data electronically between Health Service Districts and Corporate Office. This added functionality will allow Health Service District/hospital staff to submit monthly extracts to the Data Services Unit via the Wide Area Network (WAN).

The Health Service District will be responsible for ensuring that data checks have been undertaken with the intention of sending "clean" data to DSU and will be required to endorse each hospital's monthly data set on the basis of accuracy, timeliness and completeness. Health Service Districts will determine their own policy as to whether all data must be forwarded via them or whether it may be permitted for hospitals to send data to DSU with Health Service District endorsement of the quality.

Private hospitals should submit data direct to DSU (not via a Health Service District).

Data are to be submitted before the deadline to the Health Service District to enable the Health Service District to forward it to DSU within the required time.

The Health Service District will process the data and forward it to:

Data Services Unit
Health Information Centre
Queensland Health Building
13th floor
GPO Box 48
BRISBANE QLD 4001

3.4.2 Validation Reports

Errors identified by DSU after running validation checks on the data will be returned on ***Validation Reports*** to the hospital for correction and re-submission (via the Health Service District if applicable). All hospitals must return the Validation Reports to DSU, and note on the Reports that amendments have been made. This may be at the time of submission of the next month's data or before.

The Validation Report has several components which are explained below. The date on top of the report is the date the report was printed at DSU. The report will include edits from the previous month and all other edits that have not been corrected. Therefore, the arrival of a new Validation Report at the hospital makes previous Validation Reports redundant. The Patient ID is the patient's UR number supplied by the hospital. The Unique ID is created by DSU (for Paper Hospital hospitals) or by the hospital (for HBCIS hospitals) and is a unique number (within each facility) for every episode of care for every patient. Paper Hospital hospitals have an M in front of this unique ID, with the rest of the ID made up of the year (Y), month (M), bundle number (B) and page number (P) of the form (YYMMBBBPPP). Episode ID is a hospital created episode number. The Validation Report then has the admission or episode start date, the discharge or episode end date, message type (fatal or warning), message text and message code. Appendix M will explain in more detail the error message types.

It is recommended that hospitals maintain a record of the completion and dispatch of the monthly data and responses to Validation Reports. The Validation Report should be returned to DSU on completion.

Private Paper Hospital Hospitals

Validation Reports returned to private Paper Hospital hospitals for correction must be re-submitted to DSU within one week of receipt of the report with the corrections noted on the report. DSU will enter those corrections and subsequently re-run the Validation Report to ensure that all corrections have been made.

Private Electronic Hospitals

Validation Reports are sent to private electronic hospitals on the return of their data tape. Corrections on the Validation Report must be submitted to DSU within one week of receipt of the report. The corrections listed on the returned report are made manually at DSU and must be finalised before the next month's data can be loaded. Any errors that were not corrected from this month will appear on the next months' Validation Report.

Public Paper Hospitals

Corrections from Validation Reports for public paper hospitals are done either by:
i) the HBCIS hospital which does data entry in consultation with the originating hospital; or
ii) made on the Validation Report by the paper hospital and sent to the HBCIS hospital which does the corrections on HBCIS (or the Health Service District).

HBCIS Hospitals

Validation Reports are sent to HBCIS hospitals when that month's tape is returned. Amendments are sent to DSU as part of the next extract of data. It is emphasised that HBCIS sites must still forward the Validation Report (via Health Service District) with the appropriate corrections made on the report (either with the next month's data or before).

Additional Information or Amendments

If amendments and additional information are not available at the time of initial submission, then they must accompany data for the following month. However, it is expected that most of each months' data will be submitted, processed and corrected by the five-week deadline. If DSU does not have these amendments before the next month's data is loaded, the existing errors will be regenerated on the next Validation Report.

Authorisation Form

This form (FRM-QH-003) is used by HBCIS hospitals to authorise DSU to amend records. It should only be used for amendments which cannot be made by the HBCIS hospital itself. The reason for using this authorisation form should be recorded on the form. A copy of the form is located in the back of this Manual.

3.4.3 Hospital-generated amendments to data

It is recognised that hospitals may wish to amend data already submitted (for example, a change in ICD-10-AM codes or compensable status). Amendments can be made for any one financial year up to 21 September of the next financial year. Thus, a change to data for a patient separated on 3 May 2000 can be accepted by DSU up to 21 September 2000. Amendments for all hospitals need to be supplied manually after the June extract for that financial year's data has been accepted.

3.4.4 Ordering Forms

All hospitals (public and private) can obtain forms by contacting their QHAPDC contact in DSU.

3.5 SUGGESTED RESPONSIBILITY FOR COMPLETION OF DATA ITEMS

Items marked (*) are not required for QHAPDC but are included for completeness.

3.5.1 Administrative Data

Admitting Staff

The admitting staff member may be a nurse, clerk or other staff member who is documenting the patient and admission details. The admitting staff member should complete the following administrative data items at the time of admission. For mental health details, the information will be collected by the admitting staff of the designated psychiatric unit.

- account and payment class (HBCIS only) (*)
- admission date
- admission number/episode ID

- admission time
- admission unit
- Australian South Sea Islander
- admission ward
- baby admission weight (where <2500 grams or < 29 days)
- boarder
- care type
- chargeable status
- compensable status
- contact and usual address
- country of birth
- date of birth
- date of birth flag (HBCIS only)
- DVA file number (DVA only)
- DVA card type (DVA only)
- elective patient status
- emergency contact name, address and telephone number (*)
- employment status (mental health item)
- facility name and number for transfers in (source code [HBCIS only])
- facility name and number
- first admission for palliative care treatment (palliative care item)
- first admission for psychiatric care (mental health item)
- hospital insurance
- Indigenous status
- language (HBCIS ONLY) (*)

- marital status
- Medicare eligibility and Medicare number
- patient surname and given names
- pension status (mental health item)
- planned same day
- previous specialised non-admitted palliative care treatment (palliative care item)
- previous specialised non-admitted psychiatric care treatment (mental health item)
- recent discharge information (i.e. previous hospitalisation) (*)
- religion (*)
- sex
- source of referral/transfer (admission source [HBCIS only])
- standard ward code
- type of usual accommodation (mental health item)
- UR number
- accommodation (intended) (EAM item)
- date not ready for care (EAM item)
- last date not ready for care (EAM item)
- listing date (EAM item)
- planned length of stay (EAM item)
- site procedure indicator (EAM item)
- planned procedure date (EAM item)
- standard unit code and SNAP items

Discharging Staff

Discharging staff should complete administrative data items relating to separations. The following must be completed. Mental health details are expected to be completed by staff at the designated psychiatric unit.

- separation date
- separation time
- band (paper only)
- funding source
- mode of separation
- separation number (*)
- (transferring to) facility number
- baby admission weight (if not completed on admission)
- referral to further care (mental health item)
- mental health legal status indicator (mental health item)

3.5.2 Clinical Data

Medical Practitioner

It is the responsibility of the medical practitioner in charge of the case to complete in writing on the medical record, the details that allow the coder to assign ICD-10-AM diagnosis and procedure codes pertaining to that admission:

- principal diagnosis/condition
- secondary/other conditions (sequelae/complications)
- procedures/surgical and non-surgical that are coded
- procedure dates (collected for a range/ranges of block codes)
- external cause; place of occurrence
- morphology of neoplasm
- treating doctor and signature

Coding Staff

Coders must code clinical details using the current Australian Coding Standards.

3.6 COUNTING RULES

3.6.1 Calculation of Length of Stay

Every day the patient is an admitted patient is known as a patient day (sometimes referred to as an occupied bed day) . The length of stay of an episode of care is the total of all the patient days accrued during a particular episode.

There are two ways of calculating the length of stay:

- Retrospective (after the patient has been discharged): separation date minus admission date minus total leave days.

EXAMPLE

A patient was admitted on 4 January 2001 and discharged on 11 January 2001. There was one day of leave in that time. The length of stay is (11- 4) -1 = 6 days.

- Progressive (while still in hospital): sum of the accrued patient days at a point in time.

EXAMPLE

A patient was admitted on 4 January 2001. As of 8 January 2001, with no days of leave, the length of stay is 4 days.

3.6.1.1 Rules

There are rules which allow consistent calculation of length of stay.

(1) The sum of patient days and leave days must equal the number of days elapsed between admission date and separation date.

(2) For any given date, either a patient day or a leave day may be counted, but not both.

(3) Patient days are not accrued when the patient is out of hospital on leave, even though a bed may be "held" for the patient during his/her absence.

(4) For patients admitted and separated on different dates, count one patient day for day of admission; do not count a patient day for day of separation.

(5) For patients admitted and separated on the same date, count one patient day; no leave days. The length of stay is one day.

(6) A same day patient cannot go on overnight leave.

(7) A period of leave cannot exceed seven days.

(8) Normally, the day of going on leave is counted as a leave day, and the day of returning from leave is counted as a patient day.

(9) When, on the same date, a patient is admitted and goes on leave, count this day as a patient day. When, on the same date, a patient returns from leave and again goes on leave, count this day as a leave day. When, on the same date, a patient returns from leave and is separated, do not count this day as either a patient day or a leave day.

(10) For QHAPDC, leave is reported only where the patient is away at midnight. Midnight is recorded as the start of a new day (not the end of the previous one).

(11) If an admitted patient goes from one hospital to another to receive same day treatment (as an admitted patient) and the patient has not been placed on contract leave, he/she must be separated and re-admitted on return (if applicable).

(12) Patients cannot be charged for "leave days" even if they had treatment and accommodation for part of that day.

3.6.1.2 Counting rules for contract leave

For QHAPDC, contract leave is reported by the hospital from which the patient is being contracted, whether the leave is same day or overnight. The patient is not required to be away at midnight.

3.6.2 Calculation of leave days

The number of leave days is calculated as the date returned from leave minus the date went on leave during a period of treatment or care. A day is measured from midnight to midnight.

The day the patient goes on leave is counted as a leave day. The day the patient returns from leave is <u>not</u> counted as a leave day, but as a patient day.

Therefore, a patient starting leave on Monday, 10 June, must return to the hospital on or before Monday, 17 June. No patient day charges are raised whilst the patient is on leave, nor are patient days calculated.

The rules for the calculation of the leave days in which the patient is out of hospital are as follows.

(1) The sum of patient days and leave days must equal the number of days elapsed between admission date and separation date.

(2) For any given date, either a patient day or a leave day may be counted, but not both.

(3) Patient days are not accrued when the patient is out of hospital on leave, even though a bed may be "held" for the patient during his/her absence.

(4) A same day patient cannot go on overnight leave.

(5) A period of leave cannot exceed seven days.

(6) Renal dialysis patients are not on leave between treatments; each dialysis session is a separate admission.

(7) Normally, the day of going on leave is counted as a leave day, and the day of returning from leave is counted as a patient day.

(8) When, on the same date, a patient is admitted and goes on leave, count this day as a patient day. When, on the same date, a patient returns from leave and again goes on leave, count this day as a leave day. When, on the same date, a patient returns from leave and is separated, do not count this day as either a patient day or a leave day.

(9) For QHAPDC, leave is reported only where the patient is away at midnight.

(10) If an admitted patient goes from one hospital to another to receive same day treatment (as an admitted patient) and this is not on contract, they must be discharged and re-admitted on return (if applicable).

(11) Patients cannot be charged for a "leave day" even if they had treatment and accommodation for part of that day.

CALCULATION OF LEAVE

The rules for calculation of leave days during which the patient is out of hospital are as follows:

The day the patient leaves the hospital is considered day one of the leave days. The day the patient returns to the hospital is not counted as a leave day, but as a day of admitted care (patient day). This patient day counts towards the 35-day qualifying period for calculation of nursing home type patients. Therefore, a patient starting leave on Monday, 10 June, must return to the hospital on or before Monday, 17 June, in order to continue the accrual of his/her qualifying period.

It is important to emphasise that a period of leave cannot exceed seven days. A patient who goes on leave but does not return within the specified seven-day limit is to be formally separated from the hospital from the date that he/she left the hospital. The ***mode of separation (discharge status)*** is to be recorded as:

PAPER HOSPITAL
Mode of separation: 09 Non-return from leave.

HBCIS
Discharge status: 09 Non-return from leave.

If the patient subsequently returns to hospital, he/she is to be treated as a new admission. This seven day maximum leave rule also applies to psychiatric hospitals.

3.7 BOUNDARIES

Confusion is caused by the grey areas that exist in trying to distinguish between the classification some patients fall into. Whilst definitions do exist and have been used as the basis for the descriptions in this QHAPDC manual, they are often broad descriptions and difficult to apply to a specific situation or hospital. This section describes these terms and clarifies the differences.

3.7.1 Same day patients and overnight (or longer) stay patients

A same day patient is admitted and separated on the same date. An overnight (or longer) stay patient receives hospital treatment for a minimum of one night. In both instances, the patients must have met the criteria for admission.

- An overnight (or longer) stay patient is a patient who receives hospital treatment for a minimum of one night.
- Same day patients are patients who were admitted and discharged on the same day (date) and include intended overnight (or longer) stay patients, Day Only Procedure patients and certified Type C professional attention procedure patients.
- The same day patient received care that did not require an overnight (or longer) stay in hospital and is a patient who met the criteria for same day admission or was an intended overnight (or longer) stay patient who was subsequently discharged on the day of admission.
- A public or private patient who was admitted with the intention of an overnight (or longer) stay, but who was subsequently separated on the day

of admission, is a same day patient. The patient is not banded as they were not an intended day only procedure patient. Private patients are charged the equivalent of a Band 1 charge. For example, a private patient who was admitted for observation from Accident and Emergency but was subsequently discharged on the same day is not banded, but charged the equivalent of Band 1. This patient is a same day patient, but not a day only procedure patient. See Section 4.4.1 for information on Same Day Procedure Patients.

3.7.2 Same day patients and non-admitted patients

The following factors should be considered when determining whether a patient is a same day patient or a non-admitted patient. The latter includes, for example, casualty and outpatient department attendees. It is true that a patient may meet the criteria for same day admission but the practitioner may wish to treat him/her on an outpatient basis. It is the policy of Queensland Health that all patients eligible for admission should be admitted, unless there are clear clinical reasons for treating the patient on a non-admitted bases. This allows comparisons with other hospitals within the State and across Australia.

- A same day patient meets the criteria for admission and is admitted and separated on the same day. Patients who receive a procedure which would not normally warrant admission but the clinician deems that an admission is necessary, should have a Day Only Certification completed by the attending medical practitioner, for public as well as for private patients. For example, if a patient requires admission for a plaster cast or removal of sutures, they are admitted on Band 1B with the appropriate certification.

- The non-admitted patient receives a service which is often simpler and less prolonged than that given to a same day patient. Whether the patient actually occupies a bed is not relevant to classifying patients to one of these categories.

- If the patient is admitted as a day only banded patient, but the intended procedure was cancelled, the admission should also be cancelled where possible. If the admission is still necessary, then the patient should be formally admitted (refer to Appendix F).

- Patients who attend psychiatric day or partial day care programs should be recorded as non-admitted occasions of service patients, not as same day admissions. Use of same day admissions is only valid where patients meet the conditions as described earlier in this section (3.7.2).

3.7.3 Acute Care Certificate and nursing home type (NHT) patients

The following factors should be used when classifying patients as ***NHT***:

- NHT patients are normally expected to require nursing home type care indefinitely. By definition, a NHT patient is one who has been in hospital for a continuous period exceeding 35 days and is not the subject of a current acute care certificate. To be charged NHT fees, a patient must be a NHT patient. This accumulated 35 continuous day period excludes leave days. This accumulation can occur in one or more hospitals (excluding public psychiatric hospitals).

- To accrue NHT days the patient must be in a maintenance episode of care.

- An acute/rehabilitation/palliative/geriatric evaluation and management/ psychogeriatric admitted patient cannot be classified as a NHT patient. It is possible to remain acute, palliative or any other care type after 35 days if a medical practitioner signs an Acute Care Certificate. The patient's 35-day period can take into account a maximum break of seven consecutive days.

- Generally, patients receiving acute care in a psychiatric hospital, security patient's hospital or other extended treatment facility (including facilities designated as an 'other place' under the Mental Health Regulation 1985) who are in receipt of an acute care certificate are covered under Part 2B of the Health Services Regulation 1992. These patients do not qualify to be NHT patients until after they have been admitted for 35 days and they are not covered by an acute care certificate

- However, for any period the 35 day period does not apply if the patient was a resident of a residential care facility immediately before admission to a psychiatric hospital, security patient's hospital or other extended treatment facility (including facilities designated as an 'other place' under the Mental Health Regulation 1985). Unless covered by an acute care certificate, such patients should be classified on admission as NHT.

- An Acute Care Certificate is required for all admitted patients where the period of hospitalisation exceeds 35 days and the patient is not classified as nursing home type. If a patient is (re)classified as nursing home type but subsequently requires acute care, the qualifying period of 35 days does not start again.

3.7.3.1 Nursing home residents and nursing home type (NHT) patients

A nursing home resident is a person who has been classified as such and occupies a designated nursing home bed.

A resident in a nursing home is not generally expected to leave the nursing home to live anywhere else, although it is possible for a nursing home resident to require treatment in an acute hospital (for example, following a fall and

sustaining an injury that requires acute care). The resident then becomes an acute admission to the acute hospital for the duration of the treatment. The patient will be discharged back to his/her nursing home as a nursing home resident after treatment is complete.

An NHT patient is one who has been a patient in one or more public and/or private hospitals for a continuous period of more than 35 days, with a maximum break of seven consecutive days, and for whom the attending medical practitioner has not signed an Acute Care Certificate.

It would be possible for a nursing home resident to be an NHT patient. For example, a resident who resides "permanently" in a nursing home and who falls over and sustains a fractured hip will be admitted to an acute hospital as an acute patient. If the patient stays in hospital for more than 35 days, and the doctor does not complete a certificate, then that patient must change to a maintenance care type, if not already, and be classified as a NHT patient in the acute hospital. When the patient is returned to the nursing home, he/she is discharged from the acute hospital, and is a nursing home resident again. However, it would be generally expected that patients would return to their places in nursing homes once they are no longer acute.

3.7.4 Respite care patients and respite care residents in nursing homes

Respite care residents (in nursing homes) receive nursing home care. As such, the charges that apply to them are based on those that apply to other residents in nursing homes. In the case of maintenance care patients (receiving respite care) accommodated in hospitals (not nursing homes) with public status, no charges can be raised for the first 35 days. After that period, they are classified as NHT patients and are charged as such.

3.7.5 Calculation of Nursing Home Type (NHT) days

A patient should be classified as NHT after 35 consecutive days of hospitalisation when the treating doctor has not completed an Acute Care Certificate (issued under section 3B of the Health Insurance Act 1973 (Cwlth) or, alternatively, an order made under section 3A of that Act which determines that the patient is in need of acute care for a specified period). A recent ruling from the Crown Solicitor has determined that third party patients are to be classified as NHT patients after the normal 35 day period unless an exclusion applies (ie. an Acute Care Certificate has been issued or the Commonwealth Minister for Health has issued a notice declaring a certain class of people not to be NHT patients). It follows that ineligible patients are to be treated the same way.

Note that the 35 day qualifying period may accrue in more than one hospital (public or private or both) and includes extended treatment facilities and psychogeriatric unit facilities. Generally, public psychiatric hospital long stay patients are covered under Regulation 63 of the Mental Health Act and do not qualify to become NHT patients. However, there are acute wards at Wolston Park and Baillie Henderson hospitals where such patients can qualify for NHT status.

Patients who go on leave or are separated from hospital, but return within seven days, may continue accruing their 35 days. Patients who leave hospital and do not enter another hospital for at least seven days will begin at day one on their next admission to hospital.

Note that leave days and days out of hospital do not count in accruing the 35 days.

The rules for calculation of leave days during which the patient is out of hospital are as follows:

CALCULATION OF LEAVE

The rules for the calculation of the leave days in which the patient is out of hospital are as follows:

The day the patient leaves the hospital is considered day one of the leave days. The day the patient returns to the hospital is not counted as a leave day, but as a day of admitted care (patient day). This patient day counts towards the 35-day qualifying period for calculation of nursing home type patients. Therefore, a patient starting leave on Monday, 10 June, must return to the hospital on or before Monday, 17 June, in order to continue the accrual of his/her qualifying period.

If a patient is no longer classified as NHT (e.g. patient broke arm and requires acute care) the 35 day qualifying period does not begin again.

4 DATA DEFINITIONS

Definitions used for the collection of hospital morbidity data conform largely to the requirements of the ***National Health Data Dictionary*** version 9.0 and the *Queensland Health Data Dictionary* version 3.1.

4.1 ADMITTING HOSPITAL

All public recognised hospitals which are covered by the Australian Health Care Agreement and licensed private hospitals are listed in Appendix A are entitled to admit patients. Public psychiatric hospitals may also admit patients and have been required to supply data for QHAPDC from 1 July 1996, although at this stage those admissions are not counted towards targets set in the Australian Health Care Agreement or for Casemix purposes. In the future this data will be used as part of the Casemix model.

If a doctor with admitting rights at one of these hospitals believes he/she has a patient that requires or warrants admission, the patient must meet the criteria set out below. Provided it is to one of the recognised/licensed hospitals, an admitted patient is not required to occupy a bed.

4.2 ADMISSION POLICY

Admission means the process by which a hospital records the commencement of treatment and/or care and accommodation of a patient. Patients may be admitted **as same day** (sometimes known as day-only) or **overnight (or longer) stay**.

Queensland Health has a policy, based on the Australian Health Care Agreement that describes the patients who can be admitted. The policy is reproduced in detail in **Appendix F**. It can be summarised as stating that there are three main criteria, at least one of which must be met before patients can be admitted. **It is the policy of Queensland Health that all patients who are eligible for admission should be admitted, unless there are clear clinical reasons for treating them on a non-admitted basis.**

Boarders : From 1 July 1999 Boarders should be registered and data submitted to DSU. More detail on this is found in section 4.10.

4.3 OVERNIGHT (OR LONGER) STAY PATIENTS

An overnight (or longer) stay patient is a patient who is admitted to and separated from the hospital on different dates. This patient:

- has been registered as a patient at the hospital;
- meets the minimum criteria for admission;
- has undergone a formal admission process;
- remains in hospital at midnight on the day of admission.

Boarders are excluded from this definition (see Section 4.10).

Note:

- An overnight stay patient in one hospital cannot be concurrently an admitted patient in another hospital, unless they are on contract leave. If not on contracted leave, a patient must be discharged from one hospital and admitted to the other hospital on each occasion of transfer.
- Treatment provided to an intended same day patient who is subsequently classified as an overnight stay patient shall be regarded as part of the overnight episode.
- A non-admitted (emergency/outpatient) service provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

4.4 SAME DAY PATIENTS

A same day patient is a person who is admitted and separates on the same date. This patient:

- has been registered as a patient at the hospital;
- meets the minimum criteria for admission;
- has undergone a formal admission process;
- is separated prior to midnight on the day of admission.

Boarders are excluded from this definition (see Section 4.10)

Note:

- Same day patients may be either intended to be separated on the same day, or intended overnight stay patients who were separated, died or were transferred on their first day in hospital.

- Treatment provided to an intended same day patient who is subsequently classified as an overnight stay patient shall be regarded as part of the overnight episode.

- Non-admitted (emergency/outpatient) services provided to a patient who is subsequently classified as an admitted patient shall be regarded as part of the admitted episode. Any occasion of service should be recorded and identified as part of the admitted patient's episode of care.

- Data on same day patients are derived by a review of admission and separation dates. The data excludes patients who were to be discharged on the same day but were subsequently required to stay in hospital for one night or more.

4.4.1 Same Day Procedure Patients

There is considerable confusion over the use of this terminology. This has not been helped by the Commonwealth changing the name of the related manual from the *Day Only Procedures Manual* to the *Same Day Procedures Manual* when it was reissued in August 1996. Same day procedure patients are a subset of same day patients. They are patients who are admitted for, and have carried out, one of the Type B procedures as defined in the Commonwealth Same Day Procedures Manual, August 1996 or in subsequent amendments, and are *discharged, transferred or die* before midnight on the day of admission; or Type C exclusion patients for whom a Day Only Procedure Certificate (part of form 1830) is completed. A same day procedure patient cannot have any related episodes during a hospital stay.

The following notes may help clarify some issues regarding banding of same day procedure patients.

- Patients admitted for observation who are separated before midnight on the day of admission are not banded.

- Patients who die on the day of admission, prior to any procedure being performed, are not banded.

- Patients who received a Type C procedure with an accompanying certificate can only be banded as Band 1B, irrespective of anaesthetic type or theatre time.

4.5 NEWBORNS

Previously a newborn was recorded as being either acute or unqualified, and a change in status resulted in a statistical discharge and readmission. However as an unqualified episode of care is not a phase of treatment a 'newborn' care type has been developed which is clinically more meaningful and allows for a DRG allocation to a single episode.

All babies 9 days old or less should be admitted as a newborn episode of care. A newborn episode of care is initiated when the patient is nine days old or less at the time of admission and continues until the care type changes or the patient is separated. At any time during their stay the newborn has a qualification status of either acute or unqualified.

4.5.1 Newborns - Acute Qualification Status

A newborn has an acute qualification status if it is nine days old or less and meets at least one of the following criteria:

- the newborn is the second or subsequent live born infant of a multiple birth; or
- the newborn is admitted to an intensive care facility in a hospital, being a facility approved by the Commonwealth Health Minister for the purpose of the provision of special care; or
- the newborn is in hospital without its mother.

If a baby is nine days old or less and transferred to another hospital, it is to be admitted as a newborn with an appropriate qualification status by the receiving hospital. For example,

- if it is transferred without its mother; or
- the mother is admitted as a boarder; or
- the baby is the second of subsequent live born infant of a multiple birth; or
- baby is admitted to an intensive care facility in the receiving hospital;

the baby is to be admitted as a newborn with a qualification status of acute. For newborns with an admission qualification status of acute, the parent/s or legal guardian/s must elect whether the baby is to be treated as a public or private patient. It is possible for the mother and the baby to be classified differently.

Also, all newborns who still require clinical care when they turn 10 days of age must have a qualification status of acute. Newborns who turn 9 days of age and who do not require clinical care on day ten, must be separated. Babies not admitted at birth (eg transferred from another hospital) aged greater than 9

days are either boarders or admitted as an acute care type. Newborns waiting for adoption who turn 9 days of age and who remain in hospital without their mother, and require no clinical care/treatment, should be formally separated and then registered as boarders (on and before 9 days of age, they are classified according to the normal rules).

If the mother remains in hospital after the period in which she requires clinical care/treatment, but is staying in hospital with a baby who does require care and is 9 days old or less, the mother should be classified as a boarder and the baby must be assigned an acute qualification status.

Only acute newborn days are eligible for Health Insurance benefit purposes and should be counted under the Australian Health Care Agreement. Unqualified newborn days should not be counted under the Australian Health Care Agreement and are not eligible for Health insurance benefit purposes. Stillborn babies are not admitted.

4.5.2 Newborns - Unqualified Qualification Status

A newborn has a qualification status of unqualified if they are nine days old or less and do not meet the criteria for being admitted as a newborn with a qualification status of acute. An unqualified baby may be born in the hospital or before arrival at hospital, or transferred after birth to another hospital with its mother. A newborn may or may not require clinical care/treatment, but where that care/treatment is required and is delivered outside an approved ICN/SCN facility, they continue to have a qualification status of unqualified. Newborns with a qualification status of unqualified (classified as either public or private patients) under the Australian Health Care Agreement are not eligible for health insurance benefit purposes and therefore cannot be charged.

4.5.3 Changes in qualification status of newborns

Sometimes a change in the condition of a newborn results in their status changing between acute and unqualified: e.g. an unqualified newborn is admitted to an intensive care facility or remains in hospital without its mother. This must be recorded as a change in qualification status (see Section 8.7).

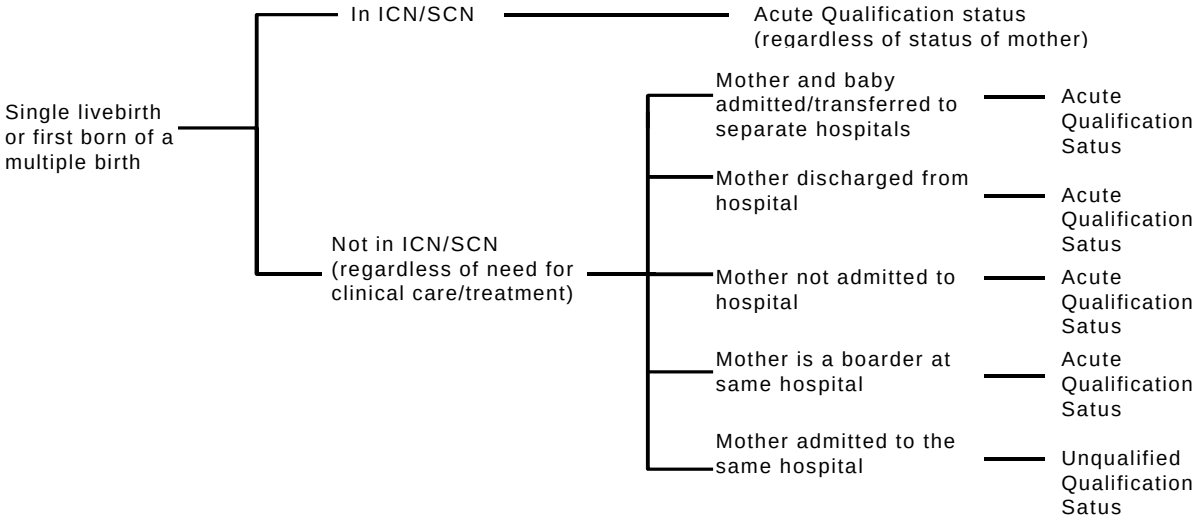
All changes in qualification status must be recorded. If more than one change of qualification status occurs on a single day, then the final qualification status for that day should be provided to the Data Services Unit.

A baby born on 1 March and admitted to hospital prior to 11 March must be admitted with a care type of '05 – Newborn'.

A baby born on 1 March and admitted with a care type of '05 – Newborn', and remaining in hospital and still requiring clinical care when it turns 10 days old on 11 March, must have a qualification status of 'Acute' from 11 March until the day it is separated. If the qualification status needs to be changed from 'Unqualified' to 'Acute', this may be done at any time on 11 March (but no later).

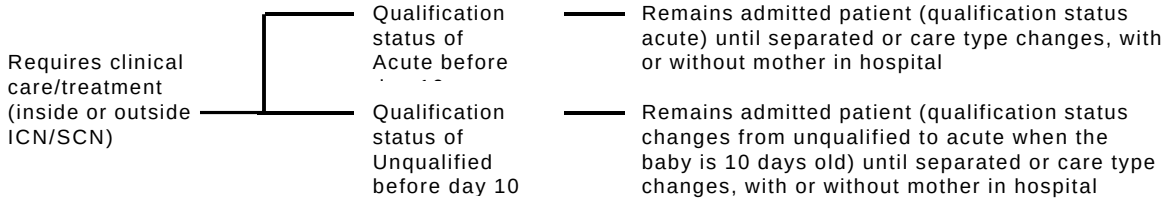
The flowchart below summarises how to classify newborns according to the Health Insurance Act,including born before arrival at hospital, born in the hospital or transferred to another hospital.

NEWBORN 9 DAYS OF AGE OR LESS

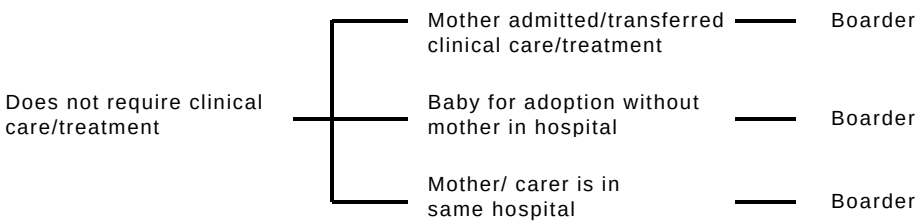


Note that all newborns 9 days of age or less are admitted for statistical purposes in line with the National Health Data Dictionary definitions. However, only newborns with an acute qualification status attract health insurance benefits and count towards Medicare patient days. Note that all newborns 10 days old or more who require clinical care/ treatment are classified as admitted patients.

NEWBORN 10 DAYS OF AGE OR MORE



All newborns, 10 days of age or more, that require clinical care/treatment require admission. This includes new admission and care type changes.



4.5.4 Some Examples

This section provides examples of when changes need to be made to the care type or qualification status of a Newborn. Given that the fundamental rule for getting these changes correct is that a baby becomes one day older at the start of each new day, you need to know what time signifies the start of the day.

HBCIS Hospitals
On HBCIS, the start of the reporting day is 00:01, with midnight (24:00) being the end of the reporting day. As a result, a baby born at 11.20 on 1 March is one day old at the start of 2 March, that is at 00:01 on 2 March. A baby born at 23.20 on 1 March is also one day old at the start (00:01) of 2 March.

So, any babies born from the start (00:01) to the end (24:00) of 1 March become 9 days old at the start (00:01) of 10 March and 10 days old at the start (00:01) of 11 March.

HBCIS HOSPITALS

Born	*Turns 1 day old*	*Turns 2 days old*	*Turns 3 days old*	*Turns 4 days old*	*Turns 5 days old*	*Turns 6 days old*	*Turns 7 days old*	*Turns 8 days old*	*Turns 9 days old*	*Turns 10 days old*
00:01 to 24:00 1 March	*00:01 2 March*	*00:01 3 March*	*00:01 4 March*	*00:01 5 March*	*00:01 6 March*	*00:01 7 March*	*00:01 8 March*	*00:01 9 March*	*00:01 10 March*	*00:01 11 March*

Therefore, a baby born on 1 March and admitted to hospital on 11 March is 10 days old, and must be admitted with an episode of care type of '01 - Acute'.

A baby born on 1 March and admitted to hospital prior to 11 March must be admitted with an episode of care type of '05 – Newborn'.

A baby born on 1 March and admitted with an episode of care type of '05 – Newborn', and remaining in hospital **and still requiring clinical care** when it turns 10 days old on 11 March, must have a **qualification status** of 'Acute' from 11 March until the day it is separated. If the qualification status of the Newborn episode needs to be changed from 'Unqualified' to 'Acute', this may be done at any time on 11 March (but no later).

A baby born on 1 March and admitted with an episode of care type of '05 – Newborn', and remaining in hospital **and not requiring clinical care** when it turns 10 days old on 11 March, must be separated at the end of 10 March and registered as a boarder at the start of 11 March. That is, the date and time of separation from the 'Newborn' episode of care would be 10 March at 24:00, and the date and time of the registration of the 'Boarder' episode of care would be 11 March at 00:01.

Please note that Data Services Unit will accept a time of 24:00 for the QHAPDC if that is when an event actually occurs, it is just that we need to convert it when the record is loaded onto our system.

Paper Hospitals
For **Paper** hospitals, the start of the reporting day should be midnight (00:00), with 23:59 being the end of the reporting day. As a result, a baby born at 11.20 on 1 March is one day old at the start of 2 March, that is at 00:00 on 2 March. A baby born at 23.20 on 1 March is also one day old at the start (00:00) of 2 March.

So, any babies born from the start (00:00) to the end (23:59) of 1 March become 9 days old at the start (00:00) of 10 March and 10 days old at the start (00:00) of 11 March.

PAPER HOSPITALS

Born	*Turns 1 day old*	*Turns 2 days old*	*Turns 3 days old*	*Turns 4 days old*	*Turns 5 days old*	*Turns 6 days old*	*Turns 7 days old*	*Turns 8 days old*	*Turns 9 days old*	*Turns 10 days old*
00:00 to 23:59 1 March	*00:00 2 March*	*00:00 3 March*	*00:00 4 March*	*00:00 5 March*	*00:00 6 March*	*00:00 7 March*	*00:00 8 March*	*00:00 9 March*	*00:00 10 March*	*00:00 11 March*

Therefore, a baby born on 1 March and admitted to hospital on 11 March is 10 days old, and must be admitted with an episode of care type of '01 - Acute'.

A baby born on 1 March and admitted to hospital prior to 11 March must be admitted with an episode of care type of '05 – Newborn'.

A baby born on 1 March and admitted with an episode of care type of '05 – Newborn', and remaining in hospital **and still requiring clinical care** when it turns 10 days old on 11 March, must have a **qualification status** of 'Acute' from 11 March until the day it is separated. If the qualification status of the Newborn episode needs to be changed from 'Unqualified' to 'Acute', this may be done at any time on 11 March (but no later).

A baby born on 1 March and admitted with an episode of care type of '05 – Newborn', and remaining in hospital **and not requiring clinical care** when it turns 10 days old on 11 March, must be separated at the end of 10 March and registered as a boarder at the start of 11 March. That is, the date and time of separation from the 'Newborn' episode of care would be 10 March at 23:59, and the date and time of the registration of the 'Boarder' episode of care would be 11 March at 00:00.

4.6 DIALYSIS, CHEMOTHERAPY AND RADIOTHERAPY

Dialysis and chemotherapy are day benefit procedures and the patients can be admitted. It is usual practice in Queensland that they should be admitted, often to a recliner chair in a recognised hospital. Radiotherapy is not a day benefit procedure, and patients coming to a facility specifically for radiotherapy would normally be treated on a non-admitted (outpatient) basis. If a patient who is already an admission in hospital has radiotherapy, the radiotherapy does not alter his/her admission status. A patient should be admitted and discharged for each occasion of day procedures, not be put on leave.

4.7 PATIENTS IN ACCIDENT AND EMERGENCY AND OUTPATIENT DEPARTMENTS

Patients attending these locations in a hospital who come for a procedure that is classified as a day benefit procedure (in other words, they meet the criteria for admission) should be formally admitted.

4.8 TIME AT HOSPITAL

The length of time a patient spends in areas such as Outpatients or Accident and Emergency, is no indication of the need to admit the patient. Admission is allowed only on the basis that the medical practitioner wants the patient admitted and the patient meets one of the criteria listed in the policy. The concept of "four hours" does not apply. The patient should be admitted at the time indicated by the medical practitioner, not at the time the patient arrived in Outpatients or Accident and Emergency.

4.9 CHANGE IN CARE TYPE

Patients changing from one care type to another, e.g. acute to maintenance within the same hospital, are to be statistically separated and re-admitted. They have a change of care type and are recorded as such by using a code ***06*** in the ***source of referral/ transfer*** and ***mode of separation*** data items.

4.10 BOARDERS

A boarder is defined as a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care. For example, a two-year-old baby who does not meet the criteria for admission, accompanying his/her mother who is currently admitted is considered a boarder; as is a mother accompanying her child who is admitted for a tonsillectomy. A baby who remains in hospital without its mother awaiting adoption and does not require clinical care/treatment should be separated when the baby is 9 days of age and registered as a boarder when the baby is ten days of age.

Boarders receive no formal care or treatment and are therefore not considered admitted patients. However, boarders are within the scope of this collection and the Data Services Unit has collected information regarding boarders, since 1 July 1999 including leave days but not including mental health details. Hospitals should register such people and forward this information to the Data Services Unit.

When a hospital registers a boarder, the boarder should be allocated with a ***Source of Referral/transfer = 21,*** a ***Type of episode = 08*** and a ***Mode of separation = 14.*** If a boarder meets the criteria for admission they should be formally admitted, that is code 06, Care Type change for source of referral/transfer or mode of separation should not be used.

Data on boarders **must** be submitted to the Data Services Unit.

4.10.1 Boarder who is subsequently admitted

If a boarder has been accommodated at a hospital and a change in his/her condition subsequently allows him/her to be an admission under the minimum criteria, this cannot be recorded as a change in status. As the hospital has previously "registered" the person as a boarder, the patient must be admitted and treated as a first-time admission. Do not use 06 care type change for either the source of referral/transfer or mode of separation. If the person subsequently changes circumstances again, they should be formally separated prior to being registered as a boarder once more.

4.11 ORGAN DONORS

4. 11.1 Live Donors

A live donor is admitted to an acute episode of care to donate organs. Live donors can not be registered as a posthumous care type.

4.11.2 Posthumous Organ Procurement

Posthumous organ procurement is the procurement of human tissue for the purpose of transplantation from a donor who meets the following criteria: brain death, consent for organ procurement received and the patient is clinically eligible to donate organ/s.

Before a patient who has died can proceed to organ procurement, that patient should be formally separated (separation mode = 05) and then registered using the codes listed below (ie. code 06 episode change for *Source of referral/transfer* or *Mode of separation* should not be used).

Note: Public Hospitals utilising HBCIS do not have the capacity to register patients to the organ procurement care type. Public hospitals performing organ procurement, should contact the Data Services Unit for further information.

EPISODE WHERE BRAIN DEATH OCCURS	ORGAN PROCUREMENT REGISTRATION
The episode of care where brain death occurs has a *Mode of Separation* code of Died in Hospital (05). Organ *of*	The organ procurement registration has a *Care Type* of Organ Procurement (07) and a *Source of Referral/Transfer* code of 20 - Procurement and a *Mode Separation* code of 13 - Organ Procurement.

4.12 COMPENSABLE PATIENT

A compensable patient is a patient who may be entitled to the payment of, or who has been paid compensation for, damages or other benefits (including payment in settlement of a claim for compensation, damages or other benefits) in respect of injury, illness or disease for which he/she is receiving care and treatment.

A compensable patient is a person who:

- is entitled to claim damages under Motor Vehicle Compulsory Third Party insurance; or
- is entitled to claim damages under the Workcover Queensland Act 1996 or under a Workers' Compensation Act other than Queensland (e.g. if an employee of the Commonwealth or if employed interstate); or
- has or may have an entitlement to claim under public liability.

A Department of Veterans' Affairs (DVA) patient is not compensable in the strict interpretation of the word, but is a patient for whom another agency (DVA) has accepted responsibility for the payment of any charges relating to his/her episode of care.

People admitted to hospital from motor vehicle accidents occurring after 1 September 1994, must be classified as either Motor Vehicle (Queensland) or Motor Vehicle (Other):

- **Motor Vehicle (Queensland)**: Patients admitted to hospital from accidents where liability lies with a Queensland registered vehicle; or
- **Motor Vehicle (Other)**: Patients admitted to hospital from accidents where liability lies with a vehicle registered elsewhere (not in Queensland).

People admitted to hospital from motor vehicle accidents occurring before 1 September 1994, must be classified as Other Third Party:

- ***Other Third Party***: Patients who receive care and treatment for an injury, illness or disease. These patients at any time may receive, or establish a right to receive, compensation or damages for the injury, illness or disease.

The Motor Accident Insurance Act (MAIA) 1994 commenced on 1 September 1994. This Act establishes a levy system for the recovery of costs from Compulsory Third Party (CTP) Insurers, covering the liability arising out of the negligence of owners and drivers of Queensland registered vehicles, for personal treatment to other parties.

For patients classified as ***Motor Vehicle (Queensland)*** there will be no individual charges raised (whether public, private shared, or private single) since they are covered by the new levy bulk payment. Patients classified as Motor Vehicle (Other) involved in motor vehicle accidents are to have charges raised as for other Third Party Compensable patients.

The levy does not apply to accidents that:

- are not associated with CTP; or
- involved single vehicle accidents with only the driver suffering injury; or
- occurred before 1 September 1994; or
- only involved vehicles registered in States other than Queensland.

Patients from accidents which involve vehicles from both Queensland and other States, and where the liability is dubious or where there is the possibility of shared liability, are to be classified as ***Other Third Party*** and charges raised. They may need to be reassessed after a settlement has been reached.

A patient who appears to be both a Motor Accident Insurance Act (MAIA) patient, and a Workcover Queensland patient, should be classified as a Workcover Queensland patient.

To ensure that correct information is obtained, the following questions should be asked of the patient or accompanying person:

- "Was it a single or multiple vehicle collision?"
- "Were the vehicles registered in Queensland or elsewhere?"
- "When did the accident occur (date)?"

Answers to these questions will help determine whether these cases are ***Other Third Party*** or ***Motor Vehicle (Queensland)*** or ***Motor Vehicle (Other)***.

It should be noted that persons admitted to hospital following an accident have rarely had their claims assessed prior to separation.

4.13 CONTRACTED HOSPITAL CARE

A contract patient receives care that is provided under an agreement between a purchaser of hospital care (contractor) and a public or private hospital or day facility providing admitted or non-admitted services (service provider). These definitions **do not** apply to patients who **are not admitted to either hospital** and receive service only as a non-admitted patient.

A contractor is a purchaser of hospital care from a service provider. A contractor can be a health authority, public or private hospital. A service provider can be a public or a private hospital or a day facility. Where the contractor is a health authority, the service provider must be a private hospital or private day facility.

Accurate recording of contracted hospital care is essential because:

- funding arrangements require that the DRG assigned to a patient accurately reflects the total treatment provided, even where part of the treatment was provided under contract;
- funding arrangements requirements that potential double payments are identified and avoided;
- unidentified duplication in the reporting of separations, patient days and procedures must be avoided to enable accurate analyses as required for funding, casemix, resource use and epidemiological purposes; and
- The Commonwealth Department of Health and Aged Care requires the details of contracted public patients attending private hospitals to be reported, under the Australian Health Care Agreement:

4.13.1 Scope of Contracted Care

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

To be in scope, contracted hospital care must involve *all* of the following:

- a purchaser, which can be a public or private hospital, a health authority or another external purchaser;
- a contracted hospital, which can be a public or private hospital or day procedure centre;

- the purchaser making full payment to the contracted hospital for the contracted service.

- the patient being physically present in the contracted hospital for the provision of the contracted service

Thus, services provided to a patient in a separate facility during their episode of care where the *patient* is directly responsible for payment of this additional service are not considered contracted services for reporting purposes to the Data Services Unit; and

Pathology or other investigations performed at another location on specimens gathered at the contracting hospital are *not* considered contracted services for reporting purposes to the Data Services Unit.

Procedures performed by a health care service (ie not a recognised hospital) should be coded if appropriate but are not considered to be contracted hospital procedures. However, hospitals that wish to record this information could do this using the contract flag functionality and a dummy facility identifier. See section 4.13.6.6 and 9.11 for more details.

Allocation of diagnosis and procedure codes should not be affected by the contract status of an episode: the *Australian Coding Standards* should be applied when coding all episodes. In particular, procedures that would not otherwise be coded should not be coded solely because they were performed at another hospital under contract.

4.13.2 Location of Contracted Care Data Items on HBCIS

Contracted Care Data Item	HBCIS Screen Location	Triggered By
Contract Type	Contracted Care Screen	Admission Source = 11, 12 or 13 Leave Category = C Discharge Code = 10 or 11
Contract Role	Contracted Care Screen	As above
Contract Procedure Flag	Inpatient ICD Coding Screen	As above
Date Transferred for Contract Service	Patient Leave Screen	Leave Category = C
Date Returned from Contract Service	Patient Leave Screen	Leave Category = C
Contract Leave	Patient Leave Screen	Leave Category = C

4.13.3 Contract Role

Contract role was introduced in 1 July 2000. It identifies whether a hospital is the purchaser of hospital care (contracting hospital) or the provider of an admitted or non-admitted service (contracted hospital).

Hospital **A** is the contracting hospital (purchaser)
Hospital **B** is the contracted hospital (service provider)

4.13.4 Contract Leave

Contract leave is a period spent as an admitted patient at a contracted (service provider) hospital, during an episode where the patient is also admitted to the contracting (purchasing) hospital. A patient **cannot** be admitted to two facilities at the same time, unless they are on **contract leave**.

A patient can go on contract leave for services that are same day or overnight (or longer). If there is **no agreement** between the two facilities, then the patient must be **formally separated/transferred** if he/she is to be admitted to the second facility.

Contract leave days are reported only by the contracting (purchasing) hospital and are treated as patient days and included in the length of stay at that hospital. Patients going on contract leave are **not separated**.

See also section 8.5 for more information.

4.13.5 Contract Flag

A Contract Flag is an indicator that designates that a procedure was performed by another hospital as a contracted service. It also indicates whether the procedure performed was an admitted or non-admitted service by using a code of **1** (contracted admitted procedure) or **2** (contracted non-admitted procedure). All services provided as part of a contract arrangement must be flagged using the Contract Flag. **Diagnosis codes should not** be flagged, unless it is to indicate that a contracted service was not carried out. See Section 9.11 for more information.

Since 1 July 1999, HBCIS hospitals have able to use the Contract Flag functionality without placing a patient on contract leave.

4.13.6 Types of Contracted Hospital Care

There are five contract types; these are described below. In these examples, the contracting (purchasing) hospital (or authority) is termed Hospital **A**. The contracted (service provider) hospital is termed Hospital **B**.

The various contract types are represented by one of the following numerical values:

1 = B
2 = ABA
3 = AB
4 = (A)B
5 = BA

4.13.6.1 Contract Type 1 (Also referred to as contract type - B)

Definition:
Admission as a same day or overnight (or longer) stay patient to a private hospital under contract to Queensland Health or a District Health Service.

Procedure:
Hospital **B** records:

- Admission Source/Source of Referral **12**
- Contract Type code **1** (Contract Type B)
- Contract Role code **B** (Hospital B)
- Appropriate Discharge/Separation Code

4.13.6.2 Contract Type 2 (Also referred to as contract type - ABA)

Definition:
One hospital **(A)** contracts with another hospital **(B**) to provide an admitted or non-admitted (or outpatient) service. The patient returns to hospital **A**.

Note:
Where the service is a **non-admitted** service provided at hospital **B**, B does **not** admit the patient.

If the patient does not return to Hospital A, see the procedure for Contract Type 3 (AB).

Procedure:
Hospital **A** records

- Appropriate Admission Source/Source of Referral
- Admission Date: actual date admitted at **A**
- Contract Type code **2** (Contract Type **ABA**)
- Contract Role code **A** (Hospital **A**)
- Contract establishment identifier (Destination/Extended Source Code) of Hospital **B**
- Date patient transferred for contract service
- Date patient returned from contract service
- Diagnosis and procedure codes: include any additional diagnoses identified by **B**, and procedures provided by **B** each with relevant contract procedure flag (**1** or **2**)
- Discharge/Separation date: actual date the patient left **A** after returning from **B**
- Appropriate Discharge Status/Mode of Separation code after returning from **B**

If admitted by Hospital **B**, **B** records

- Admission Source/Source of Referral code **11**
- Admission date: actual date care commenced at **B**
- Contract Type code **2** (Contract Type **ABA**)
- Contract Role code **B** (Hospital **B**)
- Contract establishment identifier (Extend Source/Extended Source Code) of Hospital A

- Diagnosis and procedure codes: only in relation to care provided by **B**
- Discharge/Separation date: actual date separated from **B**
- Discharge Status/Mode of Separation code **11**

4.13.6.3 Contract Type 3 (Also referred to as contract type - AB)

Definition:
One hospital (A) contracts with another hospital (B) to provide an admitted or non-admitted (or outpatient) service. The patient does not return to A and is not placed on contract leave.

Note:
Where the service is a non-admitted service provided at hospital B, B does not admit the patient.

The patient is not placed on contract leave to attend hospital B.

Procedure:
- Hospital **A** records (irrespective of the original intention for the patient to return or not)
- Appropriate Admission Source/Source of Referral
- Admission Date
- Contract Type code **3** (Contract Type **AB**)
- Contract Role code **A** (Hospital **A**)
- Contract establishment identifier (Destination/Extended Source Code) of Hospital **B**
- Diagnosis and procedure codes: include any additional diagnoses identified by **B**, and procedures provided by **B** each with relevant contract procedure flag (1 or 2)
- Discharge/Separation date: actual date separated from **A**
- Discharge Status/Mode of Separation code **10**

If admitted by **B**, **B** records:

- Admission Source/Source of Referral code **11**
- Admission date: actual date of commencement of care at **B**
- Contract Type code **3** (Contract Type **AB**)
- Contract Role code B (Hospital **B**)
- Contract establishment identifier (Extend Source/Extended Source Code) of Hospital **A**
- Diagnosis and procedure codes: only in relation to care provided by **B**
- Discharge/Separation date: actual date separated from **B**
- Appropriate Discharge Status/Mode of Separation code

4.13.6.4 Contract Type 4 (Also referred to as contract type (A)B)

Definition:
Admission as a same day or overnight (or longer) stay patient to a hospital (**B**) under contract from another hospital (**A**).

Note:

Hospital **A** does not record an admission.

Procedure:
B records:
- Admission Source/Source of Referral **11**
- Admission date: date actually admitted at **B**
- Contract Type code **4** (Contract Type (A)B)
- Contract Role code **B** (Hospital B)
- Contract establishment identifier (Extend Source/Extended Source Code) of Hospital **A**
- Diagnosis and procedure codes
- Discharge/Separation date
- Appropriate Discharge Status/Mode of Separation code

4.13.6.5 Contract Type 5 (Also referred to as contract type BA)

Definition:
A contracts **B** for an admitted service prior to the patient's admission to **A**.

Procedure:
B records:
- Admission Source/Source of Referral code **11**
- Admission date: actual date admitted at **B**
- Contract Type code **5** (Contract Type BA)
- Contract Role code **B** (Hospital B)
- Contract establishment identifier (Extend Source/Extended Source Code) of Hospital **A**
- Diagnosis and procedure codes provided by **B**
- Discharge/Separation date: actual date separated from **B**
- Discharge Status/Mode of Separation code **11**

A records:
Admission Source/Source of Referral code **13**
- Admission date: actual date admitted at **A**. This should equal the date separated from **B**
- Contract Type code **5** (Contract Type **BA**)
- Contract Role code **A** (Hospital **A**)
- Contract establishment identifier (Extend Source/Extended Source Code) of Hospital **B**
- Diagnosis and procedure codes: include any additional diagnoses identified by **B**, and procedures provided by **B** each with relevant contract procedure flag (**1 or 2**)
- Discharge/Separation date: actual date separated from **A**
- Appropriate Discharge Status/Mode of Separation code

4.13.6.6 Recording of Procedures Performed at Private Health Organisations

Private health organisations provide services such as radiology and pathology, but are not licensed as a hospital. That is, they do not have a Queensland Health facility number.

Private health organisations do not fall within the scope of the National 'Contracted Hospital Care' data item. Consequently, the recording of these types of arrangements is optional. Hospitals that wish to record procedures performed by private health organisations can do so by using the 'contract flag' functionality and dummy facility identifier of 99998. Procedures performed within a hospital by a private health organisation may also be flagged using this functionality.

4.14 LEAVE

A leave patient is a patient who leaves the hospital for a short period and intends to return to the hospital to continue the current course of treatment. Under current national guidelines, an admitted patient may be granted leave for up to a maximum of seven days. Same day patients are not generally placed on leave.

4.14.1 Contract leave

Contract leave is used to allow a patient to receive a contracted admitted or non-admitted service which is not available at the hospital where the patient is currently admitted. For more information, refer to 3.6.1.2 - Counting rules for contract leave.

4.15 PATIENTS ON LIFE SUPPORT

Patients who are on life-support are considered 'admitted patients' until they have been declared clinically dead, after which time they should be formally discharged.

Patients who remain on life support after being declared clinically dead for the purposes of organ procurement, must be formally discharged from their episode of care and registered to an 'Organ Procurement Episode Type'.

4.16 HOSPITAL IN THE HOME (PUBLIC HOSPITALS ONLY)

From July 1 2001, there is a Commonwealth requirement to report on Hospital in the Home (HITH) Care.

4.16.1 Hospital in the Home Reporting

Only approved acute services provided by public hospitals are to be reported. Services previously introduced under the 1998 draft *Guidelines for the Credentialling of Hospital in the Home Services* and listed in Appendix P are considered approved.

Hospitals developing HITH services not listed in Appendix P must follow the procedures described in the 2001 *Guidelines for approval of Hospital in the Home services*.

4.16.2 Hospital in the Home Care Type

Patients who qualify as a HITH patient must be admitted as Acute (code 01).

4.16.3 Hospital in the Home Admitting Ward

HITH patients can be either admitted directly to a *Home* ward from the Emergency Department or Outpatients Department, or may be transferred from a hospital ward to the *Home* ward.

4.16.4 Hospital in the Home Source of referral

For patients admitted directly to a *Home* ward, the Source of Referral (field 59) on the HBCIS Patient Admission screen must be either Emergency (code 02) or Outpatient (code 03). Source of referral can be any valid corporate code when patients are transferred from another hospital ward to the *Home* ward.

4.16.5 Hospital in the Home Account Class Code

The HBCIS Account Class Code must be General Public Eligible (GPE) for the complete episode of care (ie. the period in the hospital ward **and** the period in the *Home* ward) for all patients admitted to or transferred to a *Home* ward. Hospital in the Home does not apply to private, maternity, compensable, third party, or nursing home type patients.

4.16.6 Hospital in the Home Ward Code

Home wards will be coded HOMEXX, where XX is optional and may be replaced by characters to identify one *Home* ward from another.

4.16.7 Hospital in the Home Unit Code

Unit codes will be entered according to current practice in order to identify the unit responsible for the patient in the *Home* ward (eg. Unit code = SURG; Ward code = HOME).

4.16.8 Hospital in the Home Allocation of beds

The number of beds attached to a *Home* ward in the Ward Codes Reference file will be zero.

4.16.9 Hospital in the Home Discharging Patients

The separation process (HBCIS Patient Discharge Screen) for HITH patients is as per standard separation process for admitted patents.

4.16.10 Hospital in the Home Acute Care Certificate

As Hospital in the home patients can only be classified as acute, an acute care certificate is required for all HITH patients where the period of hospitalisation exceeds 35 days. Days accumulated by HITH patients are included towards determining whether an acute care certificate is required.

5 FACILITY DETAILS

5.1 FACILITY NUMBER

The facility number is a numerical code that uniquely identifies each health care facility. Health care facilities are public and private hospitals, including hospital outposts, day surgery centres, outpatient centres and psychiatric centres.

This manual covers the facilities listed in Attachment A recognised hospitals, licensed private hospitals and psychiatric hospitals. All these hospitals are able to admit patients, although not all will wish to do so.

It should be noted that there are some facilities which, although they share the same management, and in some cases the same site, are treated as separate facilities, have separate facility numbers and are to submit data to QHAPDC separately. For example:

- Mater Mothers' Private and Mater Mothers' Public.

Patients moving between these hospitals (for example, Mater Mothers Private to Mater Mothers Public) are counted as separate admissions and separations.

Nursing home residents moving from a nursing home bed to an acute bed at another facility should be admitted as an acute patient from the date they occupy the acute bed . Their absence from the nursing home bed is counted as leave. Their stay in the nursing home bed is not to be part of the QHAPDC collection.

This is not to be confused with a person's status as a nursing home type patient in an acute bed. Refer to section 3.7 (***Boundaries***) for a detailed description of the differences.

The facility number is numeric. Facility numbers are listed in Appendix D. **Paper** hospitals must zero-fill this field for their hospital; HBCIS hospitals allocate their facility number automatically when data is extracted using HQI.

6 PATIENT DETAILS

6.1 UR NUMBER

The unit record (UR) number is a unique number allocated to each patient by the hospital. Allocation might be done manually or automatically by the computer. The number is used for each admission to identify the patient. The unit record number may be numeric or alphanumeric.

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All spaces in the field should be filled, using leading zeros where necessary.
For example:

- UR A6841602

A	6	8	4	1	6	0	2

- UR 68259

0	0	0	6	8	2	5	9

HBCIS

In some hospitals, the number is allocated automatically, in others it is obtained from a manual UR register and entered manually. If the patient already has a number, search the patient master index and select the correct number. If the number is known, record the exact number. No leading zeros or filler digits are required as these will be inserted automatically when data are extracted using HQI.

6.2 PATIENT SURNAME/FAMILY NAME

Record the surname of the patient. If the name is not known put ***unknown***. This field may only be left blank by private hospitals.

6.3 GIVEN NAMES

6.3.1 First name

Record the first given name of the patient.
If the patient has no first given names, leave blank or record as ***unknown***. Blanks are allowed in this field.

6.3.2 Second name

Record the second given name of the patient.
If the patient has no second given name, leave blank or record as ***unknown***.
Blanks are allowed in this field.

6.4 SEX

Record the code for the sex of the patient using one of the following codes:

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Code	*Description*
1	Male
2	Female
3	Indeterminate

HBCIS

Code	*Description*	*Extracted and mapped by HQI as*	
M	*Male*	*1*	*Male*
F	*Female*	*2*	*Female*
I	*Indeterminate*	*3*	*Indeterminate*

To avoid problems with edits, transsexuals undergoing a sex change operation should have their sex at time of the hospital admission recorded.

Note that ***Indeterminate*** will generally only be used for neonatal patients where the sex has not been determined.

6.5 DATE OF BIRTH

Record the date of birth of the patient using the full date (i.e. ddmmyyyy) and leading zeros where necessary.

EXAMPLE

For 5 September 1959, record

0	5	0	9	1	9	5	9

Paper

- If the day of birth is unknown, use 15.
- If the month of birth is unknown, use 06.
- If the year of birth is unknown, estimate the year from the age of the patient.
- the age of the patient is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious patients, use the year 1900).

EXAMPLE

If a patient who is admitted in 2001 does not know his exact date of birth but knows he is 91 years of age, record the date of birth as follows:

1	5	0	6	1	9	1	0

Although provision is made for recording an unknown date of birth (using 15/06/1900), every effort should be made during the course of the admission to determine (and record) the patient's actual date of birth. The patient's date of birth is an important requirement for the accurate assignment of a Diagnosis Related Group (DRG) at a later date.

HBCIS

- If the day of birth is unknown, use **.
- If the month of birth is unknown, use **.
- If the year of birth is unknown, estimate the year from the age of the patient.
- If the age of the patient is unknown and it is not possible to estimate an age and hence a year of birth (e.g. for unconscious patients, use the year 1900).

EXAMPLE

If a patient who is admitted in 2001 does not know his exact date of birth but knows he is 91 years of age, record the date of birth as follows:

*	*	*	*	1	9	1	0

Although provision is made for recording an unknown date of birth (using **/**/1900), every effort should be made during the course of the admission to determine (and record) the patient's actual date of birth. The patient's date of birth is an important requirement for the accurate assignment of a Diagnosis Related Group (DRG) at a later date.

6.6 DATE OF BIRTH FLAG (HBCIS ONLY)

The Date of Birth Flag indicates whether the patient's date of birth has been estimated.

If an asterisk has been used in place of either the day or the month, then a Date of Birth Flag of '1 – Estimated' will be allocated when data is submitted to the Data Services Unit.

6.7 ADDRESS OF USUAL RESIDENCE

6.7.1 Number and street of usual residence

Record the building number and street name of the usual residential address of the patient. The usual residential address is the place where the patient lives. For example, it is not the address where the patient might be staying temporarily before or after the period of hospitalisation.

Post office box numbers/property names/mail service numbers should not be recorded. Use a building number and street name wherever possible. Even country properties have access roads which have names.

EXAMPLE

"Emohruo Homestead", Dusty Road

Use the postcode as an indicator. For example, If the patient states the address is "Emohruo Homestead", off Dusty Road, Elbow Valley, via Warwick, and both Elbow Valley and Warwick have postcodes, put the property name and access road name in this field. Put Elbow Valley in the field *suburb/town of usual residence* (see section 6.6.2). Warwick need not be entered at all. Do not enter the word "via".

If Elbow Valley had no postcode, then the property name and the access road (Dusty Road) only should be entered in this field. Warwick is entered in the field *suburb/town of usual residence* (see section 6.6.2). Elbow Valley should not be recorded.

Unknown number and street of usual residence

If the number and street of the usual address are unknown (e.g. an unconscious patient is unable to provide the information), leave blank.

Temporary residence

If the patient is temporarily resident with relatives, in a hotel or place other than his/her home, do not use the temporary address in this field, but attempt to ascertain his/her usual residential address.

Baby for adoption

If the patient is a baby for adoption, record the address of the hospital.

HBCIS

HBCIS hospitals have the option to record three types of addresses:

- ***Permanent****: as per the above description for paper hospitals*
- ***Temporary***: allows recording of the address at which the patient may be residing immediately before and after hospitalisation.
- ***Mailing***: allows for the mailing address, for example PO box numbers.

6.7.2 Suburb/town of usual residence

The location of the usual residence of the patient is the suburb or town in which the patient usually lives. Do not record the location of temporary accommodation, or a (farm) property name in this field (refer to comments above).

Interstate and overseas patients

It is particularly important to record the correct address for patients who generally live interstate or overseas. This is because funds are transferred between state health departments for patients who are treated outside their state of usual residence.

If the patient lives interstate, the actual suburb or town of usual residence should be recorded.

If the patient is from overseas, also record the country in which he/she normally resides.

Unknown suburb/town

If the suburb/town of the usual address is unknown (e.g. an unconscious patient is unable to provide the information), record ***unknown***. Do not leave the field blank.

Baby for adoption

If the patient is a baby for adoption, record the town or suburb of the hospital.

No fixed address

Record no fixed address.

At sea

Record usual address or at sea.

6.7.3 Postcode of usual residence

Record the postcode of the usual residential address of the patient.

If the patient is not an Australian resident or has no fixed address, use one of the following supplementary codes:

Code	*Description*
9301	**Papua New Guinea**
9302	**New Zealand**
9399	**Overseas other (not PNG or NZ)**
9799	**At sea**
9899	**Australian External Territories**
9989	**No fixed address**
0989	**Not stated or unknown**

Please note that it is particularly important to record the country of residence accurately for patients from Papua New Guinea and New Zealand.

Identify Australian External Territories separately as code 9899, not as the overseas code. Australian External Territories include the following : Christmas Island (Australia), Cocos (Keeling) Islands, Norfolk Island, Other Australian External Territories.

Unknown postcode

If the postcode of the usual address is unknown (e.g. an unconscious patient is unable to provide the information), record code ***0989 Not stated or unknown***. Do not leave the field blank.

Although provision is made for recording an unknown or not stated postcode (using code 0989), every effort should be made during the course of the admission to determine (and record) the patient's actual postcode.

Baby for adoption

If the patient is a baby for adoption, record the postcode of the address of the hospital.

6.7.4 State of usual residence

This item is required because the first number of a postcode is not always an indication of the State from which the patient comes.

Record the code that corresponds to the State in which the patient usually lives. Note: do not rely on the postcode for this information as there are some Queensland postcodes for patients who live over the border in other States such as New South Wales.

Code	*Description*
0	**Overseas/Australian External Territories (e.g. Christmas Island)**
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**

Australian External Territories include the following : Christmas Island (Australia), Cocos (Keeling) Islands, Norfolk Island, Other Australian External Territories.

Unknown state of usual residence

If the state of usual residence of the usual address is unknown (e.g. an unconscious patient is unable to provide the information, or no fixed address), use code 9.

Baby for adoption

If the patient is a baby for adoption, record the state code for the hospital.

6.7.5 Statistical local area (SLA)

This item records the numerical statistical local area (SLA) code for the usual residential address of the patient. It is used for epidemiological purposes in particular.

For Queensland residents the code is taken from the latest version of the ***National Localities Index*** from the Australian Bureau of Statistics. Business Application Services, Information Services will release the latest version of this file for use in public hospitals from 1 July, 2001. This file is used to allocate a SLA code from the address of the patient. As new localities arise or changes to postcodes of current localities occur, please notify the DSU so that these changes can be confirmed with Australian Bureau of Statistics and Australia Post and the appropriate SLA and postcodes allocated. On confirmation of the new details, the changes can be made on the reference files at DSU as well as the hospital that has logged the change.

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Hospitals are not required to record the SLA as during processing the Data Services Unit autocoder automatically assigns the SLA on the basis of the address.

HBCIS

Automatically assigns the SLA code when extracting data via HQI.

For non-Queensland residents, the following supplementary codes are used:

Code	*Description*
1989	**New South Wales**
2989	**Victoria**
4989	**South Australia**
5989	**Western Australia**
6989	**Tasmania**
7989	**Northern Territory**
8989	**Australian Capital Territory**
9301	**Papua New Guinea**
9302	**New Zealand**
9399	**Overseas - other (not PNG or NZ)**
9799	**At sea**
9899	**Australian External Territories**
9989	**No fixed address**
0989	**Not stated/unknown**

Australian External Territories

Identify Australian External Territories separately as SLA 9899, and do not code them as overseas. Australian External Territories include the following: Christmas Island (Australia), Cocos (Keeling) Islands, Norfolk Island, Other Australian External Territories.

Unknown statistical local area (SLA)

If the SLA of the usual address is unknown (e.g. an unconscious patient is unable to provide the information), use code 0989.

Baby for adoption

If the patient is a baby for adoption, use the SLA code applicable to the hospital.

6.8 MEDICARE ELIGIBILITY

This item records whether the patient is eligible to be treated as a Medicare patient. All patients should be asked.

The majority of patients admitted will be eligible for Medicare. An eligible person, as specified in the Commonwealth Health Insurance Act (1973), is a person who resides in Australia and is one of the following:

- an Australian citizen;
- a permanent resident;
- a New Zealand citizen;
- a temporary resident who has applied for permanent residency and who has either an authority to work in Australia or an immediate family member who is an Australian citizen or permanent resident;
- A person, or class of persons, who has been declared eligible for Medicare for the purposes of the *Health Insurance Act* 1973.

Other persons, as temporary residents, who are fully eligible for Medicare include:

- a person who is a head or member of a diplomatic mission or consular post or is a member of such in a person's family, where there is a Reciprocal Health Care Agreement in place between Australia and the country they represent (currently United Kingdom, Republic of Ireland, the Netherlands, Malta, Italy, Sweden and Finland) - with the exception of New Zealand diplomats.

Other persons, as visitors or temporary residents, who are eligible for Medicare, in certain circumstances, include:

- persons who are visiting Australia and are eligible persons because there is a Reciprocal Health Care Agreement in place between Australia and their usual country of residence (currently United Kingdom, Republic of Ireland, the Netherlands, Malta (eligibility limited to 6 months), Italy (eligibility limited to 6 months), Sweden, Finland and New Zealand - it should be noted that the RHCA with New Zealand and the Republic of Ireland limits the access to medical services for their residents to that of public patients in public hospitals) - with the exception of New Zealand diplomats.

With respect to hospital services, persons covered by an RHCA (except RHCA diplomats as they have fully Medicare eligibility) are eligible only as public patients in a public hospital and are ineligible persons if they are admitted as a private patient in either a public or a private hospital.

It should also be noted that some patients can be both an 'eligible person' and either personally or a third party liable for the payment of charges for hospital services received; for example:

- prisoners
- patients with Defence Force personnel entitlements
- compensable patients
- Department of Verterans' affairs beneficiaries
- Nursing Home Type Patients

Newborn babies take the eligibility status of the mother.

PAPER HOSPITAL

Record the Medicare eligibility of the patient using one of the following codes:

Code	***Description***
1	Eligible for Medicare
2	Not eligible for Medicare
9	Not stated/unknown

HBCIS

This item is derived from the **payment class** *item in HBCIS. Codes for payment class are:*

Code	***Description***	***Extracted and mapped by HQI as***
CU	*Unsighted Medicare Card*	*1 Eligible*
DVA	*Department of Veterans Affairs*	*1 Eligible*
MC	*Medicare*	*1 Eligible*
MVQ	*Motor Vehicle Queensland*	*1 Eligible*
MVO	*Motor Vehicle Other*	*1 Eligible*
MVOI	*Motor Vehicle Other Ineligible*	*2 Not Eligible*
MVQI	*Motor Vehicle Queensland Ineligible*	*2 Not Eligible*
NE	*Not Eligible*	*2 Not Eligible*
RC	*Reciprocal Country*	*1 Eligible*
TPE	*Third Party Eligible*	*1 Eligible*
TPI	*Third Party Ineligible*	*2 Not Eligible*
WCO	*Workers Compensation Other*	*1 Eligible*
WCQ	*Workers Compensation Queensland*	*1 Eligible*
WCOI	*Workers Compensation Other Ineligible*	*2 Not Eligible*
WCQI	*Workers Compensation Queensland Ineligible*	*2 Not Eligible*

Note: Members of the defence force are eligible to have a Medicare number and can claim on Medicare. However, in most cases they are referred to a facility with approval letters outlining the procedures/services they are to be admitted for. Defence Force personnel are generally admitted as private patients, and the cost of their care is charged to the Defence Force.

Defence Force personnel should be asked whether or not they are covered for the procedure/service they are being admitted for by the Defence Force fund. If they are not covered and are eligible for Medicare, they should apply for a Medicare number, if they do not already have one. This also applies to non-admitted procedures/services provided to Defence Force personnel.

6.9 PAYMENT CLASS (HBCIS ONLY)

The payment class in HBCIS is used to derive Medicare eligibility. Codes are as follows:

HBCIS

Codes for payment class are:

Code	***Description***	***Extracted and mapped by HQI as***	
CU	*Unsighted Medicare Card*	*1*	*Eligible*
DVA	*Department of Veterans Affairs*	*1*	*Eligible*
MC	*Medicare*	*1*	*Eligible*
MVO	*Motor Vehicle Other*	*1*	*Eligible*
MVOI	*Motor Vehicle Other Ineligible*	*2*	*Not Eligible*
MVQ	*Motor Vehicle Queensland*	*1*	*Eligible*
MVQI	*Motor Vehicle Queensland Ineligible*	*2*	*Not Eligible*
NE	*Not Eligible*	*2*	*Not Eligible*
RC	*Reciprocal Country*	*1*	*Eligible*
TPE	*Third Party Eligible*	*1*	*Eligible*
TPI	*Third Party Ineligible*	*2*	*Not Eligible*
WCO	*Workers Compensation Other*	*1*	*Eligible*
WCOI	*Workers Compensation Other Ineligible*	*2*	*Not Eligible*
WCQ	*Workers Compensation Queensland*	*1*	*Eligible*
WCQI	*Workers Compensation Queensland Ineligible*	*2*	*Not Eligible*

6.10 MEDICARE NUMBER

PAPER HOSPITAL

If the patient is eligible for Medicare, record the Medicare number from the patient's Medicare card, for example:

0	**5**	**0**	**9**	**1**	**9**	**5**	**9**	**9**	**9**

If the patient is eligible for Medicare, but has not yet registered with Medicare, record the number *0000/00000/0.*
If the patient is not eligible for Medicare or if eligibility for Medicare is not known, leave blank.

HBCIS

Enter the Medicare number. A checking algorithm is part of HBCIS and ensures that a valid Medicare number is recorded.

6.11 EMERGENCY CONTACT NAME/ADDRESS/TELEPHONE NUMBER

Record the contact details of a relative or friend of the patient, who may be contacted by the hospital in an emergency.

This information is not reported to the DSU for QHAPDC; it is for hospital use only.

6.12 RELIGION

This information is not reported to the DSU for QHAPDC; it is for hospital use only. The list of codes for HBCIS appears in Appendix H.

HBCIS

If your hospital requires it, record the numerical code number of the religion.

6.13 MARITAL STATUS

Record the current marital status of the patient using one of the following codes:

PAPER HOSPITAL

Code	Description
1	Never Married
2	Married/de facto
3	Widowed
4	Divorced
5	Separated
9	Not stated/unknown

HBCIS

Code	*Description*	*Extracted and mapped by HQI as*	
A	*Separated*	*5*	*Separated*
D	*Divorced*	*4*	*Divorced*
F	*De facto*	*2*	*Married/de facto*
M	*Married*	*2*	*Married/de facto*
N	*Not stated*	*9*	*Not stated/unknown*
NM	*Never Married*	*1*	*Never Married*
W	*Widowed*	*3*	*Widowed*

Separated means those people who are legally separated or socially separated, not persons who are temporarily living apart (e.g. construction workers living in hostels or camps).

6.14 COUNTRY OF BIRTH

Record the country of birth of the patient using the numerical codes found in Appendix E. For example:

- if the patient was born in Australia, use code 1101;
- if the patient was born in New Zealand, use code 1201.

PAPER HOSPITAL
Record the country of birth and the code.

HBCIS
Record the code.

6.15 LANGUAGE

See Appendix G for the list of HBCIS language codes. This information is not reported to the DSU for QHAPDC; it is for hospital use only.

HBCIS
Record the language most preferred by the patient for communication.

6.16 INDIGENOUS STATUS

The improvement of the health of Indigenous Australians has been identified as one of the priorities in the Queensland Health Corporate Plan (1998 - 2003) Key Performance Objectives. The accurate identification of Aboriginal and Torres Strait Islander patients in Queensland Health data collections is crucial to measuring their health status and the effectiveness of intervention programs.

All persons admitted to hospitals should be asked "Are you of Aboriginal or Torres Strait Islander origin?" Persons who reply "Yes" to this question should be asked to specify which origin they are of, either Aboriginal, Torres Strait Islander, or both Aboriginal and Torres Strait Islander. This question must be asked of all admitted

patients. Where the patient is unable to provide this information, for example, when a baby or child is admitted to hospital, the parent or guardian should be asked whether the child is of Aboriginal or Torres Strait Islander origin.

Data providers must record the Indigenous status of the patient using one of the following codes:

PAPER HOSPITAL

Code	Description
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal & Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
9	Not stated (This code should only be used in the event when a patient, or next of kin cannot answer the question)

HBCIS

Code	*Description*	*Extracted and mapped by HQI as*	
11	Aboriginal but not Torres Islander Strait Islander origin	1	Aboriginal but not Torres Strait Islander origin
12	Torres Strait Islander but not Aboriginal Aboriginal origin	2	Torres Strait Islander but not Aboriginal
13	Both Aboriginal & Torres Strait Islander origin	3	Both Aboriginal & Torres Strait Islander origin
14	Not Aboriginal nor Torres Islander origin	4	Neither Aboriginal nor Torres Strait Strait Islander origin
19	Not Stated	9	Not Stated

Data providers should be aware that:

(1) Patients born outside of Australia are unlikely to be of Australian Indigenous status; and;

(2) A person's Indigenous status can not be determined by observation.

For data accuracy, the patient, their carer, or next of kin must be asked the question directly.

6.17 OCCUPATION

This information is not reported to the DSU for QHAPDC; it is for hospital use only.

HBCIS
Record the patient's occupation.

6.18 AUSTRALIAN SOUTH SEA ISLANDER STATUS

The Queensland Government recognised Australian South Sea Islanders as a distinct cultural group in September 2000. They are the Australian born descendants of the original South Sea Islanders, but primarily from the Vanuatu and Solomon Islands, who were brought to Australia sometimes by force or deception to work in the sugar industry in the nineteenth century. The government gave a commitment to recognise Australian South Sea Islanders in government service provision.

The accurate identification of Australian South Sea Islander patients in Queensland Health data collections is also crucial to measuring their health status and the effectiveness of intervention programs.

All persons admitted to hospitals should be asked the following question: "*Are you of Australian South Sea Islander ancestry?"* This question must be asked of all admitted patients. Where the patient is unable to provide this information, for example, when a baby or child is admitted to hospital, the parent or guardian should be asked whether the child is of Australian South Sea Islander ancestry.

Data providers must record the Australian South Sea Islander status of the patient using the following codes:

PAPER HOSPITAL

Code	Description
1	Yes
2	No
9	Not stated/unknown

HBCIS	
Code	*Description*
1	*Yes*
2	*No*
9	*Not stated/unknown*

Data providers should be aware that:

(1) Patients born outside of Australia are highly unlikely to be of Australian South Sea Islander status. There may be the rare instance of the child of an Australian South Sea Islander being born overseas;

(2) Patients born in Samoa, Tonga, or Fiji (sometimes referred to as Pacific Islanders) or their Australian born descendants are not to be recorded as having Australian South Sea Islander status;

(3) Patients born in countries such as Vanuatu or the Solomon Islands are not Australian South Sea Islanders (even though these are the major islands from which the orginal South Sea Islanders came). Only descendants of the original South Sea Islanders qualify;

(4) Some patients will have indigenous as well as Australian South Sea Islander ancestry. They may identify as either or both;

(5) A person's Australian South Sea Islander status can not be determined by observation. For data accuracy, the patient, their carer, or next of kin must be asked the question directly.

7 ADMISSION DETAILS

7.1 ADMISSION DATE

Record the full date (that is, ddmmyyyy) of admission to hospital. Use leading zeros where necessary.

EXAMPLE
For a patient admitted on 3 July 2001, record

0	3	0	7	2	0	0	1

7.2 ADMISSION TIME

Use the 24-hour clock to record the time of admission. Times are between 0000 (midnight), which is the start of the day, and 2359, which is the end of a day.

HBCIS hospitals: currently HBCIS will not accept 0000 as midnight. If an actual event occurs at midnight, use 2400. Where hospitals are using 2400 as a default please use 2359.

EXAMPLE
Admission time for a patient admitted at 3:10 a.m.

0	3	1	0

EXAMPLE
Admission for patient admitted at 6:05 p.m.

1	8	0	5

If the patient's time of admission is unknown, use an estimate. Ensure the time is before any period of leave or patient activity.

7.3 ADMISSION NUMBER

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Record the admission number from the Admission Register. Use leading zeros as necessary.

HBCIS

Allocated automatically by the system and it is known as the **episode number**.

7.4 ACCOUNT CLASS (HBCIS ONLY)

The account class identifies the billing classification of the patient, i.e. it determines the patient's daily bed charge (see also section 7.5, Chargeable Status). The most common codes used are as follows:

GPE	**General Public Eligible**
GRE	**General Private Eligible**
GSE	**General Shared Eligible**
MPE	**Maternity Public Eligible**
MRE	**Maternity Private Eligible**
MSE	**Maternity Shared Eligible**

A list of account class codes appears in Appendix I.

NOTE: If a patient is admitted as a same day banded patient, but remains in hospital overnight or longer, then the admission account class must be updated rather than recording an account class variation. Generally, this can only be done by staff in the accounts area.

If a newborn changes status between ***unqualified*** and ***acute***, then the account class must be changed. Hospitals should use xxQ for newborns with a qualification status of acute and xxUQ for newborns with a qualification status of unqualified when assigning an account class code.

Same day banded patients cannot have an account class change. However, other patients are able to have account class changes. The account class changes forwarded to DSU is the last account class for that day. The account class is used to derive the ***compensable status*** of the patient (section 7.10), the ***band*** (section 7.7), the ***chargeable status*** (section 7.5) and ***boarder status*** (section 7.24).

7.5 CHARGEABLE STATUS

On admission to hospital, the patient must elect to be treated as either a public patient; a private patient in single accommodation; or a private patient in shared accommodation.

PAPER HOSPITAL

Record the chargeable status of the patient using one of the following codes:

Code	*Description*
1	Public
2	Private shared
3	Private single

A Public patient is a person, eligible for Medicare, who, on admission to a recognised hospital or soon after:

- receives a public hospital service free of charge : or
- elects to be a public patient; or
- whose treatment is contracted to a private hospital.

A Private patient is a person who, on admission to a recognised hospital or soon after:

- elects to be a private patient treated by a medical practitioner of his or her choice; or
- elects to occupy a bed in a single room (where such an election is made, the patient is responsible for meeting certain hospital charges as well as the professional charges raised by any treating medical or dental practitioner); or
- a person, eligible for Medicare, who chooses to be admitted to a private hospital (where such a choice is made, the patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner).

Do not assume the chargeable status on the basis of the hospital insurance status because the two items are not always the same.

For example:

- A patient may have hospital insurance but elect to be admitted as a public patient.

- An uninsured patient may elect to be treated privately and meet the hospital and clinician charges themselves.

HBCIS
This data item is not entered separately as it is derived from the second digit of the **account class**. **P** *in account class is Public* **R** *in account class is Private* **S** *in account class is Shared*

The fees raised against public patients are covered by Medicare. Where a patient elects to be treated privately, he/she becomes responsible for the charge raised by the hospital and also the professional charges raised by the treating practitioner.

Ineligible and compensable patients who are chargeable but use public hospital doctors are classified as public. Those who use private doctors are to be classified as private.

7.6 CARE TYPE

Prior to 1 July 1995, admitted patients were classified as either Nursing Home Type (NHT) or Other. From 1 July 1995 the classification of care types was expanded to meet national reporting requirements.

This classification has been further extended from 1 July 2000. The non-acute categories have been split into maintenance, geriatric evaluation and management, and psychogeriatric care types.

An episode of care refers to the phase of treatment rather than to each individual patient day. There may be more than one episode of care within the one hospital stay period. Each episode is reported to the DSU on its completion. It is identified as a statistical separation (episode change) through the use of code ***06*** in ***the source of referral/transfer*** and ***mode of separation*** data items.

Please note that a person allocated to an organ procurement or boarder episode type can NOT have an 06 in the source of referral/transfer or mode of separation data items.

An episode of care ends when the principal clinical intent of care changes or when the patient is formally separated from the hospital.

It is necessary to link episodes within the DSU to enable analysis of a patient's hospital stay. This can be done by firstly identifying the patient's formal separation from hospital (i.e. mode of separation is not code 06). If the source of referral/transfer is also not code 06, then the patient had only one episode for

the hospital stay. The majority of patients are like this. If however the source of referral/transfer is code 06, then the patient's previous separation is found (using date of new admission = date of previous separation). The source of referral/transfer is checked, and if necessary, this process of linking continues until the source of referral/transfer indicates a true hospital admission (i.e. code is not 06). This process of linking records makes it critical for hospital staff to ensure that for any patient who changes episode, the correct codes are used for the type of episode, source of referral/transfer, and mode of separation. It is also critical that the UR Number is the same for all episodes, and that the date of separation for an episode change is the same as the date of admission for the next episode within a hospital stay.

Persons with mental illness may fall into any one of the episode of care types, and their classification is dependent upon the principal clinical intent of the care received.

PAPER HOSPITAL

Record the type of episode using one of the following numerical codes:

Code	***Description***
01	Acute
21	Rehabilitation - delivered in a designated unit
22	Rehabilitation - according to a designated program
23	Rehabilitation - principal clinical intent
31	Palliative - delivered in a designated unit
32	Palliative - according to a designated program
33	Palliative - principal clinical intent
05	Newborn
09	Geriatric Evaluation and Management
10	Psychogeriatric
11	Maintenance
06	Other care
07	Organ Procurement
08	Boarder

HBCIS

This data item is entered separately.

The following codes are entered onto the admission screen.

Code	***Description***
01	*Acute*
21	*Rehabilitation - delivered in a designated unit*
22	*Rehabilitation - according to a designated program*
23	*Rehabilitation - principal clinical intent*
31	*Palliative - delivered in a designated unit*
32	*Palliative - according to a designated program*
33	*Palliative - principal clinical intent*
05	*Newborn*
09	*Geriatric Evaluation and Management*
10	*Psychogeriatric*
11	*Maintenance*
06	*Other care*
07	*Organ Procurement (Not available on HBCIS)*
08	*Boarder*

Code 44 is not extracted as part of HQI as it can only be used for nursing home patients. Nursing home residents are not part of the scope of QHAPDC.

44	*Non-acute care - Nursing Home resident*

Definitions of the types of episodes of care for an admitted patient are as follows:

Acute care*:* is care in which the principal clinical intent or treatment goal is one or more of the following:

- manage labour (obstetric);
- cure illness or provide definitive treatment of injury;
- perform surgery;
- relieve symptoms of illness or injury (excluding palliative care);
- reduce severity of an illness or injury;
- protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function; and or
- perform diagnostic or therapeutic procedures.

Rehabilitation care*:* is care in which the clinical intent or treatment goal is to improve the functional status of a patient with an impairment, disability or

handicap. It is usually evidenced by a multi-disciplinary rehabilitation plan comprising negotiated goals and indicative time frames which are evaluated by a periodic assessment using a recognised functional assessment measure. It includes care provided:

- in an designated rehabilitation unit , or
- in a designated rehabilitation program, or in a psychiatric rehabilitation program as designated by the State health authority for public patients in a recognised hospital, for private patients in a public or private hospital as approved by a registered health benefits organisation; or
- under the principal clinical management of a rehabilitation physician, or in the opinion of the treating doctor when the principal clinical intent of care is rehabilitation.

(21) *Rehabilitation – delivered in a designated unit* ; is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for rehabilitation care and/or primarily delivers rehabilitation care.

(22) Rehabilitation – according to a designated program; is where care is delivered by a specialised team of staff who provide rehabilitation care to patients in beds that may or may not be dedicated to rehabilitation care. The program may, or may not be funded through identified rehabilitation care funding. Code 21 should be used instead of code 22 if care is being delivered in a designated rehabilitation care program and a designated rehabilitation care unit.

(23) *Rehabilitation – as a principal clinical intent*, occurs when the patient is primarily managed by a medical practitioner who is a specialist in rehabilitation care or when, in the opinion of the treating medical practitioner, the care provided is rehabilitation care even if the doctor is not a rehabilitation care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which code 21 or 22 should be used, respectively.

Coding for rehabilitation categories should be carried out in strict numerical sequence, ie the first appropriate category code should be used.

Palliative care is care in which the clinical intent or treatment goal is primarily quality of life for a patient with an active, progressive disease with little or no prospect of cure. It is usually evidenced by an interdisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the patient; and a grief and bereavement support service for the patient and their carers/family. It includes care provided:

- in a palliative care unit; or
- in a designated palliative care program; or

- under the principal clinical management of a palliative care physician or, in the
- opinion of the treating doctor, when the principal clinical intent of care is palliation.

(31) *Palliative – delivered in a designated care unit* is a dedicated ward or unit (and can be a stand-alone unit) that receives identified funding for palliative care and/or primarily delivers palliative care.

(32) *Palliative – according to a designated program* is where care is delivered by a specialised team of staff who provide palliative care to patients in beds that may or may not be dedicated to palliative care. The program may, or may not be funded through identified palliative care funding. Code 31 should be used instead of code 32 if care is being delivered in a designated palliative care program and a designated palliative care unit.

(33) *Palliative principal client intent* occurs when the patient is primarily managed by a medical practitioner who is a specialist in palliative care or when, in the opinion of the treating medical practitioner, the care provided is palliative care even if the doctor is not a palliative care specialist. The exception to this is when the medical practitioner is providing care within a designated unit or a designated program, in which case codes 31 or 32 should be used, respectively. For example, code 33 would apply to a patient dying of cancer who was being treated in a geriatric ward without specialist input by palliative care staff.

Coding for palliation categories should be carried out in strict numerical sequence ie the first appropriate category should be coded.

Geriatric evaluation and management is care in which the clinical intent or treatment goal is to maximise health status and/or optimise the living arrangements for a patient with multi-dimensional medical conditions associated with disabilities and psychosocial problems, who is usually (but not always) an older patient. This may also include younger adults with clinical conditions generally associated with old age. This care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames.

Geriatric evaluation and management includes care provided:

- in a geriatric evaluation and management unit; or
- in a designated geriatric evaluation and management program; or
- under the principal clinical management of a geriatric evaluation and management physician or, in the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

Psychogeriatric care is care in which the clinical intent or treatment goal is improvement in health, modification of symptoms and enhancement in function, behaviour and/or quality of life for a patient with an age related organic brain impairment with significant behavioural or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance. The care is usually evidenced by multi-disciplinary management and regular assessments against a management plan that is working towards negotiated goals within indicative time frames. It includes care provided:

- in a psychogeriatric care unit;
- in a designated psychogeriatric care program; or
- under the principal clinical management of a psychogeriatric physician or, in the opinion of the treating doctor, when the principal clinical intent of care is psychogeriatric care.

Maintenance care is care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting eg at home, or in a nursing home, by a relative or carer, that is unavailable in the short term.

Newborn care is initiated when the patient is born in hospital or is nine days old or less at the time of admission. Newborn care continues until the care type changes or the patient is separated:

- patients who turn 10 days of age and do not require clinical care are separated and, if they remain in the hospital, are designated as boarders.
- patients who turn 10 days of age and require clinical care continue in a newborn episode of care until separated.
- patients aged less than 10 days and not admitted at birth (eg transferred from another hospital) are admitted with a newborn care type;
- patients aged greater than 9 days not previously admitted (eg transferred from another hospital) are either boarders or admitted with an acute care type;
- within a newborn episode of care, until the baby turns 10 days of age, each day is either a qualified or unqualified day.
- a newborn is qualified when it meets at least one of the criteria detailed in the newborn qualification status.

Within a newborn episode of care, each day after the baby turns 10 days of age is counted as acute (qualified) patient day.

Newborn qualified days are equivalent to acute days and may be denoted as such. See section 4.5 for further information on newborns.

Other admitted patient care is care where the principal clinical intent does not meet the criteria for any of the above.

Organ Procurement – posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.

Diagnosis and procedures undertaken during this activity, including mechanical ventilation and tissue procurement, should be recorded in accordance with the relevant ICD-10-AM Australian Coding Standards. These patients are not admitted to the hospital but are registered by the hospital.

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

Hospital boarders are not admitted to the hospital. However, a hospital may register a boarder. Babies in hospital at age 9 days or less cannot be boarders. They are admitted patients with each day of stay deemed to be either qualified or unqualified.

7.7 BAND

All same day surgical and non-operative procedures can be allocated a number as per the Commonwealth Benefits Schedule. These are called CMBS numbers. Based on CMBS numbers and other factors, procedures can be categorised into one of four different bands. For private patients, both in public and private hospitals, the bands are used as a basis to determine the level of charges. Bands are also used to determine whether patients are admitted as same day patients, or otherwise. Please refer to the Admission Policy in Appendix F for further clarification on how bands affect the admission process.

Patients who receive a procedure which would not normally warrant admission, may be admitted with a Day Only Procedure Certificate (section of form 1830) issued by the attending medical practitioner.

Bands can only be determined reliably on patient separation when the procedure that was performed is known, and a CMBS number has been given. The band is required only for private patient day benefit procedure cases by the DSU, however hospitals may supply bands for public patients.

Do not allocate a band if the procedure was performed as a same day episode within a longer hospital stay (involving statistical admission and/or separation for a change in episode type). Band only for stand alone same day hospital stays.

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The band is required only for private patient day benefit procedure cases. You may leave the field blank if the patient is not a private patient or is not a day benefit procedure patient.
Record the band using one of the following codes:

Code	***Description***
1A	Band 1A
1B	Band 1B
2	Band 2
3	Band 3
4	Band 4

Definitions and further information on each band can be found in the current version of the ***Same Day Procedures Manual*** produced by the Commonwealth Department of Health and Aged Care (Australian Government Publishing Service, Canberra, 1999) (Internet: http://www.health.gov.au/pubs/circfinl/circlar3.htm).

Band 1A is a definitive list of procedures including gastrointestinal endoscopy, certain minor surgical items and non-surgical procedures that do not normally require anaesthetic. Band 1B relates to professional attention that embraces all other day only admission to hospital not related to bands 2,3 or 4. Bands 2,3 and 4 are determined by the anaesthetic type and theatre time. Band 2 means procedures (other than band 1) carried out under local anaesthetic with no sedation; Band 3 means procedures (other than band 1) carried out under general or regional anaesthesia or intravenous sedation with theatre time (actual time in theatre) less than one hour; and Band 4 means procedures (other than band 1) carried out under general or regional anaesthesia or intravenous sedation with theatre time (actual time in theatre) of one hour or more.

HBCIS

This data item is not entered separately as it is derived from the item **account class** *(B1A; B1B; B2; B3; B4) and translated to 1A, 1B, 02, 03 and 04. If a patient changes from same day to overnight or longer, the admission account class must be altered, rather than recording an account class variation. Usually this can only be done by accounts staff.*

7.8 SOURCE OF REFERRAL/TRANSFER (ADMISSION SOURCE)

The source of referral/transfer indicates the referral point of a patient immediately before they are admitted either formally (hospital admission) or statistically (type of episode change). Record the source of referral/transfer using one of the following codes:

PAPER HOSPITAL - SOURCE OF REFERRAL

Code	*Description*
01	Private medical practitioner (excluding psychiatrist)
15	Private psychiatrist
02	Emergency department - this hospital
03	Outpatient department - this hospital
04	Other hospital - not contract
05	Nursing home
06	Care type change
09	Born in hospital
11	Contract from other hospital
12	Contract from health authority/department
13	Other contract
16	Correctional facility
17	Law enforcement agency
18	Community service
19	Routine readmission - not requiring referral
14	Other health care establishment
29	Other
20	Organ Procurement (not available on HBCIS at this stage)
21	Boarder

NB: The scope of the QHAPDC does not include Military Hospitals. Therefore patients requiring admission following treatment at a Military Hospital should not be coded as a transfer from another hospital.

HBCIS - ADMISSION SOURCE

Code	Description	Extracted and mapped by HQI as:
01	Private medical practitioner (excl. psychiatrist)	01 Private medical practitioner (excl. psychiatrist)
15	Private psychiatrist	15 Private psychiatrist
02	A&E	02 Emergency department this hospital
03	Outpatient department	03 Outpatient department this hospital
04	Hospital transfer	04 Other hospital - not contract
05	Nursing home transfer	05 Nursing home
06	Episode change	06 Episode change
08	Outborn	02 Emergency Department
09	Born in hospital	09 Born in hospital
10	Retrieval from another hospital	04 Other hospital - not contract
11	Contract from other hospital	11 Contract from other hospital
12	Contract from health authority	12 Contract from health authority
13	Other contract	13 Other contract
16	Correctional facility	16 Correctional facility
17	Law enforcement agency	17 Law enforcement agency
18	Community service	18 Community service
19	Retrieval not from other hospital	02 Emergency Department
14	Other health care establishment	14 Other health care establishment
22	Routine readmission not requiring referral	19 Routine readmission not requiring referral
29	Other	29 Other
20	Organ Procurement	20 Organ Procurement (Not available on HBCIS at this stage)
21	Boarder	21 Boarder

The following rules are to be used in the allocation of appropriate ***source of referral/transfer (admission source)*** codes.

Code	Explanation
01 Private medical practitioner (excluding psychiatrist)	Used for patients referred to the hospital admission office by a private doctor other than a psychiatrist. Such patients will generally be private shared or private single patients whose admission will have been arranged by their treating doctor or dentist.
15 Private psychiatrist	Patients referred to the hospital admission office by a psychiatrist.
02 Emergency department - this hospital	Used for patients who present to the Emergency or Casualty Department of this hospital and are subsequently admitted immediately following their emergency consultation. They will generally not be booked patients. For example, use this code for patients who are transported by the Royal Flying Doctor Service for an unplanned (not booked) admission. Paper: you may use this for babies (qualified and unqualified) born on the way to hospital.
03 Outpatient department - this hospital	Used for patients who have attended an outpatient clinic at the hospital and are subsequently referred for admitted patient treatment. They will generally be booked patients. Patients who are transported by the Royal Flying Doctor Service to attend outpatients, and are then booked for admission, use this code. For unplanned (not booked) admissions refer to code ***02 Emergency department - this hospital***.
04 Other hospital - not contract	Used for patients who are transferred from another hospital (including psychiatric hospitals) for continuation of their care or treatment at this hospital. Note that such patients are <u>not</u> being treated under a contract arrangement. Rather, this hospital has completely taken over the care and management of the patient. This code may also be used for patients who are transferred from hospitals interstate or overseas.
05 Nursing home	Used for patients who are transferred from a nursing home, where they are usually resident, to this hospital for further care and treatment.
06 Care Type change	Used for statistical admissions where the patient has previously been admitted to an episode of care during this hospital stay, and is now changing the type of episode of care (e.g. acute to maintenance). Do not use this code for a registered boarder changing status to become an admitted patient.

08 Outborn (HBCIS only)	For babies (qualified and unqualified) who were born on the way to hospital and have not been admitted at any other hospital.
09 Born in hospital	Used for babies born at this hospital during this admission only.
10 Retrieval from another hospital (HBCIS only)	Used when a patient has been brought to the hospital from another hospital by a retrieval team.
11 Contract - from other hospital	Used to indicate that a patient has been referred by another hospital for a contracted service see section 4.13. for more information on contracts
12 Contract from health authority/department	Used for a patient whose entire hospital stay has been arranged under a contract agreement between either the health department or a Health Service District. See section 4.13 for more information on contracts.
13 Other contract	Used by contracting hospitals when the patient has been admitted at the hospital providing the contract service first (ie the service provider) See section 4.13 for more information on contracts (contract type BA).
16 Correctional facility	Patients who have been referred to the hospital from a correctional facility.
17 Law enforcement agency	Patients who have been referred to the hospital from a law enforcement agency (other than a correctional facility) such as the police or courts.
18 Community service	A patient whose admission to the hospital has been arranged by a community health service.
14 Other health care establishment	Used for patients who are admitted from alcohol and drug centres, hostels recognised by the Commonwealth Department of Health and Family Services or other health care establishments.
29 Other	Used for patients who are admitted under circumstances that do not fit any other category. However, it is expected that this code will rarely be used.
19 Routine readmission	Used for patients who are not admitted through outpatients or the emergency department eg renal dialysis patients, chemotherapy patients directly presenting to the ward for planned treatment.
20 Organ Procurement	Used to register donars (who have been declared brain dead) for the purpose of procurement of human tissue.

21 Boarder	Used to register a person who is receiving food and/or accommodation but for whom the hospital does not accept responsibility for treatment and/or care.

Note HBCIS ONLY

19 Retrieval not from other hospital	Used when a patient has been brought to the hospital from any place other than another hospital by a retrieval team (Mapped to QHIPS 29 Other)
22 Routine readmission	Used for patients who are not admitted through outpatients or the emergency department eg renal dialysis patients, chemotherapy patients directly presenting to the ward for planned treatment. Mapped to QHIPS 19 Routine readmission

Examples

(1) A patient attends a specialist (other than a psychiatrist) in the specialist's rooms. The specialist has admitting rights at your hospital. The patient is booked for admission and is admitted.

The source of referral is 01 Private medical practitioner (not psychiatrist).

(2) A patient is seen in the rooms of his/her local medical officer (general practitioner). The patient is sent to the outpatient department or emergency for review by hospital staff and admission (elective or emergency) results.

The source of referral is 03 Outpatient Department - this hospital; or 02 Emergency - this hospital.

(3) A patient comes from his/her place of permanent residence in a nursing home to the outpatient department or emergency for review by hospital staff and admission (elective or emergency) results.

The source of referral is 03 Outpatient Department - this hospital; or 02 Emergency - this hospital.

(4) A patient comes from his/her place of permanent residence in a nursing home to the hospital ward.

The source of referral is 05 Nursing home.

7.9 TRANSFERRING FROM FACILITY (EXTENDED SOURCE CODE)

The number must be recorded when this hospital receives a transferred patient for ongoing care or a referred patient for a contract service. That is, this item is mandatory if the patient's ***source of referral/transfer (admission source)*** is:

Code	Description
04	**Other hospital - not contract**
11	**Contract - from other hospital**
13	**Other Contract**
16	**Correctional facility**

PAPER HOSPITAL

Record the facility number of the hospital or correctional facility that transferred or referred the patient to this hospital for admission.

HBCIS

Record the extended source code of the hospital or correctional facility that transferred or referred the patient to this hospital for admission.

Note that numbers exist to indicate if the patient has transferred from a facility in another state or from overseas.

See Appendix D for list of facilities and their facility numbers.

7.10 COMPENSABLE STATUS

This item records information when the patient's hospitalisation is to be paid for by a third party, usually as a result of the patient being in an accident. Note that although this is recorded at the time of admission, in the belief that the patient will be eligible for compensation, there are times when the compensation claim fails, and the patient reverts to public or private status.

For a more detailed explanation of compensable status, refer to the definitions in section 4.12.

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Record the compensable status of the patient using one of the following codes:

Code	***Description***
1	Workcover Queensland
2	Workers' Compensation Board (other)
6	Motor Vehicle (Queensland)
7	Motor Vehicle (Other)
3	Other Third Party
4	Other compensable
5	Department of Veterans' Affairs
8	None of the above

A Patient Activity Form should be completed for all patients whose compensable status changes during an admission. This form is to be submitted with the patient's corresponding Identification and Diagnosis Sheet.

HBCIS

This data item is not entered separately as it is derived from the item **account class***.*

The letters from the account class are:

TP	*Other Third Party*
WC	*Workcover Queensland*
WCO	*Workers' Compensation Other*
MV	*Motor Vehicle Queensland*
MVO	*Motor Vehicle Other*
DVA	*Department of Veteran's Affairs*

Note: DVA patients are classified as Compensable.

An **activity change** *is recorded automatically as a result of changes that must be made to the* **account class***.*

DEFINITIONS

Workcover Queensland
Patient is entitled to claim damages under the Queensland Workers' Compensation Act.

Workers' Compensation Board (Other)
Patient is entitled to claim damages under a Workers' Compensation Act other than Queensland (e.g. if an employee of the Commonwealth or if employed interstate).

Motor Vehicle Queensland (MVQ)
This is used for patients admitted to hospital from accidents where liability lies with a Queensland registered vehicle. The patient has or may have an entitlement to claim under Motor Vehicle Third Party Insurance.

Motor Vehicle (Other)
This is used for patients admitted to hospital from accidents where the liability lies with a vehicle registered elsewhere (not in Queensland).

Other Third Party
Other third party cases (such as accidents involving uninsured motor vehicles, mobile machinery or equipment such as bulldozers and forklifts etc, agricultural implements etc).

Motor Vehicle Third Party Insurance
Refer to section 4.12 for details.

Other compensable
For other compensable patients, such as those who have or may have an entitlement to claim under the Criminal Code.

Department of Veterans' Affairs
A patient for whom the Department of Veterans' Affairs has accepted responsibility for the payment of any charges relating to his/her episode of care.
`

None of the above
The patient is not eligible for classification as a compensable patient in any of the above categories, or the compensable status is unknown.

Note: Compensable patients who are to be admitted for a same day band procedure are to be charged the compensable rate. It is therefore unnecessary to record a band for them (refer to section 4.12).

7.11 HOSPITAL INSURANCE STATUS

This data item is used to record whether patients have hospital level health insurance, irrespective of their ***chargeable status*** for this admission. That is, they may not choose to be admitted as private patients on this occasion, but the fact that they have hospital insurance at all should be recorded.

For example:

- A patient may have hospital insurance, but elects to be admitted as a public patient on this occasion.
- An uninsured patient may elect to be treated privately on this occasion, and meet the hospital and clinician charges himself/herself.

PAPER HOSPITAL

Record the insurance status of the patient using one of the codes below.

Code	***Description***
7	*Hospital insurance*
8	*No hospital insurance*
9	*Not stated/unknown*

Definitions

7 Hospital insurance
Used when the patient has health insurance that covers accommodation charges.

8 No hospital insurance
Used when the patient does not have health insurance that covers hospital accommodation charges.

9 Not stated/unknown
Used when the health insurance status is not known (e.g. an unconscious patient is unable to provide the information).

HBCIS

HBCIS via the extracting process of HQI will derive from the insurance fund item as either:

Y ***Hospital insurance***
Used when the patient has health insurance that covers accommodation charges.

N ***No hospital insurance***
Used when the patient does not have health insurance that covers him/her for hospital accommodation charges.

U ***Not stated/unknown***
Used when the patient is unable to identify level of insurance held.

7.12 HEALTH FUND (HBCIS ONLY)

A code for the patient's health fund should be entered in HBCIS.

7.13 SEPARATION DATE

At separation, record the full date (that is, ddmmyyyy), using leading zeros where necessary.

EXAMPLE

For a patient who was discharged on 24 July 2001, record

2	4	0	7	2	0	0	1

7.14 SEPARATION TIME

Use the 24-hour clock to record the time of separation. Times are between 0000 (midnight) and 2359. Note that midnight is the start of a new day, not the end of the previous one.

HBCIS hospitals: currently HBCIS will not accept 0000 as midnight. If an actual event occurs at midnight, use 2400. Where hospitals are using 2400 as a default please use 2359.

EXAMPLE
For a patient discharged at 9:10 a.m., record

0	9	1	0

EXAMPLE
For a patient who died at 6.05 p.m., record

1	8	0	5

If the patient's time of separation is unknown, estimate separation time. It must not be before the time of admission or during a time when the patient is on leave.

7.15 MODE OF SEPARATION (DISCHARGE STATUS)

The mode of separation (discharge status) indicates the place to which a patient is referred immediately following formal separation from hospital or indicates whether this is a statistical separation due to a change in the type of episode of care.

PAPER HOSPITAL - MODE OF SEPARATION

Record the mode of separation using one of the following numerical codes:

Code	*Description*
01	Home/usual residence
02	Other hospital - not contract
03	Nursing home
05	Died in hospital
06	Care Type change
07	Discharged at own risk
09	Non-return from leave
10	Contract - to other hospital
11	Return to other hospital following contract at this hospital
12	Correctional facility
04	Other health care accommodation
19	Other
13	Organ Procurement
14	Boarder

HBCIS - DISCHARGE STATUS		
Code	***Description***	***Extracted/mapped by HQI as:***
01	*Home/usual residence*	*01 Home/usual residence*
02	*Other hospital*	*02 Other hospital not contract*
03	*Nursing Home*	*03 Nursing home*
04	*Other health care establishment*	*04 Other health care accommodation*
05	*Died in hospital*	*05 Died in hospital*
06	*Care Type change*	*06 Care type change*
07	*Discharged at own risk*	*07 Discharged at own risk*
09	*Non-return from leave*	*09 Non-return from leave*
10	*Contract - to other hospital*	*10 Contract to other hospital*
11	*Return to contract hospital*	*11 Return to contract hospital*
12	*Correctional facility*	*12 Correctional facility*
19	*Other*	*19 Other*
13	*Organ Procurement*	*13 Organ Procurement(Not available in HBCIS)*
14	*Boarder*	*14 Boarder*

Use the following guidelines to determine the correct ***mode of separation***:

Code	Explanation
01 Home/usual residence	Used for those patients who return to their usual residence following the current hospital stay. If the patient is usually a resident of a nursing home or other institution, use this category. However, if the patient is being transferred from the hospital to a nursing home for the first time, do not use this category; use ***03 Nursing home***. Includes patients discharged to a boarding house or commercial hostel if this is their usual place of residence.
02 Other hospital (not contract)	Used for patients who are transferred to another hospital for continuation of their **admitted** care and management. The second hospital undertakes full responsibility for the patient. Note that this code may be used for patients transferred to hospitals which are interstate or overseas.
03 Nursing home	Used for patients who are discharged to a nursing home for the first time (i.e. the nursing home is not where they lived prior to their admission to hospital).
04 Other health care accommodation	Used for patients who are transferred to alcohol and drug centres, community health centres or other health care accommodation. This includes hostels recognised by the Commonwealth Department of Health and Family Services, unless this is the usual place of residence.
05 Died in hospital	Used when the patient died during his/her hospitalisation.

06 Care Type change	Used for statistical separations where the patient is to continue the hospital stay, but is now changing the type of episode of care (e.g. acute to Maintenance). Do not use this code for registered boarders changing status to become an admitted patient.
07 Discharged at own risk	Used for patients who abscond or leave hospital against medical advice.
09 Non-return from leave	Used when a patient goes on leave and does not return to the hospital within seven days. Note that the patient is to be discharged from the date that he/she left the hospital.
10 Contract - to other hospital	Used for patients who have been referred from this hospital to another facility for a contracted service, but do not return. Such patients must be discharged from this hospital. See definitions of contract patients (section 4.13) for further explanation of the use of this category.
11 Return to other hospital following contract at this hospital	Used for patients referred from another facility for a contract at this hospital when they are subsequently returned to the originating hospital.
12 Correctional facility	Patient separated to a correctional facility.
13 Organ Procurement	Used to denote the cessation of an organ procurement registration.
14 Boarder	Used to denote the completion of a boarder registration.
19 Other	Used for patients who are separated under circumstances that do not fit any other category. It is expected this code will be rarely used.

7.16 TRANSFERRING TO FACILITY

Record the facility number (***extended source*** code) for the hospital or correctional facility to which the patient is referred as an admitted patient. This item is mandatory if the ***mode of separation (discharge status)*** is:

QHAPDC Codes	*Description*
02	**Other hospital - not contract**
10	**Contract - to other hospital**
11	**Return to other hospital following contract at this hospital.**
12	**Correctional facility**

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Record the facility number of the hospital or correctional facility to which the patient is being transferred for admission.

HBCIS

Record the extended source code of the hospital or correctional facility to which the patient is being transferred for admission.

See Appendix D for list of facilities and code numbers.

7.17 BABY ADMISSION WEIGHT

Record the admission weight (grams) of neonates who are under 29 days or weigh less than 2500 grams at the time of admission. The admission weight is defined as the weight of the neonate on the day admitted, unless this is the day of birth, in which case the admission weight is taken as the birth weight.

In circumstances where babies have not been weighed a 'dummy' weight is currently being used by some hospitals. In order to standardise this procedure and to allow for the identification of 'dummy' weights, hospitals should enter the weight as 9000, in these cases.

Hospitals should note that this practice will produce an Error on the Validation Report (H148 - Baby is XXXX grams. This is much heavier than most babies under 1 month. Please check birth date and admission weight.). The hospital can no longer provide a 'dummy weight of 9000 without providing a valid reason as to why the baby was not weighted.

EXAMPLE
For a baby weighing 980 grams at admission, record

0	9	8	0

7.18 ADMISSION WARD

Record the code to indicate the specific ward to which the patient is admitted. Use the codes prepared by the hospital as the DSU does not have a predetermined list of codes for hospitals.

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A maximum of six characters is allowed.

HBCIS

A maximum of six characters is allowed.

7.19 ADMISSION UNIT

If the hospital maintains a system of units to describe clinical specialities, record the hospital code to indicate the unit to which the patient was admitted. A maximum of four characters is allowed.

7.20 STANDARD UNIT CODE

Record the standard unit code prepared by DSU to describe the unit to which the patient was admitted (see Appendix K). For HBCIS hospitals, the standard unit codes may be mapped from the treating doctor units. For paper hospitals, this is mapped from the treating doctor on the basis of his/her specialisation.

7.21 STANDARD WARD CODE (HBCIS ONLY)

Record a standard ward code if the patient has been admitted or transferred to a ward which has been assigned to a designated SNAP unit. For HBCIS this is mapped to a code of 'SNAP' and a maximum of four characters is allowed.

7.22 TREATING DOCTOR

This data item is collected for hospital use only; it is not required by DSU. Record the hospital code to describe the individual doctor chiefly responsible for treating the patient.

7.23 PLANNED SAME DAY

This item is used to indicate whether it is planned for the patient to be discharged before midnight on the same day as he/she is admitted. Such patients will generally be admitted for a Day Benefit procedure. If the patient ultimately remains in hospital longer than one day, this data item remains as originally recorded. It may be used for quality assurance studies to investigate reasons for the change in plan. Note that Band 1 same day patients who subsequently stay in overnight require an Overnight Stay Certification.

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Record the planned duration of the patient's stay using one of the following codes:

Code	***Description***
Y	Yes, planned to be separated from the hospital on the same day
N	No, planned to stay at least one night

This information will generally be obtained from a booking form or other details available from the treating doctor.

This item documents the intent. If the patient who has been recorded as "N" dies or is discharged unexpectedly on the day he/she is admitted, the code remains the same.

HBCIS

Record, in the specified field, the planned duration of the patient's stay using one of the following codes:

Code	**Description**
Y	*Yes, planned to be separated from the hospital on the same day*
N	*No, planned to stay at least one night*

This information will generally be obtained from a booking form or other details available from the treating doctor.

This item documents the intent. If the patient who has been recorded as "N" dies or is discharged unexpectedly on the day he/she is admitted, the code remains the same.

7.24 BOARDER STATUS

See the definition of a boarder in section 4.10. Since 1 July 1999 data for boarders are required to be submitted for the QHAPDC.

7.25 RECENT DISCHARGE

7.25.1 Has the patient been discharged from any hospital in the last seven days?

This information is not reported to the DSU for QHAPDC; it is for hospital use only. It is useful because fees charged to the patient may depend on whether the patient has been an admitted patient in any recognised or licensed hospital within the seven days before this admission. In addition, if the patient has been admitted in any hospital, this may affect eligibility for acute care entitlements.

HBCIS
Record the number of days in the specified field "Days Carried Forward".

7.25.2 If yes, which hospital?

This information is not reported to the DSU for QHAPDC; it is for hospital use only.

HBCIS
Record the name of the previous hospital in the specified field **other hospital**.

7.25.3 Total length of stay without breaks of more than seven days in previous hospitals

This information is not reported to the DSU for QHAPDC; it is for hospital use only.

HBCIS
Calculated automatically.

7.26 SEPARATION NUMBER

This information is not reported to the DSU for QHAPDC; it is for hospital use only.

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Record the separation number as recorded in the discharge register.

HBCIS
Not recorded.

7.27 ELECTIVE PATIENT STATUS

An emergency admission is an admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours.

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

Admissions for which an urgency status is usually not assigned are:

- admissions for normal delivery (obstetric);
- admissions which begin with the birth of the patient, or when it was intended that the birth occur in the hospital, commence shortly after the birth of the patient;
- statistical admissions; and
- planned readmissions for the patient to receive limited care or treatment for a current condition, for example dialysis or chemotherapy.

Although the following list is not definitive an emergency patient would be:

- at risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation; or
- suffering from suspected acute organ or system failure; or
- suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
- suffering from a drug overdose, toxic substance or toxin effect; or

- experiencing severe psychiatric disturbance whereby the health of the patient or other people is at immediate risk; or
- suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
- suffering acute significant haemorrahage and requiring urgent assessment and treatment; or
- suffering gynaecological or obstetric complications; or
- suffering an acute condition which represents a significant threat to the patients physical or psychological wellbeing; or
- suffering a condition which represents a significant threat to public health.

PAPER HOSPITAL

Record the following codes to indicate the elective patient status:

Code	Description
1	Emergency admission
2	Elective admission
3	Not assigned

HBCIS

Record the following codes to indicate the elective patient status:

Code	*Description*
1	*Emergency admission*
2	*Elective admission*
3	*Not assigned*

7.28 QUALIFICATION STATUS

All babies 9 days old or less should be admitted with a newborn care type. On admission the newborn will be have a qualification status of either acute (qualified) or unqualified (see section 4.5 Newborns).

Record the qualification status on admission.
If the qualification status of the newborn changes after admission then the change in qualification status is recorded as an activity (see section 8.7).

PAPER HOSPITAL

Record the following codes to indicate the qualification status of the newborn:

Code	Description
A	Acute
U	Unqualified

HBCIS

Qualification status of a newborn is derived from the account class code by HQI:

Account Class Code	***Description***
xxQ	*Acute*
xxUQ	*Unqualified*

7.29 FUNDING SOURCE

Record the expected principal source of funding for the episode. The major funding source should be recorded if there is more than one source of funding:

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Record the following codes to indicate the principal source of funds for the episode:

Code	Description
01	Australian Health Care Agreements (Public patients – not contracted or not covered by reciprocal health care agreements
02	Private health insurance
03	Self-funded
04	Worker's compensation
05	Motor vehicle third party personal claim
06	Other compensation (incl: Public liability, common law and medical negligence)
07	Department of Veteran's Affairs
08	Department of Defence
09	Correctional facility
10	Other hospital or public authority (contracted care)
11	Reciprocal Health Care Arrangements (with other countries)
12	Other
99	Not stated/unknown

HBCIS

Record the following codes to indicate the principal source of funds for the episode:

Code	Description
01	Australian Health Care Agreements (Public patients – not contracted or not covered by reciprocal health care agreements
02	Private health insurance
03	Self-funded
04	Worker's compensation
05	Motor vehicle third party personal claim
06	Other compensation (incl: Public liability, common law and medical negligence)
07	Department of Veteran's Affairs
08	Department of Defence
09	Correctional facility
10	Other hospital or public authority (contracted care)
11	Reciprocal Health Care Arrangements (with other countries)
12	Other
99	Not stated/unknown

- Patients who elect to be treated as public patients should have a funding source of '01' – Australian Health Care Agreement (Public patients – not contracted or not covered by reciprocal health care agreements.
- Patients receiving an admitted contracted service should have a funding source of '10' – 'Other hospital or public authority (contracted service)' recorded by the contracted hospital (hospital B) – see section 4.13.
- Self funded includes episodes funded by the patient, by the patient's family or friends, or by other benefactors.
- Department of Veteran's Affairs should be used for Department of Veteran's Affairs patients (See Section 13).
- Compensable patients should be recorded as Worker's Compensation, Motor Vehicle third party personal claim or Other compensation, as appropriate.
- Overseas visitors for whom travel insurance is the major funding source should be recorded as 'Other'.
- Overseas visitors who are covered by a reciprocal health care agreement and elect to be treated as a public patient should be recorded as 'Reciprocal Health Care Agreement'.

8 PATIENT ACTIVITY

This entire section refers to the action required by paper hospitals. For HBCIS hospitals, activity changes are derived automatically when other key items are changed, that is, when alterations are made to **account class** and **leave**; **ward/unit transfers**; and **contract leave**. The need for HBCIS sites to record changes in these fields is equally important as the need for paper hospitals to complete the Patient Activity Form.

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The Patient Activity Form is to be completed for each occasion of activity change, or when additional diagnostic codes are to be recorded. Note that the Patient Activity Form is to be submitted to the DSU with the corresponding Identification and Diagnosis Sheet.

8.1 PATIENT IDENTIFICATION DATA

Complete the following patient identification details on the Patient Activity Form by transcribing the same details from the Identification and Diagnosis Sheet for this admission.

Facility number
UR number
Admission number
Admission date
Admission time
Surname
Given name(s)
Sex
Date of birth

8.2 ADDITIONAL DIAGNOSTIC CODES

The Identification and Diagnosis Sheet provides for the recording of up to eight diagnostic codes. If more codes need to be reported, complete the additional coding boxes 9 to 28 on the patient activity form. If necessary, you may attach more than one patient activity form to allow recording of an unlimited number of diagnostic codes. The coding order from codes 29 onwards should be indicated. You must complete the patient identification data for all forms used.

8.3 WARD/UNIT TRANSFER

A ward/unit transfer is recorded every time the patient moves from one ward or unit to another for a different level of care, within the same hospital.

For example, a patient may initially be admitted to the Intensive Care Unit and later transferred to the general medical ward. This should be recorded on the Patient Activity Form.

A ward/unit transfer must be recorded for the date of transfer.

Record the code for the relevant field (ward, unit) together with the date and time of the transfer.

8.3.1 Ward

Record the code to indicate the specific ward to which the patient is transferred. Use the codes prepared by the hospital as the DSU does not have a predetermined list of codes for hospitals. A maximum of six characters is allowed.

8.3.2 Unit

If the hospital maintains a system of units to describe clinical specialities or combinations of wards, record the hospital's code to indicate the unit to which the patient was transferred. A maximum of four characters is allowed. If submitting a change for unit, then a unit must have been recorded on admission.

8.3.3 Standard unit code

Record the standard unit code prepared by DSU to describe the unit to which the patient was transferred. For HBCIS hospitals, this is mapped from the treating doctor units to align with the standard unit codes. For paper hospitals, this is mapped from the treating doctor on the basis of his/her specialisation.

8.3.4 Standard ward code (HBCIS only)

Record a standard ward code if the patient has been transferred to a ward which has been assigned to a designated SNAP unit. For HBCIS this is mapped to a code of 'SNAP' and a maximum of four characters is allowed.

8.3.5 Date of transfer

Record the full date (that is, ddmmyyyy) on which the transfer occurred. Use leading zeros where necessary.

EXAMPLE

For a patient who was transferred on 24 July 2001, record

2	4	0	7	2	0	0	1

8.3.6 Time of transfer

Use the 24-hour clock to record the time of transfer. Times are between 0000 (midnight) and 2359. Note that 0000 (midnight) is the start of a new day.

HBCIS hospitals: currently HBCIS will not accept 0000 as midnight. If an actual event occurs at midnight, use 2400. Where hospitals are using 2400 as a default please use 2359.

EXAMPLE
For a patient transferred at 6.10 p.m., record

1	8	1	0

If the patient's time of transfer is unknown, estimate the time. It should not be before the date and time of admission, or after the date and time of separation.

8.4 OUT ON LEAVE

Leave occurs when the patient leaves the hospital between treatments in hospital for a period of not more than seven days, and intends to return for the hospital to continue the current course of treatment. No patient day charges are raised whilst the patient is on leave, nor are the days on leave counted as patient days. See calculation of leave days in section 4.14.

If a patient who goes on leave fails to return within the seven-day limit, a separation should be recorded on the relevant admission form, to take effect from the date the patient left the hospital to go on leave.

If the patient subsequently returns to the hospital, a new admission is to be recorded. Any leave details are to be deleted in this instance.

Hospitals may report 'leave' for boarders if administrative practices at the hospital require boarders who are temporarily away from the hospital to be put on leave.

If the number of leave episodes exceeds four, and cannot be recorded on the Patient Activity Form (as there is only space to record four leave episodes) use a second Patient Activity Form and complete patient identification data on all forms used.

Only report leave to the DSU if the patient is absent at midnight.

8.4.1 Date of starting leave

Record the full date (that is, ddmmyyyy) on which the patient started leave. Use leading zeros where necessary.

EXAMPLE

For a patient who started leave on 24 July 2001, record

2	4	0	7	2	0	0	1

8.4.2 Date returned from leave

Record the full date (that is, ddmmyyyy) on which the patient returned from leave. Use leading zeros where necessary.

EXAMPLE

For a patient who returned from leave on 29 July 2001 , record

2	9	0	7	2	0	0	1

8.5 OUT ON CONTRACT LEAVE

Contract leave occurs when a patient is referred to another hospital for an admitted or non-admitted service under a contract agreement. It is intended that the patient return to the first hospital. Patients who do not return to the first hospital, must have their contract leave cancelled and be formally discharged.

If no contract agreement exists between two facilities for the service/s required, the patient must either be:

- transferred to the second facility if they are to receive an admitted service; or
- placed on 'normal' leave if they are to receive a non-admitted service.

See section 4.13 for further details on contracted hospital care and contract leave.

8.5.1 Date of starting contract service

Record the full date (that is, ddmmyyyy) on which the patient was transferred for contract service. Use leading zeros where necessary. Only to be used when the patient is to be returned to the contracting hospital after receiving contract care.

EXAMPLE

For a patient who was transferred for contract service on 24 July 2001, record

2	4	0	7	2	0	0	1

8.5.2 Facility number / destination contracted to

Record the facility number for the hospital to which the patient is transferred for contract service. See Appendix D for list of facilities and facility numbers.

8.5.3 Date returned from contract leave

Record the full date (that is, ddmmyyyy) on which the patient returned from contract service. Use leading zeros where necessary. Used for contract type **ABA.** See section 4.13.6.2

EXAMPLE

For a patient who returned transferred from contract service on 24 July 2001 , record

2	4	0	7	2	0	0	1

8.6 ACTIVITY TABLE CHANGES

8.6.1 Chargeable status change

Record the new (amended) chargeable status of the patient using one of the following codes:

Code	*Description*
1	**Public**
2	**Private shared**
3	**Private single**

Date of (chargeable status) change

Record the full date (that is, ddmmyyyy) on which the patient changed chargeable status. Use leading zeros where necessary.

EXAMPLE

For a patient who changed chargeable status on 24 July 2001, record

2	**4**	**0**	**7**	**2**	**0**	**0**	**1**

8.6.2 Compensable status change

Record the new (amended) compensable status of the patient using one of the following codes:

Code	Description
1	**Workcover Queensland**
2	**Workers' Compensation Board (other)**
6	**Motor Vehicle (Qld)**
7	**Motor Vehicle (Other)**
3	**Other Third Party**
4	**Other compensable**
5	**Department of Veterans' Affairs**
8	**None of the above**

Note that compensable patients who are to be admitted for a same day band procedure are to be charged the compensable rate.

Definitions and examples

Refer to Section 7.10 & section 4.12 for details.

Date of (compensable status) change

Record the full date (that is, ddmmyyyy) on which the patient changed compensable status. Use leading zeros where necessary.

EXAMPLE

For a patient who changed compensable status on 24 July 2001 , record

2	4	0	7	2	0	0	1

8.7 QUALIFICATION STATUS CHANGES

Record the new (amended) qualification status for the newborn using one of the qualification status codes.

Code	*Description*
A	Acute
U	Unqualified

Record the full date (that is, ddmmyyyy) on which the qualification status change occurred. Use leading zeros where necessary.

EXAMPLE

For a newborn who had a change in qualification status on 24 July 2001 , record

2	4	0	7	2	0	0	1

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 to the Data Services Unit.

For further information on newborns and Qualification Status refer to sections 4.5 and 7.28.

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The qualification status of newborn is derived from the account class code in HBCIS.
To submit a change in qualification status, a change in account class code needs to be submitted.

8.8 NURSING HOME TYPE PATIENTS

8.8.1 Nursing Home Flag

A nursing home type flag is recorded every time a patient is classified as a nursing home type patient. (i.e. does not have an acute care certificate completed. See Section 7.06). A flag of 'NHT' is recorded.

8.8.2 Date Commenced NHT Care

Record the full date (that is DDMMYYYY) on which the patient was classified as a Nursing Home Type patient.

EXAMPLE

For a patient who was classified as a NHT patient on 20 July 2001 , record

2	0	0	7	2	0	0	1

8.8.3 Date Ceased NHT Care

Record the full date (that is DDMMYYYY) on which the patient ceased being classified as a Nursing Home Type patient.

EXAMPLE

For a patient who ceased being classified as a NHT patient on 23 August 2001 , record

2	3	0	8	2	0	0	1

9 MORBIDITY DETAILS

Further information regarding the definitions and standards for morbidity coding (this includes diagnoses, external causes and procedures) can be found in the International Classification of Diseases -10-Australian Modification (ICD-10-AM)*Australian Coding Standards, Volume 5, Second Edition 1 July 2000* produced by the National Centre for Classification in Health (NCCH)(formerly the National Coding Centre).

Annual amendments to ICD-10-AM are forwarded from the NCCH and are effective as of 1 July each year. Punctuation marks (such as . , - or /) should NOT be used in recording the ICD-10-AM codes. The only alphabetical characters that are to be used when recording diagnosis details are A to Z.

Ideally, coding is performed at the hospital by a skilled coder, using the original medical record. Health Service Districts are responsible for ensuring that coding is carried out at the hospital, or by a designated person within the District who has been given responsibility for coding data for one or more sites.

For specific queries relating to coding using ICD-10-AM, contact the convenor of the Queensland Coding Committee (QCC), c/o Data Services Unit, Health Information Centre, GPO Box 48, BRISBANE 4001. Alternatively, more information on the QCC and a coding query form, can be found on the intranet at http://qheps.health.qld.gov.au/hic/qld_coding.htm

As the definition of principal procedure is no longer applicable, code all procedures that occurred during the episode of care according to Australian Coding Standard (ACS 0016 General Procedure Guidelines). Unlimited numbers of other conditions, procedures, external cause codes and morphology codes may be submitted. The terminology for these differs between HBCIS and paper hospitals. Refer to ICD-10-AM Code Identifier in section 9.1.

The sequence of codes specified by the hospital will be retained by DSU.

Coding guidelines from 1 July 2000 require external cause code(s) to be linked to the diagnosis. See the External Cause section 9.6 for examples.

A Contract Flag is used by contracting hospitals to indicate a procedure performed by a contracted hospital. It also indicates whether the procedure was performed as an admitted or non-admitted service.

9.1 ICD-10-AM CODE IDENTIFIER

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Each morbidity code is to be prefixed by an ICD-10-AM code identifier. The codes should be left adjusted and followed by trailing blanks.

Record the ICD-10-AM code identifier using the following codes:

Code	***Description***
PD	Principal Diagnosis
OD	Other Diagnoses
EX	External Cause
PR	Procedure
M	Morphology

HBCIS

HBCIS Code	***Description***	***Extracted and mapped by HQI as:***
P	*Principal Diagnosis*	*PD*
A	*Other/Associated Diagnoses*	*OD*
C	*Complications*	*OD*
PE	*External Cause associated with the Principal Diagnosis*	*EX*
AE	*External Cause related to Associated Diagnosis*	*EX*
CE	*External Cause associated with the complication*	*EX*
PM	*Morphology associated with the Principal Diagnosis*	*M*
AM	*Morphology related to Associated Diagnosis*	*M*
CM	*Morphology associated with the Complication*	*M*
	Procedure	*PR*

9.2 PRINCIPAL DIAGNOSIS

The principal diagnosis is the condition established after study to be chiefly responsible for occasioning the patient's episode of care in hospital. See Australian Coding Standard 0001 for further information.

The phrase "after study" is the evaluation of findings to establish the condition that was chiefly responsible for occasioning the care type.

Findings evaluated may include information gained from the history of illness, any mental status evaluations, specialist consultations, physical examination, diagnostic tests or procedures, any surgical procedures, and any pathological or radiological examination. The condition established after study may or may not confirm the admitting diagnosis.

Record the principal diagnosis as coded using the current edition of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM).

Only one condition may be nominated as principal diagnosis. If there are multiple diagnoses, any of which meet the criteria for principal diagnosis, refer to the ICD-10-AM Australian Coding Standards 2nd Edition, standard 0001 on Principal Diagnosis, Page 3 and 4 regarding two or more conditions meeting the definition for principal diagnosis.

Note that external cause, morphology and procedure codes are not to be used for principal diagnosis.

9.3 ADDITIONAL (OTHER) DIAGNOSES (SEQUELAE AND COMPLICATIONS)

Record additional or other diagnoses as coded using the current edition of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM).

Additional diagnoses are often described as comorbidities or complications. A comorbid condition is “a condition or complaint either coexisting with the principal diagnosis or arising during the episode of care or attendance at a health care facility.” (National Health Care Dictionary, Version 9.0, (AIHW, 2000).

For coding purposes, additional diagnoses should be interpreted as additional conditions that affect patient care in terms of requiring any of the following:

- therapeutic treatment
- diagnostic procedures
- increased nursing care and/or monitoring.

"Clinical evaluation" may be interpreted as including evaluation through diagnostic testing, consultation and observation. See Australian Coding Standard 0002 for further information.

Conditions relating to an earlier episode of ill health which have no bearing on the current hospital stay should not be coded.

Hospitals are to code any diagnoses that were determined at another hospital through contracted exploratory/ diagnostic procedures and use the contract flag to identify whether they were determined on an admitted or non-admitted basis.

9.4 MORPHOLOGY CODES

For each neoplasm code, there should be a corresponding morphology code (M code). The M codes used in ICD-10-AM are based on the International Classification of Diseases - Oncology (ICD-O).

Each morphology code consists of 5 digits; the first four identify the histology of the neoplasm and the fifth indicates its behaviour. Record the 5-digit code without a "/" between the fourth and fifth digits.

If a morphological diagnosis contains two histological terms which have different M codes, select the highest number code (as it is usually more specific). For example, a transitional cell epidermoid carcinoma has the histological terms transitional cell carcinoma NOS (coded to M81203) and squamous cell carcinoma NOS (coded to M80703). In this case, the higher number (M81203) is used.

NB: It is recognised that some hospitals may wish to record the morphology code for each lesion. This will enable individual cancers to be coded, but may result in duplicate morphology codes being recorded for each site. In such a case, the highest M code should be sequenced directly after the malignancy code to which it relates.

9.5 PROCEDURE

Procedures are coded using ICD-10-AM. There may be an unlimited number of procedures recorded. It is possible to have duplicate codes in this section: for example, bilateral lower limb varicose vein stripping. Please refer to "Bilateral Procedures" (ACS 0020 Multiple/Bilateral procedures).

All significant procedures undertaken from the time of admission to the time of discharge should be coded. This includes diagnostic and therapeutic procedures. Also include any procedures that were performed under contract at another hospital and use the contract flag to identify whether they were performed on an admitted or non-admitted basis.

The definition of a significant procedure is one that:

- is surgical in nature; and/or
- carries a procedural risk; and/or
- requires specialised training; and/or
- carries an anaesthetic risk; and/or
- requires special facilities or equipment only available in an acute care setting.

See Australian Coding Standard 0016 for further information.

9.6 EXTERNAL CAUSE

The external cause is coded using the current edition of the ICD-10-AM. It describes the precipitating event or accident leading to an injury or poisoning. These are listed in the range V01 - Y98.

Coding guidelines from 1 July 2000 require external cause code(s) to be linked to the diagnosis. An external cause code may be used in conjunction with any code in ICD-10-AM but must be used with codes from S00 -T98 and Z041 - Z045 and for complications and abnormal reactions which are classified outside the injury chapter (S00 - T98). For example, if the principal diagnosis requires an external cause code(s) it should be sequenced directly after the principal diagnosis. Examples of how to sequence codes to enable the linkage to diagnoses are as follows:

Example 1: External cause unrelated to principal diagnosis

PD	C18.7	Malignant Neoplasm of sigmoid colon
M	M8140/3	Adenocarcinoma NOS
OD	T81.2	Accidental puncture and laceration during a procedure, not elsewhere classified
EX	Y82.3	Other and unspecified medical devices associated

		with misadventures
EX	Y92.22	Health service area
PR	32090-01	[911] Colonoscopy
PR	33833-02	[708] Direct closure of wound of mesentery artery
PR	92502-02	[1910] Intravenous and inhalation general anaesthesia

Example 2: Multiple Injuries with the same external cause

PD	S52.30	Fracture of shaft of radius
EX	V19.9	Pedal cyclist injured in an unspecified accident
EX	Y92.4	Street or highway
EX	Y93.2	While working for income
OD	S70.81	Abrasion of hip and thigh
OD	S80.81	Abrasion of lower leg
EX	V19.9	Pedal cyclist injured in an unspecified accident
EX	Y92.4	Street or highway
EX	Y93.2	While working for income
PR	47363-00	[1427] Closed reduction of fracture of radius
PR	90686-01	[1628] Non-excisional debridement of skin and subcutaneous tissue
PR	92502-02	[1910] Intravenous and inhalation general anaesthesia

Example 3: Injury with external cause and non-injury condition with external cause

PD	S91.3	Open wound of other parts of foot
EX	W25	Contact with sharp glass
EX	Y92.6	Industrial and construction area
EX	Y93.2	While working for income
OD	M77.1	Lateral epicondylitis
EX	X50	Overexertion and strenuous or repetitive movements
EX	Y92.9	Unspecified place of occurrence
EX	Y93.9	Unspecified activity
OD	E11.9	Type 2 diabetes mellitus without complication
OD	I10	Essential primary hypertension
PR	30026-00	[1365] Repair of wound of skin and subcutaneous tissue of other site, superficial

Example 4: Injury with multiple external cause codes

(NOTE: HBCIS sites will not be able to use this sequencing at 1 July 2001 as enhancements are to be incorporated later in the year. In the interim, sites are to advise DSU contacts of the need to include the second external cause code. Sites will be notified when enhancements to HBCIS have been completed after which the following sequencing will apply.)

PD	S61.88	Open wound of other parts of wrist and hand (Palm)
EX	W10	Fall on and from stairs and steps

EX	W25	Contact with sharp glass
EX	Y92.0	Home
EX	Y93.3	While engaged in other types of work

Example 5: Two traditionally companion diagnosis codes (Burn and BSA) with one external cause

PD	T23.2	Partial thickness [blisters, epidermal loss] burn of wrist and hand
EX	X12	Contact with hot fluids
EX	Y92.0	Home
EX	Y93.3	While engaged in other types of work
OD	T31.00	Burns involving less than 10% or unspecified of body surface
EX	X12	Contact with hot fluids
EX	Y92.0	Home
EX	Y93.3	While engaged in other types of work

Example 6: Sequelae

PD	I77.9	Disorder of arteries and arterioles
OD	G56.3	Lesion of radial nerve
OD	T92.4	Sequelae injury nerve upper limb
EX	Y89.9	Sequelae of unspecified external cause
EX	Y92.9	Unspecified place of occurrence

There are a range of codes that do not require an external cause code to be assigned because the information is embedded in the diagnosis. Please refer to ACS 2001 External Cause Code Use and Sequencing e.g. L23.1 Allergic contact dermatitis due to adhesives. A list of these codes is included in the above coding standard.

A place of occurrence must be specified for ALL external cause codes to denote the place where the injury or poisoning occurred. To indicate the place of occurrence, use the Y92x code for the code range V01-Y89.

Also refer to section 9.7 (Place of Occurrence).

9.7 PLACE OF OCCURRENCE

A place of occurrence must be specified for ALL external cause codes in the range V01 – Y89, to denote the place of injury or poisoning. To indicate the place of occurrence, use the Y92x code listed on page 488 of the ICD-10-AM Tabular List of Diseases, Volume 1, Second Edition 1 July 2000.

Please note that post procedural disorders that **did not** require a place of occurrence code in the First Edition of ICD-10-AM **now require** a place of

occurrence code in the Second Edition. The place of occurrence code is to be sequenced directly following the external cause code. Please refer to page 217 of the Australian Coding Standards 1904 Procedural Complications, in particular page 220 – classification of early and late complications.

9.8 ACTIVITY CODES

An activity code is a separate code Y93x for use with external cause codes V01 - Y34. These characters should not be confused with, or be used instead of the recommended place of occurrence code Y92x, classifiable to V01 – Y89. Please refer to Section 9.7, Place of Occurrence. The activity code is to be sequenced directly following the place of occurrence code. Please refer to examples in section 9.6 (External Cause).

EXAMPLE

W51 Striking against or bumped into another person
Y928 At the park (place of occurrence)
Y931 While engaged in leisure activity (activity code)

9.9 DIAGNOSIS RELATED GROUP (DRG)

If the hospital has the ability to group on site using the AR-DRG system:

PAPER HOSPITAL

Record the AR-DRG code.

HBCIS

The group will be assigned automatically.

Note that the DRG information supplied will be verified and problems or inconsistencies referred back to the hospital.

It is important to use the AR-DRG version compatible with the ICD-10-AM and coding standards for the current year (current version 4.1 for 2001-2002).

9.10 MAJOR DIAGNOSTIC CATEGORY (MDC)

If the hospital has the ability to group on site using the AR-DRG system:

PAPER HOSPITAL
Record the MDC code.

HBCIS
The MDC will be assigned automatically.

Note that the MDC information supplied will be verified and problems or inconsistencies referred back to the hospital.

It is important to use the AR-DRG version compatible with the ICD-10-AM and coding standards for the current year (current version 4.1 for 2001-2002).

9.11 CONTRACT FLAG

A Contract Flag is an indicator, which designates that a procedure was performed by another hospital as a contracted service. The flag indicates whether the procedure performed was for an admitted or non-admitted service (see Section 4.13 for more details).

NB: Contracting hospitals may wish to flag certain diagnoses (Z codes only) when there is no valid procedure code available that can be flagged. For example, Z53X when contracted service was not carried out.

PAPER HOSPITAL
Record the following codes to flag a contract service: **Code** **Description** 1 Contracted admitted procedure 2 Contracted non-admitted procedure **or procedure performed by private health organisation.**

HBCIS

Record the following codes to flag a contract service:

Code	Description
1	Contracted admitted procedure
2	Contracted non-admitted procedure **or procedure performed by private health organisation.**

9.12 DATE OF PROCEDURE

The date of procedure is a new item included in the collection from 1 July 2001. The concept of recording the date of procedure has been raised at national and local forums, notably meetings of the Australian Casemix Clinical Committee (ACCC) and the Classification Update Forum on adverse events in November 2000. Currently the NCCH is drafting a proposal to the National Health Data Committee (NHDC) for the introduction of a new data element for 'date of procedure'. If accepted, this data element would be introduced in a future edition of the National Health Data Dictionary (NHDD).

The introduction of this data element will provide valuable information on the timing of the procedure in relation to the episode of care and in particular, give accurate information on pre and post-operative lengths of stay and also the measurement of time between procedures. This is of particular interest given initiatives to encourage day of admission surgery and day only procedures.

If a procedure falls within the mandatory range, enter the date the procedure was performed. This information should be provided by the patient's attending clinician and be recorded in the patient's medical record.

The date of procedure will be mandatory for all procedures with the exception of the blocks noted in Appendix Q.

The mandatory block ranges are listed below :

1	to	59
67	to	559
561	to	737
739	to	1058
1061	to	1061
1063	to	1088
1090	to	1579
1602	to	1759
1890	to	1891
1910	to	1911

10 MENTAL HEALTH DETAILS

The scope of this section is for all admitted patients episodes 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 (Mental Health Unit). These patients should have one record completed for the episode of care. No record would be completed if there were no standard unit codes in this range in the episode recorded. Those hospitals that have designated psychiatric units are listed in Appendix L.

Mental health details do not have to be reported for boarders who are registered as being in a PYAA to PYZZ standard unit code.

10.1 TYPE OF USUAL ACCOMMODATION

The type of physical accommodation the patient lived in prior to admission to the hospital.

PAPER HOSPITAL

Record the following codes to indicate the type of usual accommodation:

Code	Description
1	House or flat
2	Independent unit as part of retirement village or similar
3	Hostel or hostel type accommodation
4	Psychiatric hospital
5	Acute hospital
7	Other accommodation
8	No usual residence

HBCIS

Record the following codes to indicate the type of usual accommodation:

Code	***Description***
1	*House or flat*
2	*Independent unit as part of retirement village or similar*
3	*Hostel or hostel type accommodation*
4	*Psychiatric hospital*
5	*Acute hospital*
7	*Other accommodation*
8	*No usual residence*

10.2 EMPLOYMENT STATUS

Self-reported employment status, as defined by the categories given below, immediately prior to admission to the hospital.

Note: This item refers to self reported status. As a guide, *unemployed* refers to someone not in paid employment, who is actively seeking paid employment. People who have retired from paid employment, whether or not they are now in receipt of any form of pension or benefit may be recorded as *Other, Home duties* or *Student* as self reported by the patient. The person's pension status is collected separately by the Pension status item described in section 10.3.

PAPER HOSPITAL

Record the following codes to indicate the employment status:

Code	Description
1	Child not at school
2	Student
3	Employed
4	Unemployed
5	Home duties
8	Other

HBCIS

Record the following codes to indicate the employment status:

Code	*Description*
1	*Child not at school*
2	*Student*
3	*Employed*
4	*Unemployed*
5	*Home duties*
8	*Other*

10.3 PENSION STATUS

The pension status of a patient refers to whether or not a patient is in receipt of a pension at the time of admission to hospital. It also details the nature of the pension held by the patient. This does not imply that the pension is necessarily the recipient's main source of income.

Please note that the broad heading of 'Pensions' encompasses a range of related pensions and allowances. For example:

- The term Invalid Pension includes the Disability Support Pension.
- The term Unemployment Benefit includes Newstart Allowance and Youth Training Allowance.
- The term Age Pension includes Mature Age Allowance and Mature Age Partner Allowance.

PAPER HOSPITAL

Record the following codes to indicate the pension:

Code	Description
1	Aged
2	Repatriation
3	Invalid
4	Unemployment benefit
5	Sickness benefits
7	Other
8	No pension/benefit

HBCIS

Record the following codes to indicate the pension status of the patient:

Code	*Description*
1	*Aged*
2	*Repatriation*
3	*Invalid*
4	*Unemployment benefit*
5	*Sickness benefits*
7	*Other*
8	*No pension/benefit*

10.4 FIRST ADMISSION FOR PSYCHIATRIC TREATMENT

The status of the episode in terms of whether it is a first or subsequent admission, at any hospital for any condition, for psychiatric treatment, whether in an acute or psychiatric hospital.

PAPER HOSPITAL

Record the following codes to indicate the first admission for psychiatric treatment:

Code	Description
1	No previous admission for psychiatric treatment
2	Previous admission for psychiatric treatment

HBCIS

Record the following codes to indicate the first admission for psychiatric treatment:

Code	*Description*
1	*No previous admission for psychiatric treatment*
2	*Previous admission for psychiatric treatment*

10.5 REFERRAL TO FURTHER CARE

Referral to further care by health service agencies/facilities following discharge from the hospital (or episode of care). Many psychiatric patients have continuing needs for post-discharge care.

PAPER HOSPITAL

Record the following codes to indicate the place to which the patient is referred:

Code	Description
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
29	Other

HBCIS

Record the following codes to indicate the place to which the patient is referred:

Code	***Description***
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*
29	*Other*

10.6 MENTAL HEALTH LEGAL STATUS INDICATOR

An indication that a person was treated on an involuntary basis under the relevant state or territory mental health legislation, at some point during the hospital stay. Involuntary patients are persons who are detained under mental health legislation for the purpose of assessment or provision of appropriate treatment or care. This is collected at discharge from the hospital (or episode of care).

PAPER HOSPITAL

Record the following codes to indicate the mental health legal status indicator:

Code	**Description**
1	Involuntary patient for any part of the episode
2	Voluntary patient for all of the episode

HBCIS

Record the following codes to indicate the mental health legal status indicator:

Code	***Description***
1	*Involuntary patient for any part of the episode*
2	*Voluntary patient for all of the episode*

10.7 PREVIOUS SPECIALISED NON-ADMITTED TREATMENT

The status of the episode in terms of whether the patient has had a previous non-admitted service contact for psychiatric treatment.

PAPER HOSPITAL

Record the following codes to indicate the patient has had a previous non-admitted service contract for psychiatric treatment:

Code	Description
1	Patient has no previous non-admitted service/contracts for psychiatric treatment
2	Patient has previous non-admitted service/contracts for psychiatric treatment

HBCIS

Record the following codes to indicate the patient has had a previous non-admitted service contract for psychiatric treatment:

Code	***Description***
1	*Patient has no previous non-admitted service/contracts for psychiatric treatment*
2	*Patient has previous non-admitted service/contracts for psychiatric treatment*

11 ELECTIVE SURGERY DETAILS (PUBLIC HOSPITALS ONLY)

Elective surgery details are collected by Public Hospitals through the Elective Admission Management (EAM) . The scope of this collection includes all patients admitted to hospital for an elective procedure, for which they have been placed on a waiting list. This includes all patients separated after 1 July 1997 from a public hospital with an EAM installed. The purpose of the link between the waiting list and relevant admission episode is to provide a more complete picture of elective patient care, that is, information from the time a patient was placed on a waiting list through to separation from hospital. When a patient is admitted to hospital, it is possible to link to a waiting list entry (where one exists). If a patient has a Waiting list Status in EAM of Admitted, Treated or Cancelled, the waiting list entry can be linked to the patient episode.

Not all patients will have waiting list details. Elective surgery patients should have a waiting list entry. Some emergency patients may also have a corresponding waiting list entry, for example, if a patient had been on the waiting list and his/her condition deteriorated before they were admitted for elective surgery, then they may present as an emergency patient for the same procedure. It is important to note that some patients will have more than one entry on the waiting list and in this instance it is necessary to identify which procedure or procedures the patient has undergone and select the appropriate entries for linking.

11.1 HQI EXTRACT AND WAITING LIST ENTRIES

The HQI extract will include EAM items only where they are linked to admission episodes. Only waiting list entries that become 'completed' (i.e. treated or cancelled) during an admission need to be linked.

Mandatory conditions for acceptance in the extract (apart from separated, coded and grouped) are that the EAM entry has been linked and that the Waiting List status is two (2) or greater, i.e. treated or cancelled. EAM entries having a Waiting List status of A - Admitted that are linked will be flagged as errors in the extract. Such entries need to have their status's updated to either treated or cancelled.

Data items in the extract will be validated against the corporate reference files by DSU. It is crucial therefore that reference files are up to date.

11.2 ELECTIVE ADMISSION DETAILS

11.2.1 Entry number

Each waiting list entry has a placement number unique within the patient identifier. This number is from field 02 of the Waiting List Entry screen and is generated by HBCIS.

11.2.2 NMDS specialty grouping

The area of clinical expertise held by the doctor who will perform the elective surgery. Waiting List Specialties are derived from mapping Planned Unit codes to one of the 12 NMDS Specialty Grouping codes.

HBCIS

Code	***Description***
01	*Cardio Thoracic*
02	*ENT Surgery*
03	*General Surgery*
04	*Gynaecology*
05	*Neurosurgery*
06	*Ophthalmology*
07	*Orthopaedic Surgery*
08	*Plastic and Reconstructive Surgery*
09	*Urology*
10	*Vascular Surgery*
11	*Other - Surgical*
90	*Other - Non-Surgical*

11.2.3 Reason for removal

The Reason for Removal is derived, by HBCIS, from the Waiting List Status from field 23 of the Waiting List and Booking Entry screen. The Waiting List Status codes, from the corporate reference file are mapped to one of the following codes upon extract.

HBCIS	
Code	***Description***
01	*Admitted and treated as an elective patient for awaited procedure in this hospital*
02	*Admitted and treated as an emergency patient for awaited procedure in this hospital*
04	*Treated elsewhere for awaited procedure*
05	*Surgery not required or declined*
99	*Not Stated/Unknown*

11.2.4 Listing date

This is the date the patient was placed on the waiting list for elective surgery. This date is from field 03 of the Waiting Entry Screen and is input by the user.

11.2.5 Urgency category

Clinical urgency classification from field 20 of the Waiting List Entry Screen. This indicates the urgency with which the patient requires elective hospital care, as determined by the treating clinician.

HBCIS	
Code	***Description***
1	*Elective Surgery - Category 1*
2	*Elective Surgery - Category 2*
3	*Elective Surgery - Category 3*
4	*Other - Category 1*
5	*Other - Category 2*
6	*Other - Category 3*

11.2.6 Accommodation (Intended)

The planned type of physical accommodation for the patient as at the date placed on the waiting list. This indicates whether the patient planned to be treated as a public or private patient. This intended accommodation is from field 21 of the Waiting List Entry Screen. This item does not relate to the patient's hospital insurance status or the actual accommodation after admission.

HBCIS

Code	***Description***
P	*Public*
R	*Private Single*
S	*Private shared*

11.2.7 Site procedure indicator

This item is a planned procedure as at the date the patient was placed on a waiting list and is from field 23 of the Waiting List Entry Screen. The code must be a valid site procedure indicator code from the 314 codes in the corporate reference file. For a list of site procedure indicator codes see Appendix O.

11.2.8 National procedure indicator

This is an indicator procedure planned at the date the patient was placed on the waiting list. This item is derived, by HBCIS, from the Site Procedure Indicator that is mapped to one of the 16 National Procedure Indicator codes.

HBCIS

Code	***Description***
01	*Cataract extraction*
02	*Cholecystectomy*
03	*Coronary artery bypass graft*
04	*Cystoscopy*
05	*Haemorrhoidectomy*
06	*Hysterectomy*
07	*Inguinal herniorrhaphy*
08	*Myringoplasty*
09	*Myringotomy*
10	*Prostatectomy*
11	*Septoplasty*
12	*Tonsillectomy*
13	*Total hip replacement*
14	*Total knee replacement*
15	*Varicose Veins*
16	*Not applicable*

11.2.9 Planned length of stay

This is the intended length of stay of a patient awaiting an elective admission as estimated by the responsible clinician when placed on the list. This is from field 22 of the Waiting List Entry Screen. Please note, a planned same day admission is recorded as a 'D' and is converted to zero when extracted to DSU.

11.2.10 Planned procedure/operation date

This is the most recent Planned Procedure/Operation date for the patient for their reported waiting list entries. The data is collected from field 10 'Operation/Procedure date' of the Booking Entry screen with EAM.

This field is mandatory for patients who are treated, that is '02' Waiting List Status.

11.3 ACTIVITY RECORD DETAILS

11.3.1 Activity code

If a patient is not ready for care for a period while they were on the waiting list or any changes occur to a patient's urgency category, then a date of change of the item is reported in the activity file, using the relevant activity code. This activity code is generated by HBCIS. If the activity code = N then the Not ready for care details are forwarded to DSU. If the activity code is E - Elective Surgery details then the final details of any changes on the particular day will be forwarded to DSU.

HBCIS	
Code	***Description***
N	*Not ready for care*
E	*Elective Surgery Items*

11.3.2 For activity code details = N (not ready for care)

11.3.2.1 Entry number

Each waiting list entry has a placement number unique within the patient identifier. The entry number in the activity details must match with the corresponding entry number in the Elective Admission Details file. This number is from field 02 of the Waiting List Entry screen and is generated by HBCIS.

11.3.2.2 Date not ready for care

Each waiting list entry may have one or more periods where the patient is not ready for care. The date not ready for care is the first date in this period that the patient will not be ready for care and is from field 05 of the Waiting List Entry Screen. Not ready for care patients are those who are not in a position to be admitted to hospital.

11.3.2.3 Last date not ready for care

Each waiting list entry may have one or more periods where the patient is not ready for care. The last date not ready for care is the final date in this period that the patient is not ready for care and is from field 06 of the Waiting List Entry Screen.

11.3.3 For activity code details = E (Elective surgery items)

11.3.3.1 Entry number

Each waiting list entry has a placement number unique within the patient identifier. The entry number in the activity details must match with the corresponding entry number in the Elective Admission Details file. This number is from field 02 of the Waiting List Entry screen and is generated by HBCIS.

11.3.3.2 Urgency category

The final change on any day to the clinical urgency classification from field 20 of the Waiting List Entry Screen. This indicates the urgency with which the patient requires elective hospital care, as determined by the treating clinician.

HBCIS

Code	***Description***
1	*Elective Surgery - Category 1*
2	*Elective Surgery - Category 2*
3	*Elective Surgery - Category 3*
4	*Other - Category 1*
5	*Other - Category 2*
6	*Other – Category 3*

11.3.3.3 Date of change

The date of change for any elective admission data item in the Activity file will be recorded. The date of change is input by the user when inserting new data into fields 20 - 23 of the Waiting List Entry screen.

12 SUB AND NON-ACUTE PATIENT (SNAP) DETAILS (PUBLIC HOSPITALS WITH DESIGNATED SNAP UNITS ONLY)

The Australian National Sub and Non-Acute Patient (AN-SNAP) Classification System has been implemented in Queensland public hospitals to better inform service planning, purchasing, and clinical management. Currently sub and non-acute patient (SNAP) details are collected only for those patients in designated SNAP units.

The scope of this collection includes all admitted patient episodes where the patient's episode type is not acute, newborn, boarder, organ procurement or other care, and the ward (either at admission to the episode or through a ward transfer during the episode) is assigned to a designated SNAP unit.

A new item, standard ward code, is to be assigned a value of 'SNAP' for those wards which are assigned to a designated SNAP unit. Patients should have SNAP details reported for each sub and non-acute care type (SNAP episode) within an episode of care.

12.1 SNAP DETAILS

12.1.1 SNAP Episode Number

Each set of SNAP details will be assigned a unique SNAP episode number by HBCIS. This number will form part of each record's unique identifier when the SNAP details are forwarded to Data Services Unit.

12.1.2 SNAP Type

The SNAP type is a classification of a patient's care type based on their characteristics, primary treatment goal and evidence.

The codes for each SNAP Type are validated against valid HBCIS sub and non-acute episode types.

12.1.2.1 Palliative Care

Palliative Care is provided for a person with an active, progressive, far advanced disease with little or no prospect of cure.

Palliative care includes grief and bereavement support services for the family and carers during the life of the person and continuing after death.

Palliative Care SNAP types can only be used in conjunction with a care type of 31, Palliative – delivered in a designated unit.

12.1.2.2 Rehabilitation

Rehabilitation care is provided for a person with an impairment, disability or handicap

- *RAO – Assessment only*
  The person is seen on one occasion only for assessment and/or treatment and no further intervention by this service/team are planned.

- *RCD – Congenital deformities*
  Spina Bifida, Other Congenital.

- *RPU – Pulmonary*
  Chronic Obstructive Pulmonary Disease, Other Pulmonary.

- *RST – Stroke*
  Left Body Involvement - No paresis, Right Body Involvement - Other Stroke, Bilateral Involvement.

- *RBD – Brain Dysfunction*
  Non - Traumatic, Traumatic - unspecified, Open Injury, Closed Injury, Other Brain.

- *RNE – Neurological*
  Multiple Sclerosis, Parkinsonism, Polyneuropathy, Guillian-Barre, Cerebral Palsy, Other Neurologic.

- *RSC – Spinal Cord Dysfunction*
  Non-Traumatic Spinal Cord Dysfunction, Unspecified Paraplegia, Incomplete Paraplegia, Complete Paraplegia, Unspecified Quadriplegia, Incomplete C1-4 Quadriplegia, Incomplete C5-8 Quadriplegia, Complete C1-4 Quadriplegia,
  Complete C5-8 Quadriplegia, Other non-traumatic Spinal Cord Injury, Traumatic Spinal Cord Dysfunction, Unspecified Paraplegia, Incomplete Paraplegia, Complete Paraplegia, Unspecified Quadriplegia, Incomplete C1-4 Quadriplegia, Incomplete C5-8 Quadriplegia, Complete C1-4 Quadriplegia, Complete C5-8 Quadriplegia, Other non-traumatic Spinal Cord Injury.

- *RAL – Amputation of Limb*
  Single Upper Extremity Above the Elbow, Single Upper Extremity Below the Elbow, Single Lower Extremity Above the Knee, Single Lower Extremity Below the Knee, Double Lower Extremity Above the Knee, Double Lower Extremity Above/below the Knee, Double Lower Extremity Below the Knee, Other Amputation.

- *RDE – Debility*
  Debility, unspecified include only patients who are debilitated for reasons other than cardiac or pulmonary conditions.

- *RPS – Pain Syndromes*

Neck Pain, Back Pain, Extremity Pain, Other Pain.

- *ROC – Orthopaedic Conditions*

Status Post Hip Fracture, Status Post Femur (shaft) Fracture, Status Post Pelvis Fracture, Status Post Major Multiple Fracture, Status Post Hip Replacement, Other Orthopaedic.

- *RCA – Cardiac*

Cardiac.

- *RMT – Major MultipleTrauma (MMT)*

Brain + Spinal Cord Injury, Brain + Multiple Fracture/ Amputation, Spinal + Multiple Fracture/ Amputation, Other Multiple Trauma.

- *RBU – Burns*

Burns.

- *ROI – Other Disabling Impairments*

Other Disabling Impairments – cases that cannot be classified into a specific group.

- *RAR – Arthritis*

Rheumatoid Arthritis, Osteoarthritis, Other Arthritis.

- *RDD – Developmental Disabilities*

Developmental Disabilities.

Rehabilitation SNAP types can only be used in conjunction with a care type of 21, Rehabilitation – delivered in a designated unit.

12.1.2.3 Psychogeriatric

Psychogeriatric care is provided for an elderly person with either an age-related organic brain impairment with significant behavioural disturbance or late onset psychiatric disturbance or a physical condition accompanied by severe psychiatric or behavioural disturbance.

- *PSG - Psychogeriatric*

PSG Psychogeriatric Care of younger adults with clinical conditions generally associated with old age as well as care of people with long term psychiatric disturbance and/or substance abuse.

Psychogeriatric SNAP types can only be used in conjunction with a care type of 10, Psychogeriatric.

12.1.2.4 Geriatric Evaluation and Management

Geriatric Evaluation and Management is provided for a person with complex multi-dimensional medical problems associated with disabilities and psychosocial problems, usually (but not always) an older person.

- *GEM - Geriatric Evaluation and Management*
- *GAO - Geriatric Evaluation and Management - Assessment only*
- *GSD - Geriatric Evaluation and Management - Planned Same Day*

GEM/GAO/GSD includes evaluation and management of younger adults with clinical problems generally associated with old age.

Geriatric Evaluation and Management SNAP types can only be used in conjunction with a care type of 09, Geriatric Evaluation and Management.

12.1.2.5 Maintenance

Maintenance is provided for a person with a disability who, following assessment or treatment, does not require further complex assessment or stabilisation

- *MNH - Maintenance - Nursing Home Type*

Includes:

. care and support of a person in an inpatient setting whilst the patient is awaiting transfer to residential care or alternate support services or where there are factors in the home environment (physical, social, psychological) which make discharge to home inappropriate for the person in the short term.

. Ongoing care and support of a person in a residential setting.

. Patients in receipt of care where the sole reason for admitting the person to hospital is that the care that is usually provided in another environment e.g. at home, in a nursing home, by a relative or with a guardian, is unavailable in the short-term.

. Care and support of a person with a functional impairment for whom there is no multidisciplinary program aimed at improvement of functional capacity.

. Patients classified as Nursing Home Type Patients i.e. when a patient has been in hospital for a continuous period exceeding 35 days and does not have a current acute care certificate

- MRE - Maintenance Care (Respite) CLASS

A patient who has not qualified as NHT but is in receipt of respite care where the sole reason for admitting the person to hospital is that the care that is usually provided in another environment, e.g. at home, in a nursing home, by a relative or with a guardian, is unavailable in the short term.

- *MCO - Maintenance Care (Convalescent) CLASS*

A patient who is admitted post acutely for the purpose of maintaining functional ability to aid self caring prior to returning to the home environment.

- *MOT – Maintenance Care (Other Maintenance) CLASS*

A patient who has not qualified as NHT or would normally not require hospital treatment but where there are factors in the home environment (physical, social, psychological) which make it inappropriate for the person to be discharged in the short term.

Also includes patients treated in a psychiatric unit who has a stable but severe level of functional impairment and inability to function independently without extensive care and support and for whom the principal function is provision of care over an indefinite period.

Maintenance SNAP types can only be used in conjunction with a care type of 11, Maintenance.

HBCIS

Code	***Description***
RAO	*Rehabilitation - Assessment only*
RCD	*Rehabilitation - Congenital Deformities*
ROI	*Rehabilitation- Other disabling impairments*
RST	*Rehabilitation- Stoke*
RBD	*Rehabilitation - Brain Dysfunction*
RNE	*Rehabilitation - Neurological*
RSC	*Rehabilitation - Spinal Cord Dysfunction*
RAL	*Rehabilitation - Amputation of Limb*
RPS	*Rehabilitation - Pain Syndromes*
ROC	*Rehabilitation - Orthopaedic conditions*
RCA	*Rehabilitation - Cardiac*
RMT	*Rehabilitation - Major Multiple Trauma*
RPU	*Rehabilitation - Pulmonary*
RDE	*Rehabilitation - Debility*
RDD	*Rehabilitation - Development Disabilities*
RBU	*Rehabilitation - Burns*
RAR	*Rehabilitation - Arthritis*
GAO	*Geriatric Evaluation and Management - Assessment only*
GEM	*Geriatric Evaluation and Management*
GSD	*Geriatric Evaluation and Management - Planned Same Day*
MRE	*Maintenance - Respite*
MNH	*Maintenance - Nursing Home Type*
MCO	*Maintenance - Convalescent Care*
MOT	*Maintenance - Other*
PSG	*Psychogeriatric*
PAL	*Palliative care*

12.1.3 SNAP Group Classification

The SNAP group classification provides a summary of the various SNAP care types allocated to patients, by grouping together homogeneous SNAP care types. This then provides a means of relating the number and types of patients treated in a designated SNAP unit to the resources required by the unit. It also allows meaningful comparisons to be made of SNAP units' effectiveness and efficiency.

Initially each patient's SNAP group classification will be derived by Data Services Unit, but a SNAP grouper may in future be available on HBCIS.

12.1.4 SNAP Start Date

The start date of each SNAP episode in a designated SNAP unit. Each SNAP episode must meet the criteria for sub and non-acute admitted patient care, as identified by the SNAP types.

12.1.5 SNAP End Date

The end date of each SNAP episode in a designated SNAP unit. Each SNAP episode must meet the criteria for sub and non-acute admitted patient care, as identified by the SNAP types.

12.2 ACTIVITY RECORD DETAILS

12.2.1 SNAP Episode Number

Each set of SNAP details will be assigned a unique SNAP episode number by HBCIS. This number will form part of each record's unique identifier when the SNAP details are forwarded to Data Services Unit.

12.2.2 Activity of Daily Living (ADL) Type

ADL tools are used to objectively measure the physical, psychosocial, vocational, and cognitive functions of an individual with a disability. There are a number of ADL tools, so the type used to code the patient's functions needs to be recorded.

HBCIS

Code	***Description***
BAR	*Barthel*
FIM	*Functional Independence Measure*
HON	*Health of the Nation Outcome Scales*
MBI	*Modified Barthel Index*

RUG	*Resource Utilisation Group*

12.2.2 Activity of Daily Living (ADL) Sub-type

Two of the ADL tools require more than one score to be reported, so more than one ADL sub-type needs to be coded.

The Health of the Nation Outcome Scale (HoNOS) requires the reporting of a behaviour score, an activity of daily living score and a total score.

The Functional Independence Measure (FIM) requires the reporting of a cognition score and a motor score.

All of the remaining ADL tools require only a motor score to be reported, so only one ADL sub-type needs to be coded.

HBCIS

Code	***Description***
BEH	*Behaviour*
ADL	*Activity of daily living*
TOT	*Total*
COG	*Cognitive*
MOT	*Motor*

12.2.3 Activity of Daily Living (ADL) Score

The ADL score is the actual numerical rating reported for the ADL tool being used to measure the patient's functional ability.

More than one ADL score per SNAP episode can be collected, however only the ADL score recorded at the start of the SNAP episode will be supplied to Data Services Unit.

The HoNOS requires 3 ADL scores are to be reported, the FIM tool requires 2 ADL scores to be reported, while the remaining tools require only a single score.

HBCIS				
			ADL Score	
	Sub-type	**Description**	**Min**	**Max**
BAR	MOT	Barthel (Motor)	0	20
HON	BEH ADL	HoNOS (Behaviour) HoNOS (Activity of daily living)	0 0	4 4
	TOT	HoNOS (Total)	0	48
MBI	MOT	Modified Barthel (Motor)	0	100
RUG	MOT	Resource Utilisation Group (Motor)	4*	18
FIM	MOT	FIM (Motor)	13	91
	COG	FIM (Cognitive)	5	35

* If a RUG ADL assessment is not performed on admission, HBCIS will permit a score of 0 to be entered as the dummy ADL score.

12.2.4 ADL Date

The date of the first recorded ADL score. Must not be before the start date of the SNAP episode, or after the end date of the SNAP episode.

12.2.5 Phase Type

The phase type only needs to be reported for palliative SNAP types. More than one phase type can be reported per palliative SNAP episode, however only the phase type recorded at the start of the SNAP episode will be supplied to the Data Services Unit.
Phase type describes the distinct period or stage of illness for a palliative care phase.

Stable Phase

All clients not classified as unstable, deteriorating, or terminal. The person's symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned.

The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

Unstable Phase

The person experiences the development of a new problem or a rapid increase in the severity of existing problems, either of which require an urgent change in management or emergency treatment. The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team.

Deteriorating Phase

The person experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.

The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary.

Terminal Care Phase

Death is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:
Profoundly weak, Essentially bed bound, Drowsy for extended periods, Disoriented for time and has a severely limited attention span, Increasingly disinterested in food and drink, Finding it difficult to swallow medication.

This requires the use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues. The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

Bereaved Phase

Death of the patient has occurred and the carers are grieving. A planned bereavement support program is available including counselling as necessary.

HBCIS

Code	***Description***
01	*Stable*
02	*Unstable*
03	*Deteriorating*
04	*Terminal Care*
05	*Bereaved*

13 DEPARTMENT OF VETERANS' AFFAIRS PATIENTS

The scope of this section is to identify all patients whose charges for their hospital admission are being met by the Department of Veterans' Affairs

In the past Department of Veterans' Affairs beneficiaries have been poorly identified. It has been recognised nationally that there is a need for the accurate reporting of DVA patients to facilitate health care funding in this area.

13.1 DVA FILE NUMBER

Record the patients DVA identification number.

13.2 CARD TYPE

Record whether the DVA patient is a gold card or white cardholder. If the DVA patient is a holder of a white card, then confirmation is required from the Department of Veterans' Affairs that charges for this admission will be met.

PAPER HOSPITAL

Code	Description
G	Gold
W	White

HBCIS

Code	*Description*
Gold	*Gold Card*
White	*White Card*

14 PALLIATIVE CARE

From 1 July 2000 additional information will be collected for palliative care patients who have a care type of:

- Palliative – delivered in a designated unit
- Palliative – according to a designated program
- Palliative – principal clinical intent

14.1 FIRST ADMISSION FOR PALLIATIVE CARE TREATMENT

The status of the episode in terms of whether it is a first or subsequent admission, at any hospital for any condition, for palliative care treatment.

PAPER HOSPITAL

Record the following codes to indicate the first admission for palliative care treatment:

Code	Description
1	No previous admission for palliative care treatment
2	Previous admission for palliative care treatment

HBCIS

Record the following codes to indicate the first admission for palliative care treatment:

Code	***Description***
1	*No previous admission for palliative care treatment*
2	*Previous admission for palliative care treatment*

14.2 PREVIOUS SPECIALISED NON-ADMITTED PALLIATIVE CARE TREATMENT

The status of the episode in terms of whether the patient has had a previous non-admitted service contact for palliative care treatment.

PAPER HOSPITAL

Record the following codes to indicate the patient has had a previous non-admitted service contact for palliative care treatment:

Code	Description
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

HBCIS

Record the following codes to indicate the patient has had a previous non-admitted service contact for palliative care treatment:

Code	***Description***
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*

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