



# **ISAAC REFERENCE MANUAL**

**South Australian Admitted  
Patient Activity Data Standards**

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## Abbreviations

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ABF	Activity Based Funding
ACHA	Australian Health Care Agreement
ACHS	Australian Council of Healthcare Standards
ACS	Australian Coding Standards
AIHW	Australian Institute of Health and Welfare
ALOS	Average Length of Stay
AN-DRG	Australian National Diagnosis Related Groups
AR-DRG	Australian Refined Diagnosis Related Groups
CAMHS	Child Adolescent Mental Health Service
CEO	Chief Executive Officer
CFM	Casemix Funding Model
DFOTP	Date of First Operating Theatre Procedure
DRG	Diagnosis Related Group
DON	Director of Nursing
DVA	Department of Veterans' Affairs
ED	Emergency Department
EOQ	End of Quarter
EPAS	Enterprise Patient Administration System
GP	General Practitioner
H@H	Hospital at Home
HIC	Health Insurance Commission
ICD	International Classification of Diseases
ICD-9-CM	International Classification of Diseases, 9 <sup>th</sup> Revision, Clinical Modification
ICD-10-AM	International Classification of Diseases, 10 <sup>th</sup> Revision, Australian Modification
ICU	Intensive Care Unit
IHPA	Independent Hospital Pricing Authority
ISAAC	Integrated South Australian Activity Collection
ISAAC II	System that stores ISAAC data from 1 July 2012 on
LOS	Length of Stay
MDC	Major Diagnostic Category
NHIA	National Health Information Agreement
NHT	Nursing Home Type – removed, replaced by Maintenance Care Type from 1 July 2014
NOS	Nature of Separation
OACIS	Open Architecture Clinical Information System
OBDs	Occupied Bed Days
R@H	Rehabilitation at Home
RHCA	Reciprocal Health Care Agreement
SEPS	Separations
SLA	Statistical Local Area
SOR	Source of Referral
TFOTP	Time of First Operating Theatre Procedure
TSI	Torres Strait Islander
URN	Unit Record Number

## **SECTION 1: About the Collection**

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## About the Collection

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### Overview

All public and private hospitals in South Australia submit information to the state morbidity system, locally known as the Integrated South Australian Activity Collection (ISAAC).

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

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### Introduction

Covered in this section is information regarding:

- Confidentiality, Privacy and Security
  - Purpose of the Collection
  - Benefits and Uses of ISAAC
  - Unit of Measurement, Coverage and Scope
  - Summary of Items Collected
  - Rules for Admitted Patients
  - Collection Related Terminology
  - Development of the Collection and System
  - Contacts for the Collection
-

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## **Confidentiality, Privacy and Security**

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

The use and release of ISAAC data (eg, through the Health Information Portal (HIP)) is governed by SA Health's Code of Fair Information Practice, Data Management Protocols, various legislation and other relevant privacy codes and regulations. Other usage is properly authorised before release.

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

ISAAC data are made available for research where approval by relevant Ethics Committees is evident.

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## Purpose of the Collection

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**Purpose of the Collection**

The Integrated South Australian Activity Collection (ISAAC) contains state-wide data about patients separated from public and private hospitals.

It provides SA Health with the information necessary to effectively fund, organise, evaluate, and plan health services in South Australia.

ISAAC data also allows SA Health to meet national obligations through submissions to the Australian Institute of Health and Welfare (AIHW), the Independent Hospital Pricing Authority, the National Health Performance Authority and the National Health Funding Body. ISAAC forms part of the Admitted Patient Care National Minimum Data Set through submission to AIHW.

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## Benefits and Uses of ISAAC and its Data

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### Benefits

ISAAC has been designed primarily to satisfy the information needs of management. ISAAC is the means by which admitted patient activity can be monitored, funded, evaluated, planned for, researched and reviewed to ensure that SA Health continues to deliver efficient and equitable health services. The benefits of ISAAC are not measured in terms of the information available, but in the improvements in decision-making capacity.

The significant benefits of ISAAC are to assist health managers:

- To allocate resources through the provision of Casemix data.
- To determine the relative dependencies of patients based on age, sex, diagnoses and procedures performed.
- To monitor the use of hospital services and average lengths of stay.
- To assist research into diseases and health related problems by providing clinical and socio-demographic data profiles of patients over time.
- To provide valuable information for quality assurance studies.
- To provide the information resources necessary for Health Information Managers to effectively service the information needs of hospital management.
- To improve the costing of hospital outputs by the identification of certain forms of intensive hospital care.

All these benefits improve the decision-making capacity of hospitals through knowledge of resource utilisation and demand for services.

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### Examples of Use

#### Management

- **Strategic Planning** - identifies admission trends for socio-demographic and clinical groups, so that planning and delivery of health services is consistent with community needs.
- **Resource Allocation** - identifies priorities in hospital resource allocation based upon output measures across the state.
- **Performance Measurement** - enables service delivery performance measurement.
- **Casemix** – is a key data source for the State's Casemix funding system, which delivers a consistent method of classifying types of patients, their treatment and associated costs.
- **Safety and Quality** – supports the identification of adverse events during episodes of inpatient care.

#### Administration

- **Quality Assurance** - assists health care professionals in conducting quality assurance studies.
- **Resource Requirements** - provides the information necessary for hospitals to examine inpatient resource requirements for specialty groups and to review existing allocation management.
- **Patient Management** - assists clinical staff to develop standard criteria for patient management.

### Research

- **Epidemiology** - offers an array of data that is essential to epidemiological studies.
  - **Medical Research** - provides clinical staff with disease and procedure indices for research and education.
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## Unit of Measurement, Coverage and Scope

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### Unit of Measurement

The unit of measurement of the ISAAC is an **"episode of care"**.

An *"episode of care"* commences with an admission to a hospital (either formal or administrative) and ends with a separation (either formal or administrative).

**Note:** See topics "Rules for Inpatient Admissions" and "Collection Related Terminology" found later in this section for definitions of "formal" and "administrative" admissions and separations.

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### Coverage

The ISAAC database covers all admitted patient separations (discharges, transfers and deaths) from every South Australian:

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

### Scope

ISAAC commenced collection of hospital separations data in July 1985.

All hospitals covered by ISAAC (listed in Coverage) are required to submit details for every episode of care of every admitted patient, noting the exclusions in the next section.

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### Exclusions

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

- Patients in Developmental Disability Institutions
- Patients in Private Residential Aged Care facilities
- Patients in Outpatient and Community Health Services
- Patients in Multi-Purpose Service Hospital hostel accommodation who are not classified as admitted patients
- Residents of Community Residential Care Units
- Residents of Transitional Living Units under the Brain Injury Rehabilitation Program
- Defence force personnel treated on base
- Boarders
- Still births

**Note:** See topic "Collection Related Terminology" in this section for definitions of boarders and still births.

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### SA Residents

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

A sub-set of data items for each inpatient is supplied to SA Health annually by each State/Territory health authority.

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## Summary of Items Collected

### Introduction

This topic provides a listing of all items collected for ISAAC in 2016 -17 in alphabetical order. The list describes the field length, field type and mandatory status for each data item collected.

### Mandatory Status

Definitions:

- Mandatory: The item must be reported for every separation for every patient.
- Mandatory where applicable: The item is mandatory but only for separations to which it applies. For example, if a patient was transferred from another hospital and has a 'Source of Referral' as "inter-hospital" transfer then it is mandatory that the 'Hospital Transferred From' data item be captured also.
- Mandatory – newborns only: The item is mandatory but only for separations pertaining to newborns.
- Mandatory – WCH: This item is mandatory but only for separations at Women's and Children's Hospital (WCH).
- Mandatory – designated hospitals only: This item is mandatory but only for separations at designated hospitals.
- Not Mandatory: The item is not mandatory to be reported.
- Mandatory – public metropolitan and country hospitals: The item must be reported by public metropolitan and country hospitals. It is desirable for private hospitals to provide this information

DATA ITEM NUMBER	ITEM DESCRIPTION	MANDATORY STATUS	LENGTH	TYPE	YEAR MODIFIED	COMMENTS
93	Activity when injured	Mandatory where applicable	5	N	Modified 2002	ICD-10-AM
15	Admission category	Mandatory	1	N	Modified 2003	(e.g. Elective, Emergency, etc)
21	Admission date	Mandatory	8	N		DDMMYYYY
19	Admission election	Mandatory	1	N		(e.g. Public vs Private)
68	Admission number	Not mandatory	8	N	Modified 2002	
67	Admission time	Mandatory	4	N	1995	HHMM
20	Admission type	Mandatory	1	N	Modified 2001, 2014	(e.g. Ordinary, LS-Acute, LS-NHT) Code 3 name changed
11	Admission weight (grams)	Mandatory – newborns only	4	N		
86	Adult/Child flag	Mandatory – WCH only	1	A	1996	
2	Clinic code	Not mandatory	3	N		
92, 97, 97a – 97x,	Condition onset flag	Mandatory	1	N	2008	

DATA ITEM NUMBER	ITEM DESCRIPTION	MANDATORY STATUS	LENGTH	TYPE	YEAR MODIFIED	COMMENTS
98, 99						
63	Contract provider hospital patient unit number	Mandatory where applicable	10	N	1994	
10	Country of birth	Mandatory	4	N	1995	Modified to 4 digits
64	Date admitted to contract provider hospital	Mandatory	8	N	1994	DDMMYYYY
9	Date of birth	Mandatory	8	N	2014	DDMMYYYY DOB default changed
91	Date of birth accuracy flag	Mandatory – where applicable	1	N	1998	
96	Date of First Operating Theatre Procedure	Mandatory – designated hospitals only	8	N	2007	DDMMYYYY
52	Date of Transfer to Discharge Lounge	Mandatory – public metropolitan and country hospitals	8	N	Introduced 2010	
46A-X	Diagnosis – Additional (29 occurrences)	Mandatory where applicable	5	A/N		ICD-10-AM format
45	Diagnosis - Principal	Mandatory	5	A/N		ICD-10-AM format
88	Employment Status (Psych Adm only)	Mandatory where applicable	1	N	1997	
51	Episode of care	Mandatory	1	N	Modified 1998, 2014, 2015, 2016	Added “Hospital @ Home” domain (1998), NHT name change (2014), four MH codes added (2014), changes to MH definitions (2015), added new care type - Posthumous Organ Procurement (2016)
47	External cause	Mandatory where applicable	5	A/N		
95	Funding Source	Mandatory	2	N	Modified 2007	Added “Other hospital or Public Authority” and “No charge raised” domains
1	Hospital code	Mandatory	4	N		
17	Hospital insurance	Mandatory	1	N	Modified 1997	
18	Hospital transferred from	Mandatory where applicable	4	N		
44	Hospital transferred to	Mandatory where applicable	4	N		
40	Hours in intensive care unit	Mandatory where applicable	5	N	Modified 2010	

DATA ITEM NUMBER	ITEM DESCRIPTION	MANDATORY STATUS	LENGTH	TYPE	YEAR MODIFIED	COMMENTS
41	Hours on mechanical ventilation	Mandatory where applicable	4	N	Modified 1997	
13	Indigenous status	Mandatory	1	N	Modified 2003	Previously termed "Race"
71	Legal status	Mandatory where applicable	1	N	1995	
12	Marital status	Mandatory	1	N		
100	Medicare number Individual Reference Number (IRN)	Mandatory	1	N	Introduced 2013	
4	Medicare number	Mandatory	10	N		
83	Mental health linking variable	Mandatory where applicable	10	N	1996	
42	Nature of separation	Mandatory	1	A/N	Modified 2008	Added "Retrieval" domain
84	OACIS linking variable	Not mandatory	10	N	1996	
3	Patient unit number	Mandatory	10	N		
14	Patient category - intent	Mandatory	1	N		(Overnight, Sameday, Type C)
89	Pension status (Psych Adm only)	Mandatory where applicable	1	N	1997	
32, 34, 36, 38	Leave - From date	Mandatory where applicable	8	N		DDMMYYYY
33, 35, 37, 39	Leave - To date	Mandatory where applicable	8	N		DDMMYYYY
73, 75, 77, 79	Leave - From time	Mandatory where applicable	4	N	1996	HHMM
74, 76, 78, 80	Leave - To time	Mandatory where applicable	4	N	1996	HHMM
48	Place of occurrence – ICD-9-CM	Mandatory where applicable	1	N		ICD-9-CM (not currently collected)
94	Place of occurrence – ICD-10-AM	Mandatory where applicable	5	A/N	2002	ICD-10-AM
6	Postcode	Mandatory	4	N		
101	Previous specialised treatment	Mandatory where applicable	1	N	Introduced 2013	
49A-Y	Procedures (25 occurrences)	Mandatory where applicable	7	N		ICD-10-AM format
85A-Y	Procedure location indicator (25 occurrences)	Mandatory where applicable	1	N	1996	ICD-10-AM format
72	Referral for further health care	Mandatory	1	N	Modified 1998, 2012 & 2013	Added "Hospital @ Home" domain, modified 2 and added 4 domains (2013)

DATA ITEM NUMBER	ITEM DESCRIPTION	MANDATORY STATUS	LENGTH	TYPE	YEAR MODIFIED	COMMENTS
65	Provider of contract services - hospital number	Mandatory where applicable	4	N	1994	
104	RUG-ADL Score	Mandatory where applicable	5	AN	Introduced 2015	
43	Separation date	Mandatory	8	N		DDMMYYYY
70	Separation time	Mandatory	4	N	1995	HHMM
8	Sex	Mandatory	1	N	Modified 2003	Added "Indeterminate" domain
7	SLA	Mandatory	4	N	2001	LGA also available
16	Source of referral	Mandatory	1	A/N	Modified 2001, 2013, 2014	Modified 1 and added 2 domains (2013), added domain (2014)
22, 25, 28	Status change - admission election	Mandatory where applicable	1	N		
23, 26, 29	Status change - admission type	Mandatory where applicable	1	N	Modified 2001, 2014	Code 3 name changed (2014)
24, 27, 30	Status change - date effective from	Mandatory where applicable	8	N		DDMMYYYY
5	Suburb/locality	Mandatory	20	A		
81	Time of First Operating Theatre Procedure Performed	Mandatory – designated hospitals only	4	N	Introduced 2008	
53	Time of Transfer to Discharge Lounge	Mandatory – public metropolitan and country hospitals	4	N	Introduced 2010	
90	Type of usual accommodation	Mandatory	1	N	Modified 2008 & 2013	Extended to all patients admitted to any public or private hospital or day surgery (2008), deleted 1, modified 1 and added 9 domains (2013)
69	Veteran card number	Mandatory where applicable	9	A/N	Modified 1997	
31	Veteran card type	Mandatory where applicable	1	A	Modified 1996	
54	Ward on admission	Mandatory – public metropolitan and country hospitals	10	A/N	Introduced 2010	
66	Ward on discharge	Mandatory – public metropolitan and country hospitals	10	A/N	Introduced 2008	

*Note: Data Items 48, 50 and 55-62 not currently used.*

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## Rules for Admitted Patients

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**Introduction** This topic provides general rules and definitions for admitting a patient to a hospital.

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**Admitted Patient Definition** A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients).

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

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

**Types of Admissions**

An admission may be one of the following :

- **Formal Admission** - the administrative process by which a hospital records the commencement of treatment and/or care and accommodation of a patient.
  - **Administrative Admission (also known as Type Change Admission)** - the administrative process by which a hospital records the start of each episode of care (relating to any change in Service Category) occurring within the one stay in hospital.
  - **End of Quarter (EOQ) Admission** – the administrative process by which a hospital reports an admission for a patient who was an inpatient at the beginning of a quarter. This is only applicable to public hospitals and currently only for Maintenance Care patients and some specific mental health patients at specific sites. The reporting of these types of records allows hospitals to receive work-in-progress payments for admissions which may continue indefinitely.
- 

**Formal Admissions**

When formally admitted, a patient is classified as either sameday or overnight stay.

**Sameday Definition**

A sameday patient is a patient who is admitted and separates on the same calendar day, and who meets one of the following minimum criteria:

- Patient receives Same-day Surgical and Diagnostic Services as specified in bands 1A, 1B, 2, 3, and 4 within the Health Insurance Basic Table as defined in s.4 (1) of the National Health Act 1953 (Commonwealth);
- Patient receives Type C Professional Attention Procedures as specified in the Health Insurance Basic Table as defined in s.4 (1) of the National Health Act 1953 (Commonwealth) with accompanying certification from a medical practitioner that an admission was necessary on the grounds of the medical condition of the patient or other special circumstances that relate to the patient.

Sameday patients include intended overnight-stay patients who left of their own accord, died or were transferred on their first day in the hospital.

### Overnight Stay Definition

- A patient who, following a clinical decision, receives hospital treatment for a minimum of one night (i.e. who is admitted to and separated from the hospital on different dates).
- Treatment provided to an intended sameday patient who is subsequently classified as an overnight stay patient is regarded as part of the overnight episode.
- Patients who leave of their own accord, die or are transferred on their first day in hospital are sameday not overnight stay patients.

### Administrative Admissions

An Episode of Care Category change admission must occur when the principal clinical intent of the care changes.

When an Episode of Care Type change occurs:

- The separation date of the ending episode record must equal the admission date of the new episode record.
- The separation time of the ending episode record must be 1 minute before the admission time of the new episode record.
- The Nature of Separation of the ending episode record must be 'A – Administrative Discharge'.
- The Source of Referral of the new episode record must be 'A –Administrative Admission'.

**Note:** 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 overnight stay period.

Refer to data item Episode of Care for more information on reporting Episode of Care Type changes.

### Outpatient services

Some services are classified as outpatient services. However, if the Doctor believes the patient requires admission to hospital, based on individual need, then the patient can be admitted in accordance with appropriate 'Day Only Procedures – Certification'. Refer to [Private Health Insurance \(Benefit Requirements\) Rules 2011](#).

### Additional Information

Supplementary information relating to rules for admitted patients can be found in the following documents:

- SA Health Casemix Manual (Methodology, Technical Bulletins and Algorithms), in particular -
  - Technical Bulletin 01:26 Admission Criteria for ED Shortstay Admissions
  - Technical Bulletin 04:28 Admission Criteria
  - Technical Bulletin 05:29 Screening Algorithm for Inappropriate Same Day Admissions
- South Australian Morbidity Coding Standards and Guidelines (Inpatients)

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## Collection Related Terminology

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<b>Introduction</b>	This topic provides descriptions of the terminology related to the Integrated South Australian Activity Collection.
<b>Overnight Stay Patient</b>	An "Overnight Stay Patient" is a patient who is admitted to and separated from the hospital on different dates. The admission and separation may be formal, or administrative (i.e. an episode of care type change).
<b>Sameday Patient</b>	A "Sameday Patient" is a patient who is admitted and separated on the same calendar day. The admission and separation may be formal or administrative (ie an episode of care type change).
<b>Formal Separation</b>	A "Formal Separation" is a separation when the treatment and/or care, and the accommodation of the patient has been completed. The completion may be brought about by formal discharge, transfer to another hospital, or death.
<b>Administrative Separation</b>	An "Administrative Separation" occurs when the type of treatment and/or care has changed on an on-going basis (i.e. Episode of Care has changed) but the patient has not been formally separated from the reporting hospital. The Nature of Separation recorded must be "A – Administrative Separation".
<b>End of Quarter Separation</b>	The administrative process by which a hospital reports a separation for a patient who was an inpatient at the end of a quarter. This is only applicable to public hospitals and currently only for Maintenance Care patients and some mental health patients at specific sites. The reporting of these types of records allows hospitals to receive payment for admissions which may continue indefinitely. An "End of Quarter Separation" occurs only at the end of the quarterly reporting period. The Nature of Separation recorded must be "E – End of Quarter Reporting".
<b>Formal Admission</b>	A "Formal Admission" is the administrative process by which a hospital records the commencement of treatment and/or care and accommodation of a patient.
<b>Administrative Admission</b>	An "Administrative Admission" follows an Administrative Separation. It occurs when the type of treatment and/or care has changed on an on-going basis (ie Episode of Care has changed) within the one hospital stay. The Source of Referral recorded must be "A – Administrative Admission".
<b>End of Quarter Admission</b>	The administrative process by which a hospital reports an admission for a patient who was an inpatient at the beginning of a quarter. This is only applicable to public hospitals and currently only for Maintenance Care patients and some specific mental health patients at specific sites. The reporting of these types of records allows hospitals to receive payment for admissions which may continue indefinitely. The Source of Referral recorded must be "E – End of Quarter Reporting".

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**Boarders**

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

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

**Note:** "Boarders" are not included in ISAAC.

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**Live birth**

A "live birth" is a complete expulsion or extraction from the mother of a baby, irrespective of the duration of the pregnancy which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.

**Note:** This definition of "live birth" is a standard of the World Health Organisation. All "live births" must be reported to the ISAAC.

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## Development of the Collection and System

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**System**

The ISAAC system itself was redeveloped and replaced by “ISAAC II” in 1 July 2012. The new system provides data processing efficiencies and additional quality assurances. In particular, ISAAC II enables the automated processing of data submissions (files) by using an Electronic Control Log. For information on how to complete the Log, please refer to the Guidelines for Submission of Data section (see [page 18](#)), and the Appendices ([see page 232](#)).

**Collection  
Review**

Opportunities for updating the ISAAC collection have traditionally been undertaken via an annual change review process. The ISAAC Unit maintains a change request log which, at the appropriate time, is reviewed, assessed and considered by relevant stakeholders before being authorised as a “1 July Change”.

Formal change request forms are available via the ISAAC Resources web page. Refer to the section: Contacts for the Collection. ([page 17](#))

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## Contacts for the Collection

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**ISAAC Unit**

The ISAAC Unit can assist with information about:

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

You can contact the Unit via:

Email: [health.isaacsubmissions@sa.gov.au](mailto:health.isaacsubmissions@sa.gov.au)

Phone: (08) 8226 7322

Website:

[www.sahealth.sa.gov.au/isaac](http://www.sahealth.sa.gov.au/isaac)

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**Medical Record  
Advisory Unit**

Medical Record Advisory Unit can supply further information about:

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

**You can contact the MRAU via:**

Email: [medicalrecords@sa.gov.au](mailto:medicalrecords@sa.gov.au)

Phone: (08) 7425 3585

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## **SECTION 2: Guidelines for Submission of Data – non EPAS hospitals**

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## Guidelines for Submission of Data – non EPAS hospitals

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<b>Overview</b>	All hospitals must submit separation data to ISAAC on a monthly basis in accordance with the data standards and submission schedule set by ISAAC Unit, SA Health.
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<b>Introduction</b>	This section provides information regarding:
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- Methods of submission
  - Data submission standards
  - Submission schedule
-

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## Methods of Submission – non-EPAS hospitals

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### Methods of Submission

Approved hospitals may submit data on standard paper forms that list all mandatory data items or electronically via email. As email is the most efficient method of submission, emailing of monthly data direct to ISAAC is the preferred method.

### Post and Courier

Hospitals may submit data electronically (email) or send data on hardcopy forms.

Paper forms must be sent directly to ISAAC Unit in SA Health via secure post or courier. Refer next page for postal/delivery address.

"Confidential" must be clearly stated on the front of the envelope.

### Data Standards

All data submitted to ISAAC must conform to the standards set by ISAAC Unit, SA Health. This means all required items must be completed and all responses must be within the valid range of codes.

A completed Control Log must accompany each submission. The named files must match the file names as per the control log.

For data submitted electronically the submission must also comply with the standard layout specifications and variable coding structures relevant to the collection format.

### Multiple Hospitals

Where more than one hospital is included in the same submission:

- For electronic submissions, all records can be placed in the one file so long as each record has its respective ISAAC hospital code recorded. ISAAC will produce individual error reports for each hospital.
- For paper forms, forms for each hospital must be bundled separately.

### Paper Forms

Bundles of paper forms must be accompanied by an ISAAC Forms/Reports Control Log which provides the following information:

- The hospital name and ISAAC hospital code
- The hospital/regional contact person for problems/queries
- For each batch, the month the majority of separations fall in and the number of records for the batch.

**Note:** Courier deliveries must only be made between the hours of 8:30am and 5:00pm. Please inform the courier of this in advance.

### Address

The addresses for postal, courier and email submissions are provided below:

<b>Courier Submissions:</b>	"Confidential" ISAAC Unit Data and Reporting Services SA Health 3 <sup>rd</sup> floor, CitiCentre Building 11 Hindmarsh Square Adelaide SA 5000 Contact Phone: (08) 8226 7322
<b>Postal Submissions:</b>	"Confidential" ISAAC Unit Data and Reporting Services SA Health PO Box 287, Rundle Mall, Adelaide SA 5001
<b>Email Submissions:</b>	<a href="mailto:health.isaacsubmissions@sa.gov.au">health.isaacsubmissions@sa.gov.au</a>

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## Electronic Submission

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### Introduction

This topic provides information about the standard layout required for submissions of ISAAC data.

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### File Layout

746 character file layout is the only format accepted by ISAAC.

The 746 file layout can be found on the ISAAC webpage:

[www.sahealth.sa.gov.au/isaac](http://www.sahealth.sa.gov.au/isaac) (please go to Integrated SA Activity Collection (ISAAC) Resources > Submission formats).

746 new and correction file formats are included as Appendix1 & 2 in this manual.

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### Specific Details for Submission via email

Electronic submissions must:

- be sent to the generic resource mailbox [health.isaacsubmissions@sa.gov.au](mailto:health.isaacsubmissions@sa.gov.au).
  - be received by the ISAAC Unit by no later than 5:00 pm on the 16<sup>th</sup> calendar day of each month
  - include a completed electronic control log with the ISAAC monthly data
  - have the email subject of 'ISAAC Submission'
  - follow the naming convention set out in the Electronic File Naming Convention section below
- 

### Electronic File Naming Convention

Hospitals submitting electronically must follow the following naming convention for each file submitted:

**HHHHMMTN**

Where: H = ISAAC Hospital Code

M = Month the data is being submitted

T = Type of Records *[Use N for New or C for Correction Records]*

N = File Number *[Use 1 for 1<sup>st</sup> file, 2 for 2<sup>nd</sup> etc. for subsequent files]*

Example: **004909N2** shows hospital 0049 (Angaston) submitting in the month of September, new records, and this is file number 2.

---



### Control Log

Hospitals submitting electronically must complete and supply a Control Log.

Instructions for completing the Control Log are available in [Appendix 6](#).

**If information in the Control Log does not match the submission file, the submission will be rejected.**

**The Control Log Form is updated on an annual basis (effective 1 July of each year). Please ensure you download the current version of the form from the ISAAC Unit website. Expired versions cannot be processed by the ISAAC Unit.**

Details required in the Control Log include:

- hospital code
- file type - new/correction
- file edited if relevant – resubmission/trimmed
- comments field – optional as per user requirements
- month of data
- number of records

When completed the following fields will populate into the Control Log:

- hospital name
- file name
- file extension - .txt only
- record length – 746 only
- ICD-10-AM coding version – 9<sup>th</sup> edition only

When data is submitted electronically to ISAAC, each record is listed as a 746 character flat file. Most information appears as numbers or codes. The format and appearance of these files is vital to the loading and processing of data through the ISAAC II system.

[illegible]

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## Paper Forms

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### Use of Paper Forms

Paper forms may only be used to report to ISAAC by the hospitals listed in the table below. These hospitals either do not have a Patient Administration System capable of capturing the information required, or do not have an ISAAC standard extract facility.

Hospital Code	Hospital
0133	Leigh Creek
0148	Marree
4363	Parkside Cosmetic Surgery
4366	Repromed
4401	Ardrossan
4402	Hamley Bridge
4404	Keith
4408	South Coast Private (Victor Harbour)

All other sites must submit ISAAC data electronically.

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### ISAAC Patient Summary Form

The form available for use by public and private hospitals is the 20a/1 ISAAC Patient Summary. This form is available from the ISAAC website, and enables the capture of relevant information about a patient's stay in hospital, including demographic, admission, separation and clinical details.

The form consists of three (3) sheets:

- Original**      ISAAC X/1 (green & white border down the right side)  
This must be retained in the patient's case-notes as a source data record.
- Duplicate**    ISAAC X/2 (red & white border down the right side)  
This sheet must be sent to ISAAC Unit.
- Triplicate**    ISAAC X/3 (yellow sheet)  
This is for internal hospital use. If not required, it can be securely destroyed. Otherwise it should be filed in the patient's case-notes.

A second form (Extra ICD-10-AM Codes 11b/X) can be used if there are more than 15 additional diagnosis, or 15 procedures to report for a single episode of care.

The Extra ICD-10-AM Codes (11b/X) Form has two (2) sheets:

- Original**      ISAAC 11b/1 (green & white border down the right side)  
This must be retained in the patient's case-notes as a source data record.
- Duplicate**    ISAAC 11b/2 (yellow sheet with red text)  
This sheet must be sent to the ISAAC Unit.

The identifying fields at the top of this form must be completed along with any additional diagnosis and/or procedures codes.

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## Submitting an Extra ICD-10-AM Codes Form

If an Extra ICD-10-AM Codes form (11b/X) is used tick ☒ in the box next to the prompt *"Tick if more codes on next page"* found on the ISAAC Patient Summary Form.

The Hospital Code, Hospital Name, Patient UR Number, Separation Date and Separation Time must also be completed on both forms so that the details from both forms can be linked to the relevant episode of care.

Once the identifying fields and additional diagnoses and/or procedures are complete, staple the Extra ICD-10-AM Codes form (11b/X) to the ISAAC Patient Summary Form.

If an Extra ICD-10-AM Codes form (11b/X) is not used **do not** tick in the box next to the prompt *"Tick if more codes on next page"* found on the ISAAC Patient Summary Form.

## Use of Non-SA Health Forms

Customised paper forms may be developed and/or used by hospitals for the collection of ISAAC information, however, the data supplied to SA Health must be in an electronic format complying with standard file layout specifications.

Any data provided to SA Health for data entry must be on the official SA Health forms (or on a form approved for use by the ISAAC Unit).

## Preparation of Forms for Submission

The ISAAC X/2 forms, with **ALL ITEMS** completed should be forwarded to the ISAAC Unit.

Only one ISAAC X/2 form should be submitted for each separation (except if the patient is a boarder in which case no form is required). Alterations and corrections to previously submitted information should be made on the Edit Detail Report or on a separate form (see Data Quality/Corrections section).

Paper forms that are sent to the ISAAC Unit for data entry must:

- Have all forms relating to one episode of care stapled together, print side up;
- Be grouped in separate bundles for each hospital; and
- The "Control Log for Dispatch/Receipt of ISAAC Forms/Reports" on top stating:
  - Contact person's name and phone number
  - Hospital Name and ISAAC Hospital Code
  - For each hospital, record the number of ISAAC X/2 forms and Xb/2 forms, if applicable
  - Month of separation the majority of records are for
  - Clinical Coding version that is to be used (i.e. ICD-10-AM 9<sup>th</sup> Ed)

Data submitted by paper must be sent directly to the ISAAC Unit via secure post or courier. To ensure confidentiality, the following should be implemented:

- Forms should be sent in a non-tear envelope or package, or at least well secured to prevent accidental opening
- Address the envelope to "ISAAC Unit"
- Include the hospital's name and address on the envelope

## Changes to Forms

It is common for forms to change effective 1 July each year. Detailed information and instructions regarding any changes are forwarded to hospitals between March and May each year.

The ISAAC system can generally accept data on the new and latest previous version of the form. Full details of usage of new and previous forms will be communicated to hospitals as per above.

### Ordering Forms

Hospitals that do not use the ISAAC Patient Summary Form as their method of submitting data to ISAAC will be charged for the supply of the form and associated freight costs.

Hospitals that submit data to the ISAAC Unit using the ISAAC Patient Summary Form will be supplied forms free-of-charge. However, as the ISAAC Unit does not manage the distribution of the forms, said hospitals are required to cover associated freight costs.

The ISAAC Patient Summary Form can be ordered as follows:

- All Oracle users should be requisitioning Item Number 20011226
  - All Non Oracle users can order the form through Customer Service, Procurement & Supply Chain Management (PSCM) by fax or email:
    - Email : [procurementcs@sa.gov.au](mailto:procurementcs@sa.gov.au)
    - Fax (08) 8124 4655
    - Tel: (08) 8425 4655
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## Data Quality

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### Introduction

This topic provides information on the data quality checks applied to data submitted to ISAAC.

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### Quality Checks

All data submitted to ISAAC is subjected to data quality checks. A standard suite of data quality (input edit) checks is applied to new data submissions. The ISAAC data quality checks identify data errors (logical inconsistencies and invalid codes) and unusual circumstances (queries). These checks ensure the business rules (instructions) have been adhered to, and identifies data that requires correcting.

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### Electronic Submission File Format

Data that is not in the specified format for the collection will need to be resubmitted in the correct format.

**Note:** Testing of the ISAAC data extract layout must be included as part of implementing new versions of patient administration systems.

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### Corrections

All data errors must be corrected in ISAAC as soon as possible, or where end of quarter deadlines have been set. Where a value has been queried, the value should be checked and either corrected, or confirmed as correct.

**Note:** See Data Quality Checks and Error Correction Section for details about making corrections to records with errors.

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## Due Dates for Submissions and Corrections

### Introduction

This topic provides information about the due dates for submissions and correction of data for the ISAAC.

### Reporting Requirements

All hospitals must submit their morbidity data on a monthly basis by the 16<sup>th</sup> day of the following month. Electronic or paper submissions received on time by the ISAAC Unit will be processed in the current processing cycle. Overdue submissions may be held over until the next monthly processing cycle.

### File Submission Due Dates

The schedule below (as published in the Casemix Funding Technical Bulletin 94.6) applies in 2016/17 for the submission of morbidity data to ISAAC.

#### Important Notes:

1. A closing time of 17:00 applies to these dates
2. If the due date is a public holiday or weekend, then the due date becomes the previous working day
3. Hospitals are still required to submit error corrections to ISAAC after the above deadlines to ensure data is maintained to a high standard
4. For reporting purposes, SA Health may be required to amend due dates for submission of data. However, hospitals will be given advance notice of any variations to due dates

Separation Dates in:	All Hospitals (New records)	All Hospitals (Corrections)
July 2016	16 August 2016	16 September 2016
August 2016	16 September 2016	16 October 2016
September 2016	16 October 2016	16 November 2016
October 2016	16 November 2016	16 December 2016
November 2016	16 December 2016	16 January 2017
December 2016	16 January 2017	16 February 2017
January 2017	16 February 2017	16 March 2017
February 2017	16 March 2017	16 April 2017
March 2017	16 April 2017	16 May 2017
April 2017	16 May 2017	16 June 2017
May 2017	16 June 2017	16 July 2017
June 2017	16 July 2017	16 August 2017
<b>Financial Year Cut-off Date</b>	<b>Public Hospitals: 15 September 2017 Private Hospitals: 15 October 2017</b>	<b>All Hospitals: 15 September 2017</b>

**Note:** This schedule applies to ALL public hospitals - both casemix and grant funded public hospitals.

**Financial Year  
Cut Off Date**

The **15<sup>th</sup> September** is the final cut-off-date for submission of data for the preceding financial year. No data are accepted beyond this date, and all data reported for the financial year are frozen.

If data or corrections are not submitted by **15<sup>th</sup> September**, no guarantee can be made that the data will be reported in the financial period. This may result in episodes not being funded, and information being unavailable for reporting and statistical purposes.

**Extensions to  
Submission  
Due Dates**

Sites must ensure that planned staff leave does not adversely impact their ability to provide a quality, complete and timely submission.

An extension to the monthly submission deadline may be negotiated with the ISAAC Unit in extenuating circumstances. Where an extension is approved, the site will be required to provide routine progress updates to the ISAAC Unit.

The ISAAC Unit may also require sites which routinely request extensions to demonstrate what long-term strategies are being implemented to address issues at a local level.

**Temporary  
Exemption  
From  
Submission**

The **15<sup>th</sup> September** is the final cut-off-date for submission of data for the preceding financial year. No data are accepted beyond this date, and all data reported for the financial year are frozen.

- If data or corrections are not submitted by **15<sup>th</sup> September**, no guarantee can be made that the data will be reported in the financial period. This may result in episodes not being funded, and information being unavailable for reporting and statistical purposes.
- A temporary exemption must include: specific details of the problem, the number/percentage of records affected, details of all hospitals affected, action which will be taken to resolve the issue/s, date for resolution, date for data availability/re-supply.

**Coroner's  
Cases and  
Autopsies**

The **15<sup>th</sup> September** is the final cut-off-date for submission of data for the preceding financial year. No data are accepted beyond this date, and all data reported for the financial year are frozen.

If data or corrections are not submitted by **15<sup>th</sup> September**, no guarantee can be made that the data will be reported in the financial period. This may result in episodes not being funded, and information being unavailable for reporting and statistical purposes.



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## Penalties for Late Submission – Public Hospitals

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### Introduction

This topic describes penalties that may be imposed on public hospitals for non-compliance with ISAAC due dates.

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### Penalties for Late Submission

Delays to submission, or significant data quality issues, may result in that hospital data being unavailable for pivotal monthly reporting. This may impact on operational and strategic decision making.

Key performance indicators for each hospital's submission completeness and deadline compliance are routinely monitored. Reports on compliance are provided to Executive.

If data or corrections are not submitted by the end of financial year cut-off of **15<sup>th</sup> September**, no guarantee can be made that the data will be reported in the financial period. This may result in episodes not being funded, and information being unavailable for reporting and statistical purposes.

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## **SECTION 3: Data Quality Checks and Error Correction**

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## Outline

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### Introduction

This section provides details about the data quality checks applied to data once it is submitted to the ISAAC. It also provides information about correcting records with errors.

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### Contents

Covered in this section is information regarding:

- Types of Data Quality Checks
  - ISAAC Error Reports
  - Content of ISAAC Error Reports
  - Methods of Correcting Errors
  - Resubmitting Records
  - Making Corrections on Error Reports
  - Making Corrections on ISAAC Correction Forms
  - Returning Corrections
-

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# Types of Data Quality Checks

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**Introduction** This section provides information about the types of data quality checks applied to data submitted to the ISAAC.

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**Types of Checks** There are three (3) groups or classes of data quality checks:

- Rejected errors (0900 and 1000 series)
- Critical errors (2000 series)
- Non-critical and warning errors (4000 series)

**Note:** These error checks apply to both administrative data elements and clinical codes.

Refer to [Section 6: ISAAC Data Quality Edits](#) for a listing of non-clinical edits and edit logic.

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**Rejected Errors** These records are rejected in entirety and not added to the database. They have severe errors on the following key data items:

- Hospital Number
- Patient Unit Record Number
- Separation Date
- Separation Time

Types of errors occurring in this group or class of error range are:

- Invalid values with any of the data items
- Logical errors between Admission & Separation Dates
- Submitting a record which already exists on the database

All rejected errors must be reviewed by the hospital and may result in resubmission of the entire record as no data has been added to the database at this stage.

**Note:** These errors have error codes in the range of "0900" to "1999".

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**Critical Errors** A critical error will arise when an invalid or inconsistent value is submitted for a data item that is required for one or more of the following:

- Assigning Australian Refined - Diagnostic Related Groups (AR-DRGs)
- Public Hospital Casemix Funding Model (CFM) calculation
- Establishing correct place of residence
- Establishing Veteran Affairs eligibility

Records that have a critical error are not assigned AR-DRGs (grouped) and are not extracted for the CFM. Consequently, all critical errors require prompt attention and correction so the record can be grouped accurately, included in the CFM and funded.

Critical Errors consist of *Invalid Errors* (where a reported value is not valid) and *Inconsistent Reporting Errors* (where a reported value is inconsistent with another reported value).

**Invalid Errors** include:

- Date of Birth invalid
- Admission Date invalid
- Diagnosis invalid
- Procedure Codes invalid
- Hours in ICU invalid

**Inconsistent Reporting Errors** include:

- Date of Birth after Admission Date
- Admission Date after Separation Date
- Hours in ICU greater than Length of Stay (LOS)
- Admission Time greater than Separation Time (when Admission Date equals Separation Date)
- Interstate Postcode with inconsistent SLA or vice versa

**Note:** These errors have error codes in the range of "2000" to "2999".

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### **Non-Critical and Warning Errors**

There are two types of errors within this range - Non-critical and Warning.

**Non-critical errors** indicate that changes have been made to the reported value because it was invalid or not required. In these cases, ISAAC has defaulted or derived a value for the data item. In a number of cases, these errors fix known Patient Administration System faults. If you agree with the "assigned value" then no further action is required. If you do not agree with the change, you will need to make a correction. See later in this section for methods of correcting errors.

**Warning errors** indicate a reported value is unusual for other information that has been provided in the record. Hospitals only need ensure the value provided in the record is truly valid. If the value is found not to be valid you will need to make a correction. See later in this section for methods of correcting errors.

#### **Examples of non-critical errors:**

##### **SLA Code Invalid**

The SLA based on the Postcode.

##### **Marital Status Invalid**

A "9-Unknown" is assigned unless the age is less than 16 when a "1-Never Married" is assigned.

##### **Hospital Transferred to Not Required**

The value in Hospital Transferred to field is removed as Nature of Separation is not "2-Other Hospital (up)" or "7-Other Hosp (down)"

#### **Examples of warning errors:**

##### **Diagnosis not compatible with age**

Check the age of the patient and ensure the diagnosis is logical for the age.

##### **Age > 100 years**

The age has been calculated to be over 100 years. Check that the patient's age really is greater than 100 years.

##### **Admission weight < 400 grams**

Check that the admission weight is actually less than 400 grams.

##### **Separation Date > 1 year ago**

Check that the separation date is more than 1 year ago.

**Note:** These errors have error codes in the range of "4000" to "4999".

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## **Improving Errors**

If you suspect that a data quality check is incorrect, or raising a large number of queries unnecessarily, please contact the ISAAC Unit to discuss your concerns.

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## ISAAC Error Reports – ‘Hospital Edit Reports’

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<b>Introduction</b>	This topic provides details about ISAAC Error Reports.
<b>What are Error Reports</b>	An ISAAC Error Report is a document that lists the data items in a record that have failed ISAAC data quality checks.
<b>Availability of Reports</b>	Each month, error reports will be produced for every hospital for every file submitted to ISAAC. They will be distributed following processing of submissions.

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## Content of ISAAC Error Reports – ‘Hospital Edit Reports’

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<b>Introduction</b>	This topic provides information about the content of the ISAAC Error Reports.
<b>Report Aims</b>	<p>The Error Reports have been designed to:</p> <ul style="list-style-type: none"><li>▪ Allow distribution in an A4 format</li><li>▪ Clearly show the variable that could have caused the error or query</li><li>▪ Allow easy identification of the most common errors so that actions can be taken to eliminate the error at point of data collection or entry</li><li>▪ </li></ul>
<b>Report Layout</b>	<p>The Error Reports are provided as Excel documents titled with the hospital code. The Excel documents have the header ‘Hospital Edit Report’ and contain 2 tabs:</p> <p><b>Tab 1</b> Summary <b>Tab 2</b> Details – reject, critical and warning errors</p>
<b>Tab 1 - Summary</b>	<p>An example summary report is available overleaf.</p> <p>The number of rows reported for each error is listed. This tab also shows the number of records added to the database (i.e. excludes rejected records), the number of valid records, and the number of records with each category of error.</p>
<b>Required Actions</b>	<p>The Summary tab information should be used to:</p> <ul style="list-style-type: none"><li>▪ Monitor data quality over time</li><li>▪ Identify the most common errors for your hospital</li><li>▪ Eliminate the most common errors at their source</li></ul>



Example: Tab 1- Summary Hospital Edit Report

 <b>Government of South Australia</b> SA Health		<b>Hospital Edit Report</b> S.A.Health - Integrated South Australian Activity Collection				
<b>Batch No:</b>		109454,109460,109636				
<b>Hospital Code:</b>		0019	<b>Hospital Name:</b> Royal Adelaide Hospital			
Data File Name	Batch	Record Count	Total Valid Records	Total Rejected	Total Critical Errors	Total Warning
001905N1rev.txt	109454	7052	7037	0	15	1005
	109460		-1	1	0	0
	109636		-1	1	0	0
Data File Name	Edit Code	Edit Description				Total Records
001905N1rev.txt	2320	Incorrect Election for Fund Source type				2
001905N1rev.txt	2753	SAMEDAY SCOPE-reportd inpatient notfundd				3
001905N1rev.txt	2754	SAMEDAY CHEMO-reportd inpatient notfundd				6
001905N1rev.txt	2757	SAMEDAY BRONCHO-reportd inpat. notfundd				4
001905N1rev.txt	4000	Inappropriate Sameday Admission				12
001905N1rev.txt	4010	Postcode Invalid				10
001905N1rev.txt	4012a	Diag. code must have cond.onset flag				3
001905N1rev.txt	4012b	Diag. code must have cond.onset flag				1
001905N1rev.txt	4012c	Diag. code must have cond.onset flag				3
001905N1rev.txt	4022	COB has changed since last episode of care				81
001905N1rev.txt	4090	J350 required with tonsillectomy				8

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**Tab 2 – Details**

An example detail report is available overleaf.

This tab shows the details of the errors for each record in error.

**1. Header Information** is reported at the top of every page. It shows:

- Hospital Code and Name (Unit)
- Batch Number(s)

The following are reported for each record found to be in error during the data quality checking process.

**2. Record Identification Details** show:

- Patient Unit Record Number
- Record Identification number (internal ISAAC Unit use only)
- Admission Date/Time
- Separation Date/Time
- File Name – submission file name for each record

For every error found the following are reported:

**3. Data Item and Value in Error**

- *Item Number* - the item(s) checked in this edit
- *Value in Error* - the value(s) ISAAC received for these item(s) (i.e. as submitted by your hospital or as keyed from the ISAAC Patient Summary Form
- *Assigned Value* - when appropriate, the defaulted value ISAAC has assigned for the data item in question

**4. Error Details**

- Error code
- Message - error description

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**Required  
Actions**

All hospitals are required to correct all errors listed in the detail section by the due date stated on the slip accompanying the report.

Rejected records must be resubmitted in full. No records have been added to the central collection.

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Example: Tab 2- Details – reject, critical and warning errors

 Government of South Australia SA Health		<b>Hospital Edit Report</b> S.A.Health - Integrated South Australian Activity Collection							
Batch No:		109510,109511							
Hospital Code:		0999	Hospital Name:		Adelaide Hospital				
Patient Unit No	Rec No	Admission Date Time	Separation Date Time	Item No	Value in Error	Assigned Value	Error Code	Message	File Name
0000001316	4	02052013 0930	02052013 1330	49A	3120500		4000	Inappropriate Sameday Admission	011505n2.dat
0000001316	4	02052013 0930	02052013 1330	49B-49Y			4000	Inappropriate Sameday Admission	011505n2.dat
0000001483	6	30052013 1720	30052013 1746	46C	T426 ,R55 ,X61		4885	Activity code reqd in additional diag	011505n2.dat
0000001483	6	30052013 1720	30052013 1746	47	X42		4885	Activity code reqd in additional diag	011505n2.dat
0000001483	6	30052013 1720	30052013 1746	93	U738		4885	Activity code reqd in additional diag	011505n2.dat
0000001483	6	30052013 1720	30052013 1746	94	Y9209		4885	Activity code reqd in additional diag	011505n2.dat
0000005048	22	13052013 1715	13052013 1800	13	9(4)		4206	Indigenous status has changed since last episode of care	011505n2.dat
0000005704	25	07052013 0800	07052013 1445	13	4(9)		4206	Indigenous status has changed since last episode of care	011505n2.dat
0000006670	30	09052013 0730	10052013 1330	9	03/05/1976(13/05/1976)		4691	Dob has changed since last episode of care	011505n2.dat

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## Methods of Correcting Errors

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### Introduction

This topic provides information about making corrections to records that fail the ISAAC data quality checks.

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### Options for Correction Errors

To correct errors in records that fail the ISAAC data quality checks, hospitals can either:

- Correct the error directly in the local Patient Administration System, and then create an electronic extract file; or
- Correct the error on an ISAAC Single or Multi-Record Correction Form
- If neither of the above is possible, sites may correct the error on the error report itself and email the correction to the ISAAC Unit.

**Verbal (over the telephone) corrections will not be accepted. All corrections must be documented in writing by the hospital.**

**Note:** Where correction is required to any of the key data items, the ISAAC Unit will only accept a resubmission of data.

**Note:** Detailed instructions for these methods of data correction are contained in following topics.

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## Resubmitting Records – non-EPAS hospitals

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<b>Introduction</b>	This topic provides information about resubmitting records to ISAAC.
<b>What is Re-submitting</b>	This is the process of re-sending a complete separation record for inclusion in ISAAC.
<b>When to Re-Submit</b>	<p>The most common reason for resubmitting is to submit a record/s that was rejected in previous submissions (as these records do not exist on the ISAAC database).</p> <p>Other reasons are:</p> <ul style="list-style-type: none"><li>▪ Your local Patient Administration System is not set up to send correction records</li><li>▪ Correct the errors in records that have failed the ISAAC data quality checks rather than making the correction directly on the error report</li><li>▪ A record has been updated following local discovery of an error</li></ul>
<b>How to Re-Submit</b>	<p>For a record to be added to ISAAC, a record with the same unique record key cannot already exist. If you wish to resubmit a record that already exists, you must first delete the existing record and then resubmit the new correct record.</p> <p>To resubmit a record that does not exist on ISAAC because it was originally rejected <u>or</u> has never been sent, simply ensure all data items are correct and then resubmit the new correct record.</p>
<b>Re-Submitting Paper-Based Records</b>	<p>To resubmit a record that already exists:</p> <ol style="list-style-type: none"><li>1. Complete an ISAAC Single Correction Form, ensuring a "1" is noted in the Delete Indicator box</li><li>2. Attach a correctly completed ISAAC Patient Summary Form</li><li>3. Send forms to the ISAAC Unit</li></ol> <p>For those records which do not currently exist, send a correctly completed ISAAC Patient Summary Form direct to the ISAAC Unit.</p> <p><b>Note:</b> Instructions for completing ISAAC Correction Forms can be found in the topic of the same name found later in this section.</p>

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**Re-Submitting  
Electronic  
Records**

To resubmit a record that already exists:

1. Create an electronic file of deletion record/s, one for each record to be deleted and extract to file
2. Extract all records to be resubmitted to ISAAC and extract to file
3. Complete an ISAAC Control Log
4. Send Control Log form and file direct to the ISAAC Unit in SA Health by e-mail

Records which do not currently exist, should be extracted into a file and sent directly to the ISAAC Unit.

**Note:**

- The formats for a deletion file and new record file can be found in the Appendix to this Manual
  - Details on completing an ISAAC Control Log and submitting electronically to ISAAC can be found in Section 2 – Guidelines for Submission of Data
- 

**Resubmitting  
Versus  
Correcting**

Some hospitals elect to resubmit all records found to be in error and subsequently requiring correction. This is largely due to the fact that their Patient Administration System is not setup to submit electronic corrections and doing so manually is not possible. These sites delete records and then resubmit the entire record.

The ISAAC Unit's preferred method is for correction records to be sent. This reduces processing time, and possible problems that may occur in the delete/resubmit process.

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**Special  
Arrangements**

SA Health may request, or agree to, a resubmission of records if there has been a systematic coding error, or a patient administration system error, and the impact on data quality is significant.

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## Making Corrections on Error Reports – non-EPAS hospitals

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<b>Introduction</b>	<p>This topic provides instructions for making corrections on emailed error reports.</p> <p>All corrections to ISAAC episodes should be reflected on the site's Patient Administration System (PAS). If it is not possible to correct the episode on the PAS then the correction should be documented or supported by existing documentation in the Patient's Medical Record.</p> <p>When corrected on the PAS, the correction is included in the monthly ISAAC electronic submission, per submission standards outlined in this manual, either in a correction file or through deletion and resubmission of the episode.</p> <p>Sites may also submit manual corrections identified in error reports by correcting the value on the error report or through the use of the ISAAC Single Correction Form.</p>
<b>Instructions</b>	<p>When correcting values on the Error Report it is preferable the correction is made electronically by updating the spreadsheet containing the error report.</p> <p>For sites unable to correct per the above, the site may correct the value on the printed error report and either scan and email the corrected error report or send via post to the ISAAC unit.</p> <p><u>To make a correction on an emailed error report:</u></p> <ul style="list-style-type: none"> <li>• Open the attachment and enter updated values at the end of the appropriate row. Save &amp; email the report to the ISAAC Unit</li> </ul> <p><u>To make a correction on a printed error report:</u></p> <ul style="list-style-type: none"> <li>▪ <b>With a red pen, add the correction/s</b> to the report. Be sure to clearly write next to the <b>data item that needs to be updated</b>, and provide the <b>updated value</b>.</li> </ul> <p>Corrections written directly onto the error report <b>must only relate</b> to the <b>data item that is documented</b> on the report. See <i>Exceptions</i> item listed below.</p> <p><b>Note:</b> Please <b>DO NOT</b> detail the reason for the error or any other information. Providing only the new value increases the speed that data entry staff can process the corrections.</p>
<b>Exceptions</b>	<p>The only data items which cannot be corrected, even though documented, on an error report are those which make up the unique Record Key. These are:</p> <ul style="list-style-type: none"> <li>▪ Hospital Number</li> <li>▪ Patient Unit Record Number</li> <li>▪ Separation Date</li> <li>▪ Separation Time</li> </ul> <p>Changes to these fields must be completed by <b>deleting the whole record</b> and resubmitting the correct information. Refer to <a href="#">Resubmitting Records</a> topic for detailed information on this process.</p>

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## Making Corrections on ISAAC Correction Forms – non-EPAS hospitals

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<b>Introduction</b>	This topic provides instructions for making corrections on ISAAC Correction Forms.
<b>Using Correction Forms</b>	ISAAC Single and Multi-record Correction Forms can be used to change any data items that have been previously submitted to ISAAC. They can also be used to delete a whole separation.
<b>Which Form to Use</b>	<p>Use a single record correction form when you:</p> <ul style="list-style-type: none"> <li>▪ Need to correct more than 2 data items for a single record; <u>or</u></li> <li>▪ Have only 1 record to correct; <u>or</u></li> <li>▪ Want to delete a record</li> </ul> <p>Use a multi-record correction for when you:</p> <ul style="list-style-type: none"> <li>▪ Have many records to correct; <u>and</u></li> <li>▪ Have only 1 or 2 data items to correct per record</li> </ul>
<b>Completing a Single Record Form</b>	<p>On a single record correction form at the top of the form, enter:</p> <ul style="list-style-type: none"> <li>▪ Hospital's ISAAC code and name</li> <li>▪ Patient's URN</li> <li>▪ Separation date</li> <li>▪ Separation time</li> </ul> <p><b>Note:</b> These should be the exact values as they appear on ISAAC.</p> <p>Then in the <i>Delete Indicator</i> field enter either a:</p> <p style="padding-left: 40px;">0 (zero) to make a correction to the record; or 1 (one) to delete this whole record</p> <p><b>Note:</b> If you are deleting a complete record no further information is required</p> <p>Next, enter the data item to correct and its new value.</p>

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## Completing a Multi-Record Form

On a Multi-Record Correction Form at the top of the form, enter:

- Hospital's ISAAC code and name

Then for each record requiring correction, enter:

- Patient's URN
- Separation date
- Separation time

**Note:** These should be the exact values as appear on ISAAC.

Finally, enter the data item to correct and its new value.

**Note:** You cannot use this form to delete a complete record i.e. an ISAAC Single Record Correction Form must be used.

## Entering Data Item and New Value Details

When entering a data item number the first character should be placed in the left most (ie. the first position) of the field and subsequent characters following.

**Note:** If an additional diagnosis, procedure code or procedure indicator code is being corrected you must indicate which code to correct. For example: 46C or 85J.

The new value for the data item should then be neatly entered.

**Note:** Write the word **blank** should you require a value to be removed or deleted.

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## Returning Corrections – non-EPAS hospitals

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**Introduction** This topic provides instructions for returning corrections to the point for data entry into ISAAC.

**Where to Send Corrections** Hospitals must return the corrections made on error reports and/or Correction Forms to the ISAAC Unit by the due date. See below for address details.

**What to Return** Return corrected Tab 2 – ‘Details’ of the Hospital Edit Report and/or any ISAAC Correction Forms and any new ISAAC Patient Summary Forms for resubmission.

**Note:** Keep a copy of Tab 2 – ‘Details’ (as well as the other sections of the error report) for your own records. This may be required to answer any additional queries the data entry person may have.

**Where to Return Reports** Error reports that have been annotated with corrections should be sent to:

**Couriers:** "Confidential"  
Attn: ISAAC Unit  
Data and Reporting Services  
SA Health  
Level 3, Citicentre Building  
11 Hindmarsh Square  
Adelaide SA 5000  
Contact Phone: (08) 8226 7322

**Postal:** "Confidential"  
Attn: ISAAC Unit  
Data and Reporting Services  
SA Health  
PO Box 287, Rundle Mall,  
Adelaide SA 5000

**Email:** [health.isaacsubmissions@sa.gov.au](mailto:health.isaacsubmissions@sa.gov.au)

**Fax:** (08) 8226 8150

**Due Dates for Corrections** Corrections must be received from individual hospitals by the prescribed due dates. See [Section 2: Due Dates for Submissions and Corrections](#).

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**SECTION 4: Data Items**

## ISAAC Integrated South Australian Activity Collection (2016-2017)

### Identifying and definitional attributes

<i>Metadata item type:</i>	Data Set Specification
<i>SAHMR identifier:</i>	SA1745
<i>Registration status:</i>	SA Health, Proposed 01/07/2016
<i>DSS type:</i>	Data Set Specification (DSS)
<i>Scope:</i>	The Integrated South Australian Activity Collection (ISAAC) contains state-wide data capturing information about patients separated from public and private hospitals. It provides SA Health with the information resources necessary to effectively fund, organise, evaluate, and plan health services in South Australia. ISAAC data also allows SA Health to meet national obligations through annual submissions to the Australian Institute of Health and Welfare (AIHW). ISAAC forms part of the Admitted Patient Care National Minimum Data Set through submission to AIHW.

### Collection and usage attributes

<i>Implementation start date:</i>	01/07/2016
<i>Implementation end date:</i>	30/06/2017
<i>Comments:</i>	For alignment with AIHW Admitted Patient Care NMDS 2016-2017

### Related metadata items

<i>Related metadata references:</i>	See also <a href="#">Contract Service</a> SA Health, Standard 31/12/2013 <a href="#">Supersedes ISAAC Integrated South Australian Activity Collection (2015-2016) SA Health, Candidate 01/07/2015</a>
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### Metadata items in this Data Set Specification

<i>Metadata item</i>	<i>Obligation</i>
<a href="#">Activity when injured</a>	Conditional
<a href="#">Admission Category</a>	Mandatory
<a href="#">Admission Date</a>	Mandatory
<a href="#">Admission Election</a>	Mandatory
<a href="#">Admission Number</a>	Mandatory
<a href="#">Admission Time</a>	Mandatory
<a href="#">Admission Type</a>	Mandatory
<a href="#">Admission weight</a>	Conditional
<a href="#">Adult / Child flag (WCH only)</a>	Conditional
<a href="#">Clinical Unit Code</a>	Optional
<a href="#">Condition Onset Flag</a>	Mandatory
<a href="#">Contract admission date</a>	Conditional
<a href="#">Contracted hospital patient unit number</a>	Conditional
<a href="#">Contracted Service Hospital</a>	Conditional
<a href="#">Country of birth</a>	Mandatory
<a href="#">Date of birth</a>	Mandatory
<a href="#">Date of Birth Accuracy Flag</a>	Conditional
<a href="#">Diagnoses - Additional</a>	Conditional
<a href="#">Diagnosis - Principal</a>	Mandatory
<a href="#">DOTDL</a>	Conditional
<a href="#">Employment Status</a>	Conditional
<a href="#">Episode of care code</a>	Mandatory
<a href="#">External cause</a>	Conditional
<a href="#">Funding Source</a>	Mandatory
<a href="#">Hospital code</a>	Mandatory

<a href="#">Hospital Insurance</a>	Mandatory
<a href="#">Hospital transferred from</a>	Conditional
<a href="#">Hospital transferred to</a>	Conditional
<a href="#">Hours in ICU</a>	Conditional
<a href="#">Hours on mechanical ventilation</a>	Conditional
<a href="#">Indigenous status</a>	Mandatory
<a href="#">Leave - date of resuming service</a>	Conditional
<a href="#">Leave - time of leaving service</a>	Conditional
<a href="#">Leave - time of resuming service</a>	Conditional
<a href="#">Leave -date of leaving service</a>	Conditional
<a href="#">Legal status</a>	Conditional
<a href="#">Marital status</a>	Mandatory
<a href="#">Medicare IRN</a>	Mandatory
<a href="#">Medicare Number</a>	Mandatory
<a href="#">Mental health linking number</a>	Conditional
<a href="#">Nature of separation</a>	Mandatory
<a href="#">OACIS Linking Variable</a>	Optional
<a href="#">Operating theatre - Date of first procedure (DFOTP)</a>	Conditional
<a href="#">Operating theatre - Time of first procedure (TFOTP)</a>	Conditional
<a href="#">Patient Category - Intent</a>	Mandatory
<a href="#">Patient unit record number</a>	Mandatory
<a href="#">Pension Status</a>	Conditional
<a href="#">Place of occurrence</a>	Conditional
<a href="#">Postcode</a>	Mandatory
<a href="#">Previous specialised treatment</a>	Conditional
<a href="#">Procedure location indicator</a>	Conditional
<a href="#">Procedures</a>	Conditional
<a href="#">Referral for Further Health Care</a>	Mandatory
<a href="#">RUG-ADL Score Code</a>	Conditional
<a href="#">Separation Date</a>	Mandatory
<a href="#">Separation Time</a>	Mandatory
<a href="#">Sex</a>	Mandatory
<a href="#">Source of referral</a>	Mandatory
<a href="#">Statistical local area</a>	Mandatory
<a href="#">Status Change - Election</a>	Conditional
<a href="#">Status Change - Type</a>	Conditional
<a href="#">Status Change – Date Effective From</a>	Conditional
<a href="#">Suburb / Locality</a>	Mandatory
<a href="#">TOTTDL</a>	Conditional
<a href="#">Type of Usual Accommodation</a>	Mandatory
<a href="#">Veteran Card Number</a>	Conditional
<a href="#">Veteran Card Type</a>	Conditional
<a href="#">Ward on admission</a>	Conditional
<a href="#">Ward on Discharge</a>	Conditional

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## Activity when injured

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### Identifying and definitional attributes

<i>Technical name:</i>	Event leading to hospitalisation—activity at time of occurrence, code AN[NNN]
<i>Synonymous names:</i>	ISAAC Data Item 93
<i>SAHMR identifier:</i>	SA1060
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	
Data Element Concept:	Event leading to hospitalisation—Activity at time of occurrence

### Value domain attributes

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### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	AN[NNN]
<i>Maximum character length:</i>	5

### Collection and usage attributes

<i>Guide for use:</i>	Format for Clinical Data Submission	<p>The submission of ICD-10-AM codes must be recorded in the following format:</p> <ul style="list-style-type: none"> <li>• Without decimal points</li> <li>• Include lead alpha characters</li> <li>• Record codes in sequence order</li> <li>• Left justify, blank fill</li> <li>• Where there is no 4th digit, but a 5th digit is required use "0" as a filler</li> </ul>
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For example, secondary conditions are entered as:

P 1 2 3            M 2 3 4 5            S 4 5 0 1

Hospitals submitting information to ISAAC electronically must refer to ISAAC reference table - record format for magnetic media for the correct format of the data.

### Data element attributes

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### Collection and usage attributes

<i>Guide for use:</i>	<p>Required with an external cause code in the range V00-Y34. The activity code should be placed in the Additional Diagnosis, sequence before Place of Occurrence. ISAAC will locate it and store it in a separate field. This enables us to produce reports by activity.</p>
<i>Collection methods:</i>	<p><b>Related ISAAC Edits</b></p> <p>#4860 – External cause must accompany activity code</p> <p>#4870 – Activity code not required</p> <p>#4880 – Activity code required</p> <p>#4885 – Activity code reqd in additional diag</p>

## Admission Category

### Identifying and definitional attributes

<i>Technical name:</i>	Patient admission - urgency, code N
<i>Synonymous names:</i>	ISAAC Data Item 15
<i>SAHMR identifier:</i>	SA1072
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Indicates the urgency of the patient's admission to hospital and if so, whether the admission occurred on an emergency basis. For designated booking list hospitals it also indicates where a patient is admitted from the Elective Surgery Booking List.

Data Element Concept: Patient admission—Urgency

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Elective
	2	Emergency
	3	Elective - booking list
<i>Supplementary values:</i>	4	Not applicable

### Data element attributes

#### Collection and usage attributes

<i>Guide for use:</i>	<table border="1"> <tr> <td><b>1 Elective</b></td><td> <p>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.</p> <p>If an admission meets the definition of elective, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission can be delayed by at least 24 hours.</p> </td></tr> <tr> <td><b>2 Emergency</b></td><td> <p>An emergency admission is an admission of a patient for care or treatment, which, in the opinion of the treating clinician, is necessary and should occur within 24 hours. An emergency admission occurs if one or more of the following clinical conditions is evident and requires patient admission within 24 hours:</p> <ul style="list-style-type: none"> <li>• At risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation.</li> <li>• Suffering from suspected acute organ and system failure.</li> <li>• Suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened.</li> <li>• Suffering from a drug overdose, toxic substance or toxin effect.</li> <li>• Experiencing severe psychiatric disturbance</li> </ul> </td></tr> </table>	<b>1 Elective</b>	<p>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.</p> <p>If an admission meets the definition of elective, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission can be delayed by at least 24 hours.</p>	<b>2 Emergency</b>	<p>An emergency admission is an admission of a patient for care or treatment, which, in the opinion of the treating clinician, is necessary and should occur within 24 hours. An emergency admission occurs if one or more of the following clinical conditions is evident and requires patient admission within 24 hours:</p> <ul style="list-style-type: none"> <li>• At risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation.</li> <li>• Suffering from suspected acute organ and system failure.</li> <li>• Suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened.</li> <li>• Suffering from a drug overdose, toxic substance or toxin effect.</li> <li>• Experiencing severe psychiatric disturbance</li> </ul>
<b>1 Elective</b>	<p>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.</p> <p>If an admission meets the definition of elective, it is categorised as elective, regardless of whether the admission actually occurred after 24 hours or more, or it occurred within 24 hours. The distinguishing characteristic is that the admission can be delayed by at least 24 hours.</p>				
<b>2 Emergency</b>	<p>An emergency admission is an admission of a patient for care or treatment, which, in the opinion of the treating clinician, is necessary and should occur within 24 hours. An emergency admission occurs if one or more of the following clinical conditions is evident and requires patient admission within 24 hours:</p> <ul style="list-style-type: none"> <li>• At risk of serious morbidity or mortality and requiring urgent assessment and/or resuscitation.</li> <li>• Suffering from suspected acute organ and system failure.</li> <li>• Suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened.</li> <li>• Suffering from a drug overdose, toxic substance or toxin effect.</li> <li>• Experiencing severe psychiatric disturbance</li> </ul>				

	<p>whereby the health of the patient or other people is at immediate risk.</p> <ul style="list-style-type: none"> <li>• Suffering severe pain where the viability or function of a body part or organ is suspected to be acutely threatened.</li> <li>• Suffering acute significant haemorrhage and requiring urgent assessment and treatment.</li> <li>• Suffering gynaecological or obstetric complications.</li> <li>• Suffering an acute condition which represents a significant threat to the patient's physical or psychological well being.</li> <li>• Suffering a condition which represents a significant threat to public health.</li> </ul> <p>If an admission meets the definition of emergency, it should be categorised as emergency regardless of whether the admission occurred within 24 hours of such a categorisation being made or after 24 hours or more.</p> <p>A patient on a waiting list for elective surgery can be assigned an Admission Category of emergency. For example, the patient was on the elective surgery waiting list for a particular condition. The patient's condition worsened resulting in an emergency admission to hospital for urgent surgery. The Admission Category in this instance should be 'Emergency'.</p>
<b>3 Elective - Booking List</b>	<p>An Elective-Booking List Admission is an admission of a patient from a designated booking list for surgery. Only the following designated booking list hospitals may use the domain "3=Elective-Booking List":</p> <p><b>Metropolitan Hospitals</b></p> <ul style="list-style-type: none"> <li>• Flinders Medical Centre</li> <li>• Lyell McEwin Hospital</li> <li>• Modbury Hospital</li> <li>• Noarlunga Public Hospital</li> <li>• Repatriation General Hospital</li> <li>• Royal Adelaide Hospital</li> <li>• The Queen Elizabeth Hospital</li> <li>• Women's and Children's Hospital</li> </ul> <p><b>Country Hospitals</b></p> <ul style="list-style-type: none"> <li>• Angaston District Hospital</li> <li>• Clare District Hospital</li> <li>• Gawler Health Service</li> <li>• Kangaroo Island General Hospital</li> <li>• Millicent &amp; District Hospital</li> <li>• Mount Barker District Hospital</li> <li>• Mount Gambier &amp; District Hospital</li> <li>• Murray Bridge Soldiers' Memorial Hospital</li> <li>• Naracoorte Health Service</li> <li>• Northern Yorke Pen Regional Health Service</li> <li>• Port Augusta Hospital</li> <li>• Port Lincoln Health Service</li> <li>• Port Pirie Regional Health Service</li> <li>• Riverland Regional Health Service (Berri)</li> </ul>



	<ul style="list-style-type: none"> <li>• South Coast District Hospital</li> <li>• Tanunda War Memorial Hospital</li> <li>• Whyalla Hospital &amp; Health Service</li> </ul> <p>Patients who are removed from elective surgery waiting lists on admission as an emergency patient for the procedure for which they were waiting must be assigned an urgency of admission of '2=Emergency'. See Admission Category - 'Emergency' for further explanation.</p>
<b>4 Not Applicable</b>	<p>Admissions for which an admission category status is not usually assigned. Such admissions include:</p> <ul style="list-style-type: none"> <li>• Admission for normal delivery (obstetric).</li> <li>• Admissions which begin with the birth of the patient, or when it is intended that the birth occur in the hospital, commence shortly after the birth of the patient.</li> <li>• Statistical admissions.</li> <li>• Planned readmissions for the patient to receive limited care or treatment for a current condition for example dialysis, chemotherapy or radiotherapy.</li> </ul> <p>An admission category can be assigned for admissions of the types listed above even though an admission category is not usually assigned. For example, a patient having an obstetric admission may have one or more of the clinical conditions listed above in the emergency definition and therefore should be admitted as an emergency.</p>

*Collection methods:*

**Related ISAAC Edits**

- #4001 – Admission category invalid for statistical admission
- #4002 – Admission category invalid for dialysis patient
- #4003 – Wrong admiss categ for chemo patient
- #4004 – Wrong admiss categ for radiotherapy patient
- #4006 – Wrong admiss categ for normal delivery
- #4007 – Wrong admiss categ for unqual newborn
- #4400 – Admission category invalid

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## Admission Date

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient admission—date of admission, DDMMYYYY
<i>Synonymous names:</i>	ISAAC Data Item 21
<i>SAHMR identifier:</i>	SA1077
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	<p>Date on which an overnight or a sameday patient commences an episode of care by one of the following processes:</p> <ul style="list-style-type: none"> <li>• <b>Formal admission</b> - the administrative process by which a hospital records the commencement of treatment and/or care and accommodation of a patient.</li> <li>• <b>Administrative admission</b> - the administrative process by which a hospital records the start of each episode of care occurring within a hospital stay.</li> </ul>

Data Element Concept: Patient admission—Date of admission

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

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#### Collection and usage attributes

*Guide for use:* Enter the full date of admission in the box provided using the day, month and year and leading zeros where necessary.

For example, if a patient was admitted on 6 March 2011, the date would be entered as follows:

0	6	0	3	2	0	1	1
---	---	---	---	---	---	---	---

*Collection methods:*

#### **Related ISAAC Edits**

#1050 – Date of admission after current date  
 #2000 – Date of admission invalid  
 #4160 – LOS > 92 days  
 #4170 – LOS > 1 day in a day hospital  
 #2010 – Admission date after hospital closure

## Admission Election

### Identifying and definitional attributes

<i>Technical name:</i>	Patient admission—admission election (care type), code N
<i>Synonymous names:</i>	ISAAC Data Item 19
<i>SAHMR identifier:</i>	SA1073
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Indicates the patient's election choice for this admission to hospital. All overnight stay patients and sameday patients must be given the opportunity to elect for private or hospital treatment.

Data Element Concept: Patient admission—Admission election (care type)

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table> <tr> <th>Value</th><th>Meaning</th></tr> <tr> <td>1</td><td>Hospital</td></tr> <tr> <td>2</td><td>Private</td></tr> </table>	Value	Meaning	1	Hospital	2	Private
Value	Meaning						
1	Hospital						
2	Private						

#### Collection and usage attributes

- Guide for use:*
- If election by that patient or a responsible relative cannot be made at the time of admission, or where the patient's private health insurance status cannot be determined, the patient's election may be made retrospectively to the date of admission.
  - At the time that the patient makes an election to be a private or a hospital patient, hospital staff should ensure that the patient is fully aware of the implications of this election choice. Hospital staff may advise patients regarding election, but should not bias the choice.
  - When ascertaining whether the patient has private health insurance, ensure that the patient is covered for "hospital treatment" and not just "extras".
  - This data item is independent from the patient's insurance status. For example, a patient may elect to be admitted as a hospital (Admission Election = 1, Hospital), but the patient may have private health insurance (data item 17, Hospital insurance = 3, Other private health insurance).
  - If a patient election form is not signed by the patient, then the default admission election should be 1 = Hospital.
  - Refer to the [Patient Fees and Charges Manual](#) for further detail on the appropriate admission election for patients with certain types of Funding Source.
  - If patient is DVA (Data Item 95, Funding Source=4), it is mandatory that the Admission Election = 2\_Private.
  - Admission Election is closely connected with data item 95 Funding Source. Refer to Funding Source for additional information

*Collection methods:*

<b>1 Hospital</b>	<p>A Hospital Patient is a person who, on admission to a recognised hospital or soon after, elects to be a public patient treated by <b>a medical practitioner nominated by your hospital.</b></p> <p>Additionally:</p> <ul style="list-style-type: none"> <li>• A public patient shall be entitled to receive the</li> </ul>
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	<p>care and treatment referred to in accordance with the Australian Health Care Agreement without charge.</p> <ul style="list-style-type: none"> <li>Public patients admitted to private hospitals for <u>contracted services</u>, should be recorded with an election of '1-Hospital'.</li> <li>A patient who is eligible under a Reciprocal Health Care Agreement should be admitted with an election of '1-Hospital'.</li> </ul> <p>Persons visiting Australia who are ordinarily resident in the following countries are covered by reciprocal health care agreements (RHCA's): United Kingdom, Ireland, New Zealand, Sweden, Netherlands, Finland, Belgium, Malta*, Italy*.</p> <p><b>* Only covered when visa is for six months or less.</b>  <i>Refer to the Patient Health Care Services Fees and Charges Manual for further information on RHCA's.</i></p>
<b>2 Private</b>	<p>A Private Patient is a person who:</p> <ul style="list-style-type: none"> <li>On admission to a public hospital or soon after, elects to be a private patient treated by a medical practitioner of his or her choice.</li> <li>Who chooses to be admitted to a private hospital.</li> </ul> <p>Where either of these choices are made, the patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner.</p>
<b>Compensable &amp; Non-Medicare Patients</b>	<p><u>Country Hospitals</u>  All Compensable and Non-Medicare patients must be admitted as private in country hospitals which do not employ full-time medical specialist (<i>refer to the <a href="#">Funding Source data item</a> for further definition.</i>)</p> <p><u>Metropolitan Hospitals</u>  <i>Compensable</i> patients admitted to a metropolitan hospital can be admitted as either <i>private or hospital</i> (<i>Refer to the <a href="#">Funding Source data item</a> for further definition.</i>)</p>

#### Data element attributes

#### Collection and usage attributes

*Collection methods:*

#### Related ISAAC Edits

- #4410 – Admission election invalid for private hospital
- #4410a - Admission election invalid for public hospital
- #2585 – Election type not valid with submitted funding source
- #2330 - Incorrect election for funding source type

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## Admission Number

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### Identifying and definitional attributes

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

Data Element Concept: Patient admission—Admission number

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	N(8)
<i>Maximum character length:</i>	8

### Data element attributes

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#### Collection and usage attributes

<i>Collection methods:</i>	<b><u>Related ISAAC Edit</u></b> #4510 – Admission number required
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## Admission Time

### Identifying and definitional attributes

<i>Technical name:</i>	Patient admission—admission time, hhmm
<i>Synonymous names:</i>	ISAAC Data Item 67
<i>SAHMR identifier:</i>	SA1076
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The time at which an overnight stay or sameday patient commences an episode of care by one of the following processes: <ul style="list-style-type: none"> <li>• <b>Formal admission</b> - The administrative process by which a hospital records the commencement of treatment and/or care and accommodation of a patient.</li> <li>• <b>Administrative admission</b> - The administrative process by which a hospital records the start of each episode of care occurring within a hospital stay.</li> </ul>

Data Element Concept: Patient admission—Admission time

### Value domain attributes

### Representational attributes

<i>Representation class:</i>	Time
<i>Data type:</i>	Date/Time
<i>Format:</i>	hhmm
<i>Maximum character length:</i>	4

### Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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### Data element attributes

### Collection and usage attributes

<i>Guide for use:</i>	<p><u>Additional Notes</u>  <b>2400 is NOT a valid time</b>            Any time submitted as 2400 will have the following action taken:</p> <p>Admission Time will be changed to 0000; and            Admission Date will be incremented by 1.</p> <p>Example            Record submitted with:                Admission Time = 2400                Admission Date = 30/09/2011</p> <p>Record is changed to:                Admission Time = 0000                Admission Date = 01/10/2011</p>
<i>Collection methods:</i>	<p><u>Related ISAAC Edits</u>            #2060 – Admission time invalid            #2240 – Admission time &gt; separation time            #4700 – 2400 reset to 0000 and date increased by 1 day</p>

## Admission Type

### Identifying and definitional attributes

<i>Technical name:</i>	Patient admission—predicted length of stay, admission type code N
<i>Synonymous names:</i>	ISAAC Data Item 20
<i>SAHMR identifier:</i>	SA1079
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Indicates the type and duration of care the patient will be receiving based on the principal clinical intent of the care received.
<i>Context:</i>	<b>This field must be used in conjunction with Episode of Care.</b>
Data Element Concept:	Patient admission—Predicted length of stay

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table> <thead> <tr> <th>Value</th><th>Meaning</th></tr> </thead> <tbody> <tr> <td>1</td><td>Ordinary</td></tr> <tr> <td>2</td><td>Long Stay - Acute</td></tr> <tr> <td>3</td><td>Long Stay - Maintenance Care Type</td></tr> </tbody> </table>	Value	Meaning	1	Ordinary	2	Long Stay - Acute	3	Long Stay - Maintenance Care Type
Value	Meaning								
1	Ordinary								
2	Long Stay - Acute								
3	Long Stay - Maintenance Care Type								

### Collection and usage attributes

<i>Guide for use:</i>	<table> <tr> <td><b>Qualifying Period</b></td><td> <ul style="list-style-type: none"> <li>The qualifying period may accrue in a single hospital or two or more hospitals but not in a residential aged care facility. Hospitals in which the qualifying period is accrued may be public or private.</li> <li>Transferring between hospitals has no effect on the qualifying period.</li> <li>Periods of less than seven days out of hospital do not break the qualifying period.</li> <li>If a patient does not enter another hospital within 7 days, their qualifying period restarts on the day of the next admission.</li> <li>Days spent on leave or between separations do not count e.g. a patient who has accrued 20 days then takes three days of leave will start day 21 on return to the hospital.</li> </ul> </td></tr> <tr> <td><b>Transferring to Long Stay Status</b></td><td>Following the completion of the 35-day qualifying period, a status change is to be recorded for the patient, from Ordinary to either a Long Stay-Acute, or Long Stay- Maintenance CareType. This reclassification is based on medical diagnosis.</td></tr> <tr> <td><b>Acute Care Certificates</b></td><td> <ul style="list-style-type: none"> <li>Although completion of the Acute Care Certificate is no longer legislatively mandated by the Commonwealth, SA Health have mandated that clinicians must continue to complete an Acute Care Certificate or similar documentation if they consider the patient to be acute and the patient has met the 35 day long stay, qualifying period. In the event that a dispute should arise between the hospital and health fund in relation to payment of benefits for long stay acute patients, some medical</li> </ul> </td></tr> </table>	<b>Qualifying Period</b>	<ul style="list-style-type: none"> <li>The qualifying period may accrue in a single hospital or two or more hospitals but not in a residential aged care facility. Hospitals in which the qualifying period is accrued may be public or private.</li> <li>Transferring between hospitals has no effect on the qualifying period.</li> <li>Periods of less than seven days out of hospital do not break the qualifying period.</li> <li>If a patient does not enter another hospital within 7 days, their qualifying period restarts on the day of the next admission.</li> <li>Days spent on leave or between separations do not count e.g. a patient who has accrued 20 days then takes three days of leave will start day 21 on return to the hospital.</li> </ul>	<b>Transferring to Long Stay Status</b>	Following the completion of the 35-day qualifying period, a status change is to be recorded for the patient, from Ordinary to either a Long Stay-Acute, or Long Stay- Maintenance CareType. This reclassification is based on medical diagnosis.	<b>Acute Care Certificates</b>	<ul style="list-style-type: none"> <li>Although completion of the Acute Care Certificate is no longer legislatively mandated by the Commonwealth, SA Health have mandated that clinicians must continue to complete an Acute Care Certificate or similar documentation if they consider the patient to be acute and the patient has met the 35 day long stay, qualifying period. In the event that a dispute should arise between the hospital and health fund in relation to payment of benefits for long stay acute patients, some medical</li> </ul>
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<b>Transferring to Long Stay Status</b>	Following the completion of the 35-day qualifying period, a status change is to be recorded for the patient, from Ordinary to either a Long Stay-Acute, or Long Stay- Maintenance CareType. This reclassification is based on medical diagnosis.						
<b>Acute Care Certificates</b>	<ul style="list-style-type: none"> <li>Although completion of the Acute Care Certificate is no longer legislatively mandated by the Commonwealth, SA Health have mandated that clinicians must continue to complete an Acute Care Certificate or similar documentation if they consider the patient to be acute and the patient has met the 35 day long stay, qualifying period. In the event that a dispute should arise between the hospital and health fund in relation to payment of benefits for long stay acute patients, some medical</li> </ul>						

	<p>evidence will be available.</p> <ul style="list-style-type: none"> <li>SA Health have produced generic Acute Care Certificates which are available for purchase via the SA Health Distribution Centre Ph (08) 8350 4160 Fax: (08) 8350 4161.</li> </ul>
<b>Maintenance Care Type Patients</b>	<p>This judgement is made in respect to the principal condition i.e. the main cause of hospitalisation. Thus, an elderly infirm patient not expected to recover sufficiently to leave the hospital must be classed as Maintenance Care. If a secondary condition requiring medical attention from a doctor (such as a broken limb) the Maintenance care patient can be reclassified as long stay acute. See section Transferring to Long Stay Acute.</p> <p>If a patient is classified as Acute Type, a portion of the fees (the "patient contribution") is automatically waived for the duration of the certificate. This does not affect the Board of Management's authority to remit all or part of any other patient's fees in cases of hardship - refer to the Monthly Management Summary Guidelines for further details on remission of fees.</p> <p>It should be noted that classification as Acute Type relates to the present and expected future prognosis of the patient, and cannot be made retrospectively, nor taken as altering any past liability of the patient to pay fees.</p> <p><b>Transferring to long stay acute</b></p> <p>The only circumstance in which a Maintenance care patient can be re-classified as Acute Type is when there is a revision of the doctor's opinion regarding prognosis.</p> <p>This may occur under two circumstances:</p> <ul style="list-style-type: none"> <li>Where the doctor's original opinion regarding the main cause of the patient's hospitalisation is revised; or</li> <li>Where a secondary condition requiring medical attention develops. This may occur within the hospital where the patient is currently admitted, or within transfers between hospitals.</li> </ul> <p>When a patient transfers from Long Stay Maintenance Care Type to Long Stay Acute, it is also a change in episode of care. Refer also 'episodes of care'.</p> <p><i>Every effort should be made to source more suitable community based accommodation for patients who are not acute after 35 days.</i></p> <p><b>Example 1</b></p> <p>A patient is admitted to hospital and after the 35 day qualifying period, is classified as a <i>Long Stay Maintenance Care</i> Type patient. The patient is not expected to recover sufficiently to be discharged from hospital. During hospitalisation the patient develops bronchopneumonia (which due to the patient's age has complications). The doctor may issue an Acute Care Certificate and authorise the patient to be transferred to <i>Long Stay Acute</i> classification.</p> <p>Once the patient has recovered from the bronchopneumonia (i.e. they are no longer in need of acute care), they will revert back to the <i>Long Stay Maintenance Care Type</i> classification.</p>



	<p><b>Example 2</b></p> <p>A patient is admitted to hospital and after the 35 day qualifying period is classified as a <i>Long Stay Maintenance Care Type</i> patient. During their hospitalisation at Hospital A, the patient falls, breaking their hip, necessitating a transfer to Hospital B for a hip replacement. Hospital B may admit the patient as a <i>Long Stay Acute</i> and issue an Acute Care Certificate. If the patient still requires post-operative care on return to Hospital A, then Hospital A may admit them as Long Stay-Acute. When the patient is deemed no longer acute, they should return to <i>Maintenance Care Type</i>.</p>
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### Data element attributes

#### Collection and usage attributes

Guide for use:

<b>1 Ordinary</b>	<p>A patient who has not yet reached 35th day of stay and is neither Long Stay Acute or Long Stay Maintenance Care Type.</p> <p>A patient can be classified as ordinary regardless of their Episode of Care.</p> <p>Compensable, Non-Medicare and Overseas-RHCA patients remain as Ordinary patients regardless of their length of stay.</p>
<b>2 Long Stay-Acute</b>	<p>A Long Stay-Acute is a patient who is receiving acute care and has a length of stay greater than 35 days. Refer Episode of Care for definition of acute.</p> <p>Compensable, Non-Medicare and Overseas-RHCA patients <u>cannot</u> have an admission type of Long Stay – Acute.</p> <p>Effective 1 April 2007, The Commonwealth Department of Health and Ageing are no longer providing 3B Acute Care Certificates for completion for patients transferring to Long Stay – Acute. SA Health have produced a generic Acute Care Certificate which is available for purchase via the SA Health Distribution Centre (08) 8350 4160 Fax (08) 8350 4161. SA Health still mandate the completion of the Acute Care Certificate for acute patients who have met the 35 day long stay qualifying period.</p>
<b>3 Long Stay-Maintenance Care Type</b>	<p>A Long Stay- Maintenance Care Type: If a patient is not deemed acute after 35 days then the patient should default to Long Stay-Maintenance. For patients 65 and over this includes an ACAT assessment, while for patients under 65 this includes access to specialist disability services. An ACAT assessment is not a requirement for being allocated to the Long Stay-Maintenance category.</p> <p>Compensable, Non-medicare and Overseas-RHCA patients cannot have an admission type of Long Stay – Maintenance Care Type.</p>

Collection methods:

Related ISAAC Edits

#4420 – Admission type invalid

#2340 – LOS > 35 days, ensure patient is long stay

#2341– Admission type and episode of care incompatible

## Admission weight

### Identifying and definitional attributes

<i>Technical name:</i>	Neonates—admission weight, total grams NNNN
<i>Synonymous names:</i>	ISAAC Data Item 11
<i>SAHMR identifier:</i>	SA1067
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Record the neonates' weight in grams. <b>This item is mandatory for:</b> All babies aged 28 days or less at the time of admission; and babies aged less than 365 days whose weight is less than 2,500 grams.

Data Element Concept: Neonates—Admission weight

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

### Data element attributes

#### Collection and usage attributes

<i>Guide for use:</i>	<ul style="list-style-type: none"> <li>• If a neonate is born in hospital during a current admission, then the admission weight is the birth weight.</li> <li>• For neonates born elsewhere or born during a mother's previous admission to hospital, the admission weight is the neonate's weight on admission.</li> <li>• Each change in episode of care while the patient is less than 10 days old should have the birth weight or initial admission weight recorded. There is no need to re-weigh the baby.</li> <li>• The inclusion of this data item does not mean that all neonates can be admitted. Refer to Episode of Care - Qualified/Unqualified, for more information regarding admitting neonates.</li> </ul>
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*Example of Use*      Leading zeros should be used when necessary.  
If the neonates weight is 405 grams, enter the data as:

0	4	0	5
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*Collection methods:*      **Related ISAAC Edits**

#2170 – Admission weight required for baby  
 #4350 – Baby weight < 400 grams and retain submitted value  
 #4360 – Baby weight > 6000 grams and retain submitted value  
 #4340 – Admission weight set to blank-patient not baby

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## Adult / Child flag (WCH only)

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient— adult / child flag (WCH only), code [A]
<i>Synonymous names:</i>	ISAAC Data item 86
<i>SAHMR identifier:</i>	SA1090
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	This item indicates if the patient is a child or not.
<i>Context:</i>	This item is <b>mandatory for the Women's and Children's Hospital only</b> . All other hospitals should submit this item as a blank, (stored as 'N' on ISAACII) For paper submission hospitals, who print their own ISAAC form, there is no need to include this item on the form. This item is used in calculating casemix funding for paediatric episodes.
Data Element Concept:	Patient—Age classification

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	String						
<i>Format:</i>	A						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table> <tr> <th>Value</th><th>Meaning</th></tr> <tr> <td>C</td><td>Child</td></tr> <tr> <td>O</td><td>Other</td></tr> </table>	Value	Meaning	C	Child	O	Other
Value	Meaning						
C	Child						
O	Other						

#### Collection and usage attributes

*Guide for use:*

### Data element attributes

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#### Collection and usage attributes

<i>Collection methods:</i>	<b>Related ISAAC Edits</b> #4680 – Adult/child flag required #4670 – Adult/child flag invalid #4730 – Adult/child flag not required
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## Clinical Unit Code

### Identifying and definitional attributes

<i>Technical name:</i>	Clinical unit—designation of unit, code NNN
<i>Synonymous names:</i>	ISAAC Data Item 2
<i>SAHMR identifier:</i>	SA407
<i>Registration status:</i>	SA Health, Standard 01/07/1985
<i>Definition:</i>	To identify the clinical unit under which the patient is admitted.

Data Element Concept: Clinical unit—Clinical designation of unit

### Value domain attributes

### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNN
<i>Maximum character length:</i>	3

### Collection and usage attributes

- Guide for use:*
- Hospitals may choose to develop their own Clinical Unit Codes but must then map these to the SA Health Codes.
  - Discussion between ISAAC Unit and individual hospitals is necessary before allocating any of the "reserved" numbers. This allows for consistency in definition.
  - ISAAC Unit should be advised by a hospital when the hospital begins to use clinic codes.

Additional Notes	<p>The main reasons for using standard clinic codes are:</p> <ul style="list-style-type: none"><li>• For studies where total patients seen by a specialty in one institution are compared with patients of the specialty seen in other institutions.</li><li>• For edit/audit checks by the system. That is, ensuring patients with orthopaedic disease codes do not have a clinic code for obstetrics.</li></ul> <p>Hospitals which do not have defined clinics should record the clinic code as "000".</p> <p>The first digit is reserved to identify a doctor within a code. Hospitals wishing only to identify a clinic should enter the two-digit code with a leading zero. Hospitals wishing to identify a particular group or doctor within a clinic may use a digit from 1-9 to precede the two digit Clinic code.</p> <p>Lists showing the individual doctors' names should NOT be supplied to ISAAC Unit.</p> <p>Example of identifying doctor:</p> <table><tr><th colspan="3">Dr X Cardiology</th><th colspan="3">Dr Y Cardiology</th><th colspan="3">No Doctor Identified</th></tr><tr><td>1</td><td>1</td><td>2</td><td>2</td><td>1</td><td>2</td><td>0</td><td>1</td><td>2</td></tr></table>	Dr X Cardiology			Dr Y Cardiology			No Doctor Identified			1	1	2	2	1	2	0	1	2
Dr X Cardiology			Dr Y Cardiology			No Doctor Identified													
1	1	2	2	1	2	0	1	2											
Mental Health Service Clinics	Within Glenside Health Services, patients are admitted to distinct wards to receive a specific type of care, i.e. acute, intensive care, rehabilitation, etc. Clinic codes are therefore assigned according to the ward to which the patient is admitted.																		
Additional Notes for	A transfer to another ward of a different type of care will necessitate a change in the episode of care, requiring an																		

Mental Health	<p>administrative discharge and an administrative admission. Refer section on episodes of care.</p> <p>Glenside Health Services Clinic Types &amp; ISAAC Clinical Unit Codes are available on the ISAAC website <a href="http://www.sahealth.sa.gov.au/isaac">www.sahealth.sa.gov.au/isaac</a>, click on 'Integrated SA Activity Collection (ISAAC) Resources' tab: <i>Glenside Wards &amp; ISAAC Clinical Unit Codes</i>.</p>
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## Data element attributes

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Collection methods:

### **Related ISAAC Edits**

#4370 – Clinic code invalid

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## Condition Onset Flag

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—condition onset flag, code N
<i>Synonymous names:</i>	Data Item 92, 97, 98, 99
<i>SAHMR identifier:</i>	SA1093
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	A qualifier for each coded diagnosis (including external cause, activity and place of occurrence) to indicate if the onset of the condition occurred during the episode of admitted patient care, as represented by a code.
<i>Context:</i>	Reporting of the Condition Onset Flag for each reported diagnosis code is mandatory for all separations from 1 July 2008. The focus of the Condition Onset Flag is to identify those conditions that arise during the episode of admitted patient care. The Condition Onset Flag exists in the Admitted Patient National Minimum Data Set and is mandated for reporting under the Australian Health Care Agreement and the National Health Information Agreement.
Data Element Concept:	Patient—Condition onset flag

### Data element attributes

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### Collection and usage attributes

<i>Guide for use:</i>	<ul style="list-style-type: none"> <li>• <b>An additional field has been included on the ICD-10-AM reference file from 1 July 2013, indicating the valid COF, where appropriate.</b></li> <li>• The principal diagnosis should always have a Condition Onset Flag of 2, except that from 1 July 2013 a COF of '1' or '2' is allowed for a neonate principal diagnosis.</li> <li>• The Flag on Z codes related to outcome of delivery on the mother's record (Z37), should always be assigned a value of 2. While the outcome of delivery is not known until after the commencement of the episode of admitted patient care, its onset is not during the episode.</li> <li>• The Flag on Z codes related to the outcome of delivery on the baby's record (Z38) should always be assigned a value of 2.</li> <li>• Assign the relevant Condition Onset Flag to each ICD-10-AM diagnosis code assigned to the principal diagnosis and additional diagnosis/es fields.</li> <li>• The sequencing of diagnosis codes must comply with the Australian Coding Standards and therefore diagnosis codes should not be re-sequenced in an attempt to list diagnosis codes with the same Condition Onset Flag together.</li> <li>• When it is difficult to decide if a condition was present at the beginning of the episode of admitted patient care or if it arose during the episode, assign a value of "2-Condition not noted as arising during the episode of admitted patient care".</li> <li>• The Flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code.</li> <li>• When a single diagnosis code describes a condition and that code contains more than one concept (e.g. diabetes with renal complications) and each concept within that code has a different Condition Onset Flag, then assign a value of 2.</li> <li>• When a condition requires more than one diagnosis code to describe it, it is possible for each diagnosis code to have a different Condition Onset Flag.</li> <li>• The supplementary value of 9 is only applicable for hospitals where the data element is not captured due to limitations in the data management system, and is not applied when coding the admitted patient record e.g. records prior to 1 July 2008.</li> </ul>
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<b>1 Condition with onset during the episode of admitted care</b>	<p>A condition which arises during the episode of admitted patient care and would not have been present on admission.</p> <p>Includes:</p> <ul style="list-style-type: none"> <li>• Conditions resulting from misadventure during medical or surgical care during the episode of admitted patient care.</li> <li>• Abnormal reactions to, or later complication of, surgical or medical care arising during the episode of admitted patient care.</li> <li>• Conditions arising during the episode of admitted patient care not related to surgical or medical care (for example, pneumonia).</li> </ul>
<b>2 Condition not noted as arising during the episode of admitted patient care</b>	<p>A condition present on admission such as the presenting problem, or co-morbidity, chronic disease or disease status. A previously existing condition not diagnosed until the episode of admitted patient care.</p> <p>Includes:</p> <ul style="list-style-type: none"> <li>• In the case of the neonates, the conditions present at birth.</li> <li>• A previously existing condition that is exacerbated during the episode of admitted patient care.</li> <li>• Conditions that are suspected at the time of admission and subsequently confirmed during the episode of admitted patient care.</li> <li>• Conditions that were not diagnosed at the time of admission but clearly did not develop after admission (for example, malignant neoplasm).</li> <li>• Conditions where the onset relative to the beginning of the episode of admitted patient care is unclear or unknown.</li> </ul> <p>The principal diagnosis should always have a Condition Onset Flag of 2, except that from 1 July 2013 a COF of '1' or '2' is allowed for a neonate principal diagnosis</p>
<b>9 Not Reported</b>	<p>The Condition Onset Flag could not be reported due to limitations of the data management system.</p>

Collection methods:

#### **Related ISAAC Edits**

#2770 - Invalid condition onset flag

#2771 - PDX condition onset flag must be 2 for non-neonates

#4963 - Condition exists prior to admission, COF should be "2"

#4964 - Condition onset during admission, COF should be "1"

#4868 - COF should be "1" for puerperium additional diag

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## Contract admission date

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient admission (contract service)— date of event, DDMMYYYY
<i>Synonymous names:</i>	ISAAC Data Item 64
<i>SAHMR identifier:</i>	SA1071
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The date the patient is admitted to the destination hospital for the contracted service or Component of Care.
 Data Element Concept:	 Patient admission (contract service)—Date of event

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

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#### Collection and usage attributes

<i>Guide for use:</i>	Enter the full date of admission in the box provided using the day, month and year and leading zeros where necessary. For example, if a patient was admitted on 6 March 2011, the date would be entered as follows:
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0	6	0	3	2	0	1	1
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<i>Collection methods:</i>	<b><u>Related ISAAC Edits</u></b> #4580 – Contract admission date invalid
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## Contracted hospital patient unit number

### Identifying and definitional attributes

<i>Technical name:</i>	Patient admission (contract service)-patient unit record number, identifier N(10)
<i>Synonymous names:</i>	ISAAC Data Item 63
<i>SAHMR identifier:</i>	SA1070
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The patient unit record number of the destination hospital, i.e. the hospital providing the contracted service or Component of Care.

Data Element Concept: Patient admission (contract service)-patient unit number

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	N(10)
<i>Maximum character length:</i>	10

#### Collection and usage attributes

- Guide for use:*
- The use of a unit record numbering system is a prerequisite of the system.
  - Any one patient should have only one Unit Record Number at any one hospital. Conversely, the issuing of the same number to more than one patient should not occur.
  - The same number should be used for the same patient on all admissions; the number should not be allocated to any other patient.
  - Though a patient may die or not receive treatment for a considerable period of time, with the medical record being moved to an inactive filing area, the Unit Record Number should NOT be reused for any other patient.
  - Enter the number assigned to the patient by your hospital. A maximum of 10 digits is allowed. Use numbers only. The unit record number should be entered as follows, using leading zeros where necessary:

eg UR No. 537859

0	0	0	5	3	7	8	5	9
---	---	---	---	---	---	---	---	---

eg. UR No. 76543210

0	7	6	5	4	3	2	1	0
---	---	---	---	---	---	---	---	---

### Data element attributes

#### Collection and usage attributes

<i>Collection methods:</i>	<b><u>Related ISAAC Edits</u></b>
	#4570 – Contract patient UR invalid or same as sent hospital
	#4561 - Contracted service - details not complete
	#4562 - Contracted Service - hospital code required.

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## Contracted Service Hospital

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### Identifying and definitional attributes

<i>Technical name:</i>	Contract service—Contract service name, hospital code NNNN
<i>Synonymous names:</i>	ISAAC Data Item 65
<i>SAHMR identifier:</i>	SA1052
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The hospital code of the originating hospital or the destination hospital providing the a contracted service or Component of Care.

Data Element Concept: Contract service—Contract service name

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

#### Collection and usage attributes

*Guide for use:* Enter the code number for your hospital in the box provided and the hospital name immediately to the right. **This is a mandatory data item.**

A code list for all hospitals in South Australia is available on the ISAAC website [www.sahealth.sa.gov.au/isaac](http://www.sahealth.sa.gov.au/isaac), click on 'Integrated SA Activity Collection (ISAAC) Resources' tab: *Hospital Listing – alpha* and *Hospital Listing – numeric*. Public hospitals have three digit codes and require a leading zero. The number should be entered as follows:

0	1	0	6
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Private hospitals, including day surgery facilities, have four digit codes beginning with a '4', and should be entered as follows:

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

### Data element attributes

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#### Collection and usage attributes

*Collection methods:*

#### **Related ISAAC Edits**

- #4560 - Contract Hospital invalid or same as sent hospital
- #4561 - Contracted service - details not complete
- #4562 - Contracted service - hospital code required

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## Country of birth

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—country of birth, code NNNN
<i>Synonymous names:</i>	ISAAC data Item 10
<i>SAHMR identifier:</i>	SA1094
<i>Registration status:</i>	SA Health, Candidate 31/10/2011
<i>Definition:</i>	The country in which the patient was born.

Data Element Concept: Patient—Country of birth

### Value domain attributes

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### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

### Collection and usage attributes

*Guide for use:* Enter the country code from the reference file as follows, using leading zeros where necessary:

3	1	0	4	<b>Italy</b>
1	1	0	1	<b>Australia</b>
0	0	0	3	<b>Not Stated</b>

### Data element attributes

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### Collection and usage attributes

<i>Guide for use:</i>	<b>Refer to ISAAC Reference file - Country of Birth codes</b>
<i>Collection methods:</i>	<b><u>Related ISAAC Edit</u></b>
	#4020 - Country of birth code invalid
	#4205 - Aboriginal or TSI patient-check country of birth
	#4022 - COB has changed since last episode of care

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## Date of birth

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—date of birth, DDMMYYYY
<i>Synonymous names:</i>	ISAAC Data Item 9
<i>SAHMR identifier:</i>	SA1095
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The date of birth of the patient
<i>Data Element Concept:</i>	Patient—Date of birth

### Value domain attributes

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### Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

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### Collection and usage attributes

*Guide for use:* Enter the patient's full date of birth using day, month and year and leading zeros where necessary. For example, record a patient born on 5 July 1946 as:

0	5	0	7	1	9	4	6
---	---	---	---	---	---	---	---

Use the default of 1st July 1890 (01/07/1890) when a Date of Birth for a patient is unknown.

- If only the day of birth is unknown, use 01;
- If only the month of birth is unknown, use 07;
- If the day and month of birth is unknown, use 0107;
- If year of birth is unknown, estimate the year of birth from the patient's age and use 01 as the default day and 07 as the month, e.g. 0107YYYY.
- The Date of Birth Accuracy Flag is also used in conjunction with this item. The Date of Birth Accuracy Flag must also be set to '2 - estimate/incomplete'.

### Collection methods:

#### **Related ISAAC Edits**

#2040 – Date of birth invalid  
 #2050 – Date of birth after admission date  
 #4690 – Day and month of birth missing  
 #4180 – Age > 100 years.  
 #2250 – Age > 124 years, check DOB  
 #4691 - DOB has changed since last episode of care  
 #4789 - DOB Accuracy flag must be 2 if DOB is 01/07/1890

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## Date of Birth Accuracy Flag

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—accuracy of date (birth), code N
<i>Synonymous names:</i>	ISAAC Data Item 91
<i>SAHMR identifier:</i>	SA1091
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Indicates whether the date of birth is accurate or whether any part of the date of birth is not known.
 Data Element Concept:	 Patient—Accuracy of date (birth)

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table> <thead> <tr> <th>Value</th><th>Meaning</th></tr> </thead> <tbody> <tr> <td>1</td><td>Accurate (Default Value)</td></tr> <tr> <td>2</td><td>Estimate/Incomplete</td></tr> </tbody> </table>	Value	Meaning	1	Accurate (Default Value)	2	Estimate/Incomplete
Value	Meaning						
1	Accurate (Default Value)						
2	Estimate/Incomplete						

### Data element attributes

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#### Collection and usage attributes

<i>Guide for use:</i>	<ul style="list-style-type: none"> <li>• If the date of birth is known record '1 – Accurate'.</li> <li>• If the date of birth is unknown, estimate the year of birth from the patient's age and use 30th June as the default day and month, e.g. 3006YYYY. The Date of Birth Accuracy Flag will be '2 - estimate/incomplete'.</li> </ul>
<i>Collection methods:</i>	<a href="#">Related ISAAC Edits</a> #4790 – DOB accuracy flag invalid

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## Diagnoses - Additional

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**Identifying and definitional attributes**

<i>Technical name:</i>	Patient—diagnosis type(s) - additional, code AN[NNN]
<i>Synonymous names:</i>	ISAAC Data Item 46
<i>SAHMR identifier:</i>	SA1096
<i>Registration status:</i>	SA Health, Standard 24/04/2013

Data Element Concept: Patient—Diagnosis type(s) – additional

**Value domain attributes****Representational attributes**

<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	AN[NNN]
<i>Maximum character length:</i>	5

**Collection and usage attributes**

<i>Guide for use:</i>	Format for Clinical Data Submission	<p>The submission of ICD-10-AM codes must be recorded in the following format:</p> <ul style="list-style-type: none"> <li>• Without decimal points</li> <li>• Include lead alpha characters</li> <li>• Record codes in sequence order</li> <li>• Left justify, blank fill</li> <li>• Where there is no 4th digit, but a 5th digit is required use "0" as a filler</li> </ul>
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For example, secondary conditions are entered as:

P 1 2 3                      M 2 3 4 5                      S 4 5 0 1

Hospitals submitting information to ISAAC electronically must refer to ISAAC reference table - record format for magnetic media for the correct format of the data.

**Data element attributes****Collection and usage attributes**

<i>Guide for use:</i>	<p>A maximum of 25 diagnosis codes from the appropriate code version may be recorded as additional conditions, according to the SA Morbidity Coding Standards.</p> <p>Duplicate diagnosis codes are unacceptable.</p>
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*Collection methods:***Related ISAAC Edits**

- #2520 - Additional diagnosis code invalid
- #4800 - Diagnosis not compatible with sex
- #4810 - Diagnosis not compatible with age
- #4900 - Duplicate diagnosis codes - duplicate deleted

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## Diagnosis - Principal

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—diagnosis type, code AN[NNN]
<i>Synonymous names:</i>	ISAAC Data Item 45
<i>SAHMR identifier:</i>	SA1097
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The diagnosis of the patient. Refer to ICD-10AM.

Data Element Concept: Patient—Diagnosis type – principal

### Value domain attributes

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### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	AN[NNN]
<i>Maximum character length:</i>	5

### Collection and usage attributes

<i>Guide for use:</i>	Format for Clinical Data Submission	<p>The submission of ICD-10-AM codes must be recorded in the following format:</p> <ul style="list-style-type: none"> <li>• Without decimal points</li> <li>• Include lead alpha characters</li> <li>• Record codes in sequence order</li> <li>• Left justify, blank fill</li> <li>• Where there is no 4th digit, but a 5th digit is required use "0" as a filler</li> </ul>
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For example, secondary conditions are entered as:

P 1 2 3                      M 2 3 4 5                      S 4 5 0 1

Hospitals submitting information to ISAAC electronically must refer to ISAAC reference table - record format for magnetic media for the correct format of the data.

### Data element attributes

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### Collection and usage attributes

<i>Guide for use:</i>	<p>A single ICD-10-AM diagnosis code from the appropriate code version for the principal diagnosis, according to the SA and Australian Coding Standards. <b><u>Every separation MUST have a principal diagnosis code assigned.</u></b></p>
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#### Assignment of principal diagnosis for newborn episodes of care

- Each newborn hospitalisation must be reported to ISAAC. Refer sections on episodes of care. The final ISAAC record indicating the 'real' discharge must contain all the ICD-10-AM codes to describe all the episodes of care within the single period of hospitalisation.
- If there is only a SINGLE episode of care, then this record will contain ALL the ICD-10-AM codes, regardless of whether it is unqualified or qualified.
- Alternatively, if the newborn has multiple episodes of care for the one period of hospitalisation, ONLY THE FINAL EPISODE OF CARE RECORD must contain all the ICD-10-AM codes assigned according to the SA and Australian Coding Standards.
- Submission of newborn episodes of care records may be on an episode

- basis or following formal discharge at the end of the hospitalisation period.
- The ISAAC database will link all unqualified and qualified episodes belonging to a newborn's single stay in hospital, identified by the admission number.

Please note, that **the principal diagnosis must always have associated Condition Onset Flag = "2"** - Condition not noted as arising during the episode of admitted patient care". ISAAC edits will enforce a default of "2" for the principal diagnosis

### *Collection methods:*

#### **Related ISAAC Edits**

- #2500 – Principal diagnosis invalid
- #2510 – Code not acceptable as principal diagnosis
- #2560 – Operative intervention with normal delivery
- #4800 – Diagnosis not compatible with sex
- #4810 – Diagnosis not compatible with age



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## DOTTDL

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### Identifying and definitional attributes

<i>Short name:</i>	Episode of care - transfer to discharge lounge, date DDMMYYYY
<i>Synonymous names:</i>	ISAAC Data Item 52
<i>SAHMR identifier:</i>	SA1010
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The date the patient was transferred to the Discharge/Transit Lounge during their hospital admission.
Data Element Concept:	Episode of care - transfer to discharge lounge

### Value domain attributes

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### Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

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### Collection and usage attributes

<i>Guide for use:</i>	<ul style="list-style-type: none"> <li>This information is used to calculate the percentage of overnight stay separations that occur before 11am as a proportion of all overnight stay separations.</li> <li>The percentage serves as a key performance indicator for hospitals and is reported to the Portfolio Performance Review Committee and the Emergency Access Taskforce as of the Health Performance Agreements between SA Health and the Regions.</li> </ul>
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### Collection methods:

#### **Related ISAAC Edits**

- #2761 – DOTTDL must be accompanied by TOTTDL
- #2762 – TOTTDL must be accompanied by DOTTDL
- #2763 – Transfer to D/C Lounge Date before Adm. Date.
- #2764 – Transfer to D/C Lounge Date after Sep. Date.

## Employment Status

### Identifying and definitional attributes

<i>Technical name:</i>	Patient—employment status, code N
<i>Synonymous names:</i>	ISAAC Data Item 88
<i>SAHMR identifier:</i>	SA1100
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Indicates the employment status immediately prior to admission, as reported by the patient and as defined by the categories given.

Data Element Concept: Patient—Employment status

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Child not at school
	2	Student
	3	Employed
	4	Unemployed
	5	Home duties
	6	Other
<i>Supplementary values:</i>	9	Unknown (Default Value)
	0	Not applicable

#### Collection and usage attributes

<i>Guide for use:</i>	<b>1 Child Not at School</b>	Includes pre-school children and handicapped children under 16 not otherwise employed.
	<b>2 Student</b>	Child at school; Full-time or with study occupying > 20 hours per week or more. If less than 20 hours study and does not fit into any other category record Status as '6-Other'.
	<b>3 Employed</b>	Employed (part-time or full-time); self-employed; employer.
	<b>4 Unemployed</b>	Unemployed, whether looking for work or not OR receiving unemployment benefits or not.
	<b>5 Home Duties</b>	Use this when it is the sole role of the patient.
	<b>6 Other</b>	Includes retired persons and/or pensioner; volunteers.
	<b>9 Unknown</b>	The patient's employment status is unknown.
	<b>0 Not Applicable</b>	Patient is not a psychiatric admission of the designated psychiatric units listed below.

### Data element attributes

#### Collection and usage attributes

*Guide for use:* This item is only mandatory for patients admitted to a psychiatric unit at designated metropolitan, public hospitals. (Refer to Additional Notes).

*Collection methods:* **Related ISAAC Edits**  
#4760 – Employment status invalid

*Comments:* **Additional Notes**

Record the appropriate value as reported by the patient. The collection of this data item is mandatory for patients admitted to a designated psychiatric unit at the following hospitals:

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

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

## Episode of care code

### Identifying and definitional attributes

<i>Technical name:</i>	Episode of care—nature of episode, code N
<i>Synonymous names:</i>	ISAAC Data Item 51
<i>SAHMR identifier:</i>	SA1056
<i>Registration status:</i>	SA Health, Standard 01/07/2015
<i>Definition:</i>	The overall nature of a clinical service provided to an admitted patient during an episode of care (admitted care) or the type of service provided by the hospital for posthumous organ procurement (care other than admitted care), as represented by a code
<i>Context:</i>	The majority of patients enter hospital for a specific condition, receive a specific service and are then discharged. However, there are other patients whose treatment pattern is more complex. These patients enter hospital and undergo two or more phases of treatment within the one hospital stay. These different phases of treatment are referred to as <i>episodes of care</i> , and are designed to reflect the changing diagnosis and/or treatment of the patient. It does not refer to each individual bed day. An <i>episode of care</i> ends when the care <i>type</i> changes, or the patient separates from hospital.

An *episode of care* is a phase of treatment within a single stay in hospital described by one of the following *care types* (*data item 51*):

Acute	Rehabilitation	Hospital at Home
Maintenance Care	Unqualified newborn	Psychogeriatric
Palliative	Qualified newborn	Geriatric Evaluation and Management
Mental Health Acute	Mental Health Maintenance Care	Mental Health Rehabilitation
Mental Health Psychogeriatric Care	Posthumous Organ Procurement	

An episode of care is also required for posthumous organ procurement activity.

The *type of care*, i.e. acute or rehabilitation etc. must be provided for a minimum period of 24 hours to warrant a change in care type (referred to as an *administrative separation/admission*). There are several exceptions to this rule:

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

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

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

Data Element Concept: Episode of care—Nature of episode

### Value domain attributes

#### Representational attributes

Representation class: Code  
 Data type: Number  
 Format: N  
 Maximum character length: 1  
 Permissible values:

Value	Meaning
1	Acute
2	Maintenance Care
3	Palliative Care
4	Rehabilitation
5	Unqualified Newborn
6	Qualified Newborn
7	Hospital at Home / Rehab at Home
8	Psychogeriatric Care
9	Geriatric Evaluation and Management
I	Mental Health Acute
J	Mental Health Maintenance Care
K	Mental Health Rehabilitation
L	Mental Health Psychogeriatric Care
P	Posthumous Organ Procurement

### Data element attributes

#### Collection and usage attributes

Guide for use:

<b>1 Acute</b>	<p>'Acute care' excludes care which meets the definition of mental health care.</p> <p>An acute episode of care for an admitted patient is one in which the primary clinical purpose or treatment goal is one or more of the following:</p> <ul style="list-style-type: none"> <li>• Manage labour (obstetric)</li> <li>• Cure illness or provide definitive treatment of injury</li> <li>• Perform surgery</li> <li>• Relieve symptoms or illness or injury (excluding palliative care)</li> <li>• Reduce severity of an illness or injury</li> <li>• Protect against exacerbation and/or complication of an illness and/or injury which could threaten life or normal function and/or</li> <li>• Perform diagnostic or therapeutic procedures</li> </ul>
<b>2 Maintenance Care (formerly known as Nursing Home Type Care)</b>	<p><b>Related Item</b></p> <p>'Maintenance care' excludes care which meets the definition of mental health care.</p> <p>Maintenance (or non-cute) care is care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition. Following assessment or treatment the patient does not require further complex assessment of stabilisation. Patients with a care type of maintenance care often require care over an indefinite period.</p>

	<p>The Maintenance Care episode of care is closely related to Admission Type (data item 20). If a patient's Episode of Care is 2, Maintenance Care the Admission Type must be either:</p> <ul style="list-style-type: none"> <li>1 - Ordinary; or</li> <li>3 - Long stay – Maintenance Care Type</li> </ul> <p>Reporting of the information in this manner will ensure the correct budget allocations are made for Maintenance Care patients. All end of quarter discharges of this nature must be submitted within the end of quarter reporting deadline to ISAAC. Refer Casemix Funding Technical Bulletin 94.6, Reporting Requirements.</p> <p><b>Principal Diagnosis for Maintenance Care Patients</b></p> <p>All Maintenance Care Patients are assigned a principal diagnosis as detailed in the SA Morbidity Coding Standards and Guidelines of <b>Z75.x</b>. Patient Casemix Reports or Attestations are not required to be completed for Maintenance Care episodes of care. (Refer Casemix Funding Technical Bulletin 94:3 - Clinical Information Reporting Requirements). On the final separation for a Maintenance patient (i.e. patient is transferred or expires), report the Principal Diagnosis as Z75x. All other conditions can be captured as additional diagnoses, but this optional.</p> <p><b>End of Quarter Maintenance Care Patient Reporting</b></p> <p>Casemix funding for public hospitals requires public hospitals to provide additional information to ensure that each quarter, appropriate funding is provided. All Maintenance Care patients (episode of care = 2, Maintenance Care) and other patients as formally approved in writing by the Funding Models Unit (e.g. some specific Mental Health patients), who are an in-patient at the end of the quarter in a public hospital are required to be administratively discharged from the Maintenance Care episode of care and administratively readmitted to the Maintenance Care episode of care. This requires completion of a new ISAAC form, however, the patient will retain the same admission number. The discharge date and subsequent admission date will be the same, however, the admission time should be 1 minute later than the time of discharge. (example scenario listed in Appendix 4)</p> <p><b>Multi-Purpose Service (MPS) Reporting</b></p> <p>Effective 1/03/2009 activity for Maintenance Care patients occupying an MPS bed in one of the following designated Country hospitals should not be reported to ISAAC regardless of their MPS arrangement start date. If you require any further information regarding the MPS program contact Country Health SA.</p> <ul style="list-style-type: none"> <li>• Cummins &amp; District Memorial Hospital</li> <li>• Kingston Soldiers Memorial Hospital</li> <li>• Meningie &amp; District Memorial Hospital</li> <li>• Tailem Bend District Hospital</li> <li>• Tumby Bay Hospital</li> <li>• Waikerie Hospital &amp; Health Service</li> <li>• Burra Hospital</li> <li>• Coober Pedy Hospital</li> <li>• Crystal Brook District Hospital</li> <li>• Hawker Memorial Hospital</li> <li>• Laura &amp; District Hospital</li> <li>• Leigh Creek Hospital</li> <li>• Penola War Memorial Hospital</li> <li>• Quorn Health Service</li> </ul>
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	<ul style="list-style-type: none"> <li>• Snowtown Memorial Hospital</li> <li>• Ceduna Hospital</li> <li>• Kangaroo Island Health Service</li> <li>• Eastern Eyre (Cleve District Health)</li> </ul> <p>Example scenarios listed in <a href="#">Appendix 4</a></p>
<b>3 Palliative Care</b>	<p>'Palliative care' excludes care which meets the definition of mental health care.</p> <p>Palliative care is care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.</p> <p>Palliative care is always:</p> <ul style="list-style-type: none"> <li>• Delivered under the management of or informed by a clinician with specialist expertise in palliative care, and</li> <li>• Evidenced by an individualised multidisciplinary assessment and management plan, which is documented in the patient's medical record, that covers the physical, psychosocial, emotional, social and spiritual needs of the patient and negotiated goals.</li> </ul> <p>If patient's length of stay exceeds &gt; 35 days, note that the admission type should be recorded as a <u>long stay category</u> as assigned by the responsible medical officer.</p>
<b>4 Rehabilitation</b>	<p>Rehabilitation care excludes care which meets the definition of mental health.</p> <p>Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.</p> <p>Rehabilitation care is always:</p> <ul style="list-style-type: none"> <li>• delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and</li> <li>• evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that includes negotiated goals within specified time frames and formal assessment of functional ability</li> </ul> <p>Refer to Technical Bulletin 95:16 <i>Rehabilitation</i> for further details.</p> <p><b>Acute care hospitals providing rehabilitation</b> Public hospital funding guidelines for rehabilitation are restricted to specific hospitals. Refer to Casemix Funding Technical Bulletin (95:16) for a full list.</p> <p>Rehabilitation episodes of care reported at other hospitals will be funded according to normal Casemix rules, i.e. AR-DRG weight.</p> <p><b>Types of rehabilitation</b> Rehabilitation episodes of care (as defined by the above definition) in the above hospitals will be funded according to the following patient types:</p> <ul style="list-style-type: none"> <li>• Spinal</li> <li>• Stroke, acquired brain injury, neurological, amputee</li> <li>• Orthopaedic/other</li> <li>• Psychiatric (only at Glenside)</li> </ul>

	<p>The allocation of the patient to one of the above groups is the responsibility of the treating medical officer.</p> <p>If patient's length of stay exceeds &gt; 35 days, note that the admission type should be recorded as a long stay category as assigned by the responsible medical officer.</p>
<b>5 Unqualified Newborn</b>	<p>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:</p> <p>An unqualified newborn is 9 days old or less and meets one of the following criteria:</p> <ul style="list-style-type: none"> <li>• Is a single live birth or the first live born infant in a multiple birth, whose mother is currently an admitted patient; or</li> <li>• Is not admitted to an intensive care facility in a hospital, being approved by the Commonwealth Minister for the purpose of the provision of special care.</li> </ul> <p>Unqualified newborns are not counted under the Medicare Agreement and are not eligible for health insurance benefit purposes. This is because the funding for unqualified newborns is already included in the funding for the mother's inpatient stay. However, unqualified newborns should still be reported to ISAAC.</p> <p>If an unqualified newborn remains in hospital after day 9 to receive acute care, a change of episode type to acute is required. Alternatively, if after day 9, the newborn IS NOT RECEIVING ACUTE CARE, the newborn should be discharged and recorded as a boarder at your hospital. Boarders are not submitted to ISAAC.</p> <p><b>It is important to note that stillbirths are not reported to ISAAC.</b></p> <p>Example scenarios listed in Appendix 4, '<a href="#">Newborn</a>' and '<a href="#">Hospital at Home – Home Births</a>'</p>
<b>6 Qualified Newborn</b>	<p>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:</p> <p>The following criteria should be applied in determining whether a newly born child is classified as a qualified newborn:</p> <p>The patient is 9 days old or less and:</p> <ul style="list-style-type: none"> <li>• Is the second or subsequent live born infant of a multiple birth, whose mother is currently an admitted patient; or</li> <li>• Is admitted to an intensive care unit in an approved hospital, <i>refer Casemix Funding Technical Bulletin 22 for a list of hospitals with approved paediatric intensive care units</i> and meets one of the criteria listed in the TB; or</li> <li>• Remains in hospital without its mother</li> </ul> <p>If a qualified newborn remains in hospital after day 9, a change of care type is not required. A qualified newborn is considered to be receiving acute care and therefore a change in care type unnecessary. Note, this rule applies also to twin 2.</p> <p>If the qualified newborn remains in hospital past 35 days then a change of Patient Type to Long Stay Acute would be necessary. The episode of care, however, would remain acute.</p>



**It is important to note that stillbirths are not reported to ISAAC.**

#### **Data Collection for Newborns**

Listed are some scenarios of episode changes for newborns, with the appropriate values for some of the ISAAC data items.

**As appropriate** means to assign true value, not the administrative value. For example, the value assigned for nature of separation will be to where the patient was actually discharged.

The data items that **remain the same** across different episodes of care for a single period of hospitalisation for newborns include:

Item No.	Data item description	Value
3	Patient Unit Number	as appropriate
4	Medicare number *	same as mother's
5	Suburb	as appropriate
6	Postcode	as appropriate
7	LGA	as appropriate
8	Sex	as appropriate
9	Date of Birth	as appropriate
10	Country of Birth #	as appropriate
11	Admission weight (neonates)	as appropriate
12	Marital status	1
13	Race	as appropriate
14	Patient category	as appropriate
15	Admission category	as appropriate
17	Hospital insurance	1, 2, or 3
19	Election	as appropriate
68	Admission number	as appropriate
71	Legal Status	3

\* If the newborn is awaiting adoption, complete the Medicare number according to the ISAAC Reference Manual.

# most commonly Australia-1101

These data items could change across episodes for each episode of care and should be assigned according to the ISAAC Reference Manual for each individual episode of care:

Item No.	Data item description
2	Clinic code
20	Admission type

Data items that should be totalled for the entire period of hospitalisation, with the total value submitted on the final record are:

Item No.	Data item description
40	Hours in ICU
41	Mechanical Ventilation Hours

#### Commandments of Newborn Data Collection

1. A newborn is a patient less than (<) 28 days old.
2. Each newborn hospitalisation must be reported to ISAAC.
3. A newborn episode of care is either 'unqualified' or 'qualified'.
4. Each change of care type (an episode) within a period of hospitalisation should be reported separately (i.e. statistically discharged and statistically admitted).
5. The final ISAAC record indicates the 'real' discharge and must contain all the ICD-10-AM codes to describe all the episodes of care within the total period of hospitalisation.
6. If there is only a SINGLE episode of care then this record will contain the ICD-10-AM codes, regardless of whether it is unqualified or qualified.
7. A single attestation form describing the entire period of hospitalisation is required if there has been a qualified or acute episode of care within the hospital stay.
8. The admission weight recorded on each episode of care is the same as the weight recorded for the first admission of that period of hospitalisation.
9. If an unqualified newborn remains in hospital without it's mother after day 9 to receive acute care, a change of episode type to "acute" is required. Alternatively, if after day 9, the newborn is NOT RECEIVING ACUTE CARE, the newborn should be discharged and recorded as a "boarder" at your hospital. "Boarders" are not submitted to ISAAC.
10. If a qualified newborn remains in hospital after day 9, a change of episode of care type is NOT REQUIRED. A qualified newborn is considered to be receiving "acute" care and therefore a change of episode of care type is unnecessary.
11. The Mother's admission status (i.e. Inpatient or Boarder) is not relevant for a newborn who is > 9 days of age.

Submission of newborn episode of care records may be on an episode basis or following formal discharge at the end of the hospitalisation period.

Example scenarios listed in Appendix 4, ['Newborn'](#) and ['Hospital at Home – Home Births'](#)

#### 7 Hospital at Home / Rehab at Home / Home Births

Use this value to record Hospital at Home, Rehab at Home and Home Birth episodes. Home birth episodes can only be reported from 1 July 2013 onwards.

##### Hospital at Home

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

These services usually cover the sub-acute and post-acute phases of treatment. Criteria as specified in the Casemix Funding Technical Bulletin (97:20) must be met before this value can be used.

##### Business Rules for Collecting Hospital at Home on ISAAC

- Hospital at Home is a separate episode of care

	<ul style="list-style-type: none"> <li>• Hospital at Home is treated as the final episode</li> <li>• Clinical coding is undertaken for both the Hospital at Home and the admitted patient episodes</li> <li>• It is allowable that a patient goes direct to Hospital at Home from Accident and Emergency or Outpatients.</li> </ul> <p>Refer to Technical Bulletin 97:20 <i>Hospital at Home Services</i> for further details.</p> <p><b>Rehab at Home</b> An episode of <i>Rehab at Home</i> care occurs when a patient is provided with care in their own home which otherwise would have been provided as an in-patient service. Criteria as specified in the Casemix Funding Technical Bulletin (95:16) must be met before this value can be used.</p> <p><b>Business Rules for Collecting Rehab at Home on ISAAC</b></p> <ul style="list-style-type: none"> <li>• Rehab at Home is a separate episode of care</li> <li>• Rehab at Home is treated as the final episode</li> <li>• Clinical coding is undertaken for both the Rehab at Home and the admitted patient episodes</li> </ul> <p>Patient cannot go direct to Rehab at Home. They must first have completed an admitted patient episode as an acute or rehab patient.</p> <p><b>Other Related Items for Hospital at Home patients</b></p> <p><b>Nature of Separation (Item 42)</b></p> <p><b>A Administrative Discharge</b> When a patient leaves an in-patient hospital episode to go to a Hospital at Home episode, an administrative discharge is required, and a commencement of an administrative admission (see Source of Referral).</p> <p><b>0 Discharged on Leave through to 9 – Unknown</b> When a patient leaves a hospital at home episode it is a formal discharge. Use the appropriate Nature of Separation code e.g. 1 = Home.</p> <p>When a patient leaves the hospital at home episode to return to in-patient care the patient is also formally discharged. Use 1 = Home.</p> <p><b>E End of Quarter Reporting</b> A Hospital at Home episode may not have a Nature of Separation code equal to E = End of Quarter Reporting.</p> <p><b>Source of Referral (Item 16)</b></p> <p><b>A Administrative Discharge</b> When a patient leaves an in-patient hospital episode to go to a Hospital at Home episode, an administrative discharge is required (see Nature of Separation), and commencement of an administrative admission for the Hospital at Home episode.</p> <p><b>0 Admitted on Leave through to 9 – Unknown</b> When a patient starts a Hospital at Home episode without having been a formally admitted in-patient (e.g. on to the Hospital at Home episode through Emergency or Outpatients) use the appropriate Source of Referral code e.g.6 = Casualty/ Emergency</p> <p><b>E End of Quarter Reporting</b> A Hospital at Home episode may not have a Source of Referral code equal to E</p>
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	<p>= End of Quarter Reporting.</p> <p>Example scenarios listed in <a href="#">Appendix 4</a></p>
<b>8 Psychogeriatric Care</b>	<p>Psychogeriatric Care excludes care which meets the definition of mental health.</p> <p>Psychogeriatric care is care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance, caused by mental illness, an age-related organic brain impairment or a physical condition.</p> <p>Psychogeriatric care is always:</p> <ul style="list-style-type: none"> <li>• delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and</li> <li>• evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record, that covers the physical, psychosocial, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.</li> </ul> <p>Psychogeriatric care is not applicable if the primary focus of care is acute symptom control.</p> <p>In essence, episode of care '8' is assigned for psychogeriatric care delivered outside of a mental health unit.</p>
<b>9 Geriatric Evaluation and Management</b>	<p>Geriatric Evaluation and Management care excludes care which meets the definition of mental health.</p> <p>Geriatric Evaluation and Management is care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs associated with medical conditions related to ageing, such as tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.</p> <p>Geriatric evaluation and management is always:</p> <ul style="list-style-type: none"> <li>• delivered under the management of or informed by a clinician with specialised expertise in geriatric evaluation and management, and</li> <li>• evidenced by an individualised multidisciplinary management plan, which is documented in the patient's medical record that covers the physical, psychosocial, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability.</li> </ul>

	<p><b>Additional guide for use for Episodes of Care</b></p> <ul style="list-style-type: none"> <li>• Patients are assigned to a care type based on the principal clinical intent of the care received.</li> <li>• When a patient's clinical intent changes from one type of care to another, an administrative discharge must be completed and an administrative admission must be commenced. For paper based hospitals, this will involve the completion of a new ISAAC form.</li> <li>• The same admission number is carried over from episode to episode within the one period of hospitalisation.</li> <li>• It is not possible to have the same care type following one of the same, i.e. an acute episode followed by another acute episode.</li> <li>• A formal admission implies that source of referral will have a value not equal to 'A=Administrative' or to 'E=End of Quarter' reporting.</li> <li>• An administrative admission implies that the source of referral will be equal to 'A=Administrative'.</li> <li>• The discharge date and subsequent admission date will be the same, however, the admission time should be 1 minute later than the time of discharge.</li> <li>• If there is <b>no change</b> in the patient's episode of care, an administrative admission and discharge is <b>NOT</b> required, unless for the end of quarter nursing home type reporting.</li> <li>• If a patient dies, is discharged home or is transferred, the nature of separation should never be recorded as an 'A=Administrative' discharge or 'E=End of Quarter' reporting.</li> <li>• ISAAC forms/data should not be submitted to ISAAC Unit, unless the patient has been either formally or administratively discharged, and the episode of care has been coded.</li> </ul> <p><b>Procedure for recording Episode of Care Changes</b></p> <p>When an episode of care changes during a patient's stay in hospital:</p> <ol style="list-style-type: none"> <li>1. Complete the discharge and clinical details on the ISAAC form for the previous episode of care: <ul style="list-style-type: none"> <li>• Record A for administrative discharge for the nature of separation</li> <li>• Record the date of change for the separation date</li> <li>• Record the time of change for the separation time</li> <li>• Complete the ICD-10-AM codes in accordance with the coding guidelines and ISAAC requirements for episodes (refer instructions for data items 45-49). At a minimum, the principal diagnosis code must be submitted for every record.</li> </ul> </li> <li>2. Complete the admission details on a new ISAAC form for the new episode of care: <ul style="list-style-type: none"> <li>• Record A for administrative admission for the source of referral</li> <li>• Record the date of change for the admission date</li> <li>• Record the time of change for the admission time</li> <li>• Copy the admission number from the ISAAC form for the previous episode of care</li> </ul> </li> </ol> <p>This ISAAC form will be completed when the episode of care changes or the patient is formally discharged.</p>
<p><b>I</b> <b>Mental Health</b> <b>Acute</b></p>	<p>Mental Health Acute care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder.</p> <p><i>Mental Health <u>Acute</u> care:</i></p> <ul style="list-style-type: none"> <li>• is delivered under the management of, or regularly informed by, a clinician with specialist expertise in mental health; <b>and</b></li> <li>• is evidenced by an individualised formal mental health assessment and</li> </ul>

	<p>the implementation of a documented mental health plan; <b>and</b></p> <ul style="list-style-type: none"> <li>• may include significant psychosocial components, including family and carer support.</li> </ul> <p>Specifically the principal clinical intent or treatment goal is one or more of the following:</p> <ul style="list-style-type: none"> <li>• provide definitive treatment for a mental illness.</li> <li>• provide interventions designed to reduce the intensity of positive symptoms, (e.g. reduce hallucinations and delusions, ameliorate thought disorder; reduce severity of depressive symptoms or the level of anxiety, manage hostile or aggressive behaviour related to mental illness).</li> <li>• reduce severity of a mental health illness.</li> <li>• protect against exacerbation and/or complication of a mental health illness which could threaten life or normal function.</li> <li>• perform diagnostic or therapeutic procedures.</li> </ul> <p>Please see <a href="#">additional guide for use regarding Mental Health episodes of Care</a></p>
<b>J</b> <b>Mental Health Maintenance Care</b>	<p>Mental Health Maintenance (or non-acute) care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder.</p> <p>The focus is support for a patient with impairment, activity limitation or participation restriction due to a patient's mental disorder. Following assessment or treatment the patient does not require further complex assessment or stabilisation. Patients with a care type of Mental Health Maintenance Care often require care over an indefinite period.</p> <p><i>Mental Health Maintenance care:</i></p> <ul style="list-style-type: none"> <li>• is delivered under the management of, or regularly informed by, a clinician with specialist expertise in mental health; <b>and</b></li> <li>• is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; <b>and</b></li> <li>• may include significant psychosocial components, including family and carer support.</li> </ul> <p>As a guide the principal clinical intent or treatment goal is :</p> <ul style="list-style-type: none"> <li>• to maintain the level of functioning, or improve functioning during a period of recovery, minimise deterioration or prevent relapse where the consumer has stabilised and functions relatively independently</li> <li>• minimise the risks and handicaps associated with the ongoing symptoms and psychosocial dysfunctions arising from a mental health disorder (2) strengthen the consumers' capacity to use supportive professional networks</li> </ul> <p>Please see <a href="#">additional guide for use regarding Mental Health episodes of Care</a></p>
<b>K</b> <b>Mental Health Rehabilitation</b>	<p>Mental Health Rehabilitation care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder.</p> <p>The focus is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a Mental Health condition. The patient will be capable of actively participating.</p> <p><i>Mental Health Rehabilitation care:</i></p> <ul style="list-style-type: none"> <li>• is delivered under the management of, or regularly informed by, a clinician with specialist expertise in mental health; <b>and</b></li> <li>• is evidenced by an individualised formal mental health assessment and the implementation of a documented mental health plan; <b>and</b></li> </ul>

	<ul style="list-style-type: none"> <li>• may include significant psychosocial components, including family and carer support; and</li> <li>• is in a designated mental health rehabilitation unit.</li> </ul> <p>As a guide the principal clinical intent or treatment goal is :</p> <ul style="list-style-type: none"> <li>• to improve personal, social or occupational functioning or to promote psychosocial adaptation in a consumer with impairment arising from a mental health disorder</li> <li>• Interventions designed to result in a significant improvement in the consumer's personal, social and/or occupational functioning in the short term (weeks to months). This may include the development of basic community survival skills (e.g. shopping, cooking), social skills (e.g. conversation) or vocational skills (e.g. job seeking or job maintenance).</li> </ul> <p>Please see <a href="#">additional guide for use regarding Mental Health episodes of Care</a></p>
<b>L</b> <b>Mental Health Psychogeriatric Care</b>	<p>Mental Health Psychogeriatric care is care in which the primary clinical purpose or treatment goal is improvement in the symptoms and/or psychosocial, environmental and physical functioning related to a patient's mental disorder. The focus is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance caused by mental illness, an age-related organic brain impairment or a physical condition.</p> <p><i>Mental Health Psychogeriatric care:</i></p> <ul style="list-style-type: none"> <li>• is delivered under the management of, or regularly informed by, a clinician with specialist expertise in mental health; <b>and</b></li> <li>• is evidenced by an individualised formal mental health assessment; <b>and</b></li> <li>• the includes a documented mental health plan that covers the physical, psychosocial, emotional and social needs of the patient and includes negotiated goals within indicative time frames and formal assessment of functional ability;; <b>and</b></li> <li>• may include family and carer support roles or input.</li> </ul> <p>Specifically the principal clinical intent or treatment goal <u>is not</u> mental health psychogeriatric care if the primary focus of care is acute symptom control.</p> <p>Please see <a href="#">additional guide for use regarding Mental Health episodes of Care</a></p>
<b>P</b> <b>Posthumous Organ Procurement</b>	<p>Organ procurement—posthumous is the procurement of human tissue for the purpose of transplantation from a donor who has been declared brain dead.</p> <p>Posthumous Organ Procurement episode of care should begin when the patient is transferred to theatre for the procurement process.</p> <p>Diagnoses 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.</p> <p>It is important that only procurement of organs after the patient has been declared brain dead are submitted using the episode of care value for Posthumous Organ Procurement.</p> <p>Example scenarios listed in <a href="#">Appendix 4</a></p>

**Additional guidance for use of Mental Health Episode of Care types**

- For separations falling in the 15/16 financial year Mental Health (MH) Episodes of Care (EoC) should be used when a patient's care meets the following conditions:
- From 1/7/15 it is important that inpatients meeting the episode of care definitions are assigned a Mental Health Care type as it will impact National reporting and funding.

**Instructions**

- The type of MH EoC should be determined as per current process for other EoC types by a clinician. Documented evidence should accompany this as is current practice.
- As of 1 July 2015 a patient **DOES NOT** have to be in a designated mental health ward to have a MH Episode of Care type.
- When changing EoC, as specified in the section above, this should be recorded on the PAS at the time it occurs due to the difficulty of retrospectively correcting admissions. Documented evidence should accompany a change in episode of care as is current practice for other EoC changes.
- Coding should occur on each episode as specified in Medical Record Advisory Unit (MRAU) documentation regarding MH EoC coding. Patient's admitted to a non MH EoC receiving electroconvulsive therapy (ECT) are not to be administratively discharged and readmitted to a MH EOC; current practice should continue.
- These instructions should be used in conjunction with the coding instructions provided by the Medical Records Advisory Unit.

**Actions**

- Clinicians, admissions staff, ward clerks and anyone involved in admitting or moving patients to wards should be advised of the above instructions for handling patients receiving Mental Health care.

Example scenarios listed in [Appendix 4](#)

***Collection methods:*****Related ISAAC Edits**

#2085 – Wrong nature of separation for H@H/R@H  
 #2341 - Admission or Status Change Type and Episode of Care Incompatible  
 #2342 - Admission or Status Change Type incompatible with Episode of Care 2  
 #2580 – Episode of care invalid  
 #2695 - Separation Date Time for EOQ but Nature of Separation not E  
 #2730 – Incorrect Referral – patient already H@H  
 #2740 – Incorrect SOR for H@H/R@H Ep of Care  
 #2745 – Incorrect Nature of Separation for Episode of Care Type  
 #2750 – Incorrect NOS & Ref for Ep of Care Type  
 #2341– Episode of care incompatible with admission type  
 #4980 – Newborn patient-must be qualified or unqualified  
 #4990 – Age > 9 days, incorrect episode of care



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## External cause

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### Identifying and definitional attributes

*Technical name:* Patient—condition external cause, code AN[NNN]  
*Synonymous names:* ISAAC Data Item 47  
*SAHMR identifier:* SA1092  
*Registration status:* SA Health, Standard 24/04/2013

Data Element            Patient—Condition causality  
 Concept:

### Value domain attributes

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### Representational attributes

*Representation class:* Code  
*Data type:* String  
*Format:* AN[NNN]  
*Maximum character length:* 5

### Collection and usage attributes

*Guide for use:*            Format for Clinical Data Submission    The submission of ICD-10-AM codes must be recorded in the following format:
 

- Without decimal points
- Include lead alpha characters
- Record codes in sequence order
- Left justify, blank fill
- Where there is no 4th digit, but a 5th digit is required use "0" as a filler

For example, secondary conditions are entered as:

P   1   2   3                    M   2   3   4   5                    S   4   5   0   1

Hospitals submitting information to ISAAC electronically must refer to ISAAC reference table - record format for magnetic media for the correct format of the data.

### Data element attributes

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### Collection and usage attributes

*Guide for use:*            More than one external cause code may be assigned to a record. The first external cause code must be reported as ISAAC data item 47, External Cause. Additional external cause codes must be reported as ISAAC data item 46, Additional Diagnoses.

*Collection methods:*    **Related ISAAC Edits**  
 #2540 – External cause code invalid  
 #4840 – External cause code required  
 #4860 – External cause must accompany activity code  
 #4940 – External cause must accompany place of occurrence code

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## Funding Source

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### Identifying and definitional attributes

<i>Technical name:</i>	Funding of service—source category, code NN
<i>Synonymous names:</i>	ISAAC Data Item 95
<i>SAHMR identifier:</i>	SA1061
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Record the expected principal source of funds for an admitted patient episode. The major funding source should be recorded if there is more than one source of funding.

Data Element	Funding of service—Source category
Concept:	

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code																												
<i>Data type:</i>	Number																												
<i>Format:</i>	NN																												
<i>Maximum character length:</i>	2																												
<i>Permissible values:</i>	<table> <thead> <tr> <th>Value</th><th>Meaning</th></tr> </thead> <tbody> <tr><td>01</td><td>Compensable-MVA</td></tr> <tr><td>02</td><td>Compensable-WC</td></tr> <tr><td>03</td><td>Compensable-Other</td></tr> <tr><td>04</td><td>Veteran</td></tr> <tr><td>05</td><td>Defence</td></tr> <tr><td>06</td><td>Correctional</td></tr> <tr><td>07</td><td>Overseas-RHCA</td></tr> <tr><td>08</td><td>Non-Medicare</td></tr> <tr><td>09</td><td>Private Health Insurance</td></tr> <tr><td>10</td><td>Self-funded</td></tr> <tr><td>11</td><td>Medicare</td></tr> <tr><td>12</td><td>Other Hosp or Public Authority</td></tr> <tr><td>13</td><td>No charge raised</td></tr> </tbody> </table>	Value	Meaning	01	Compensable-MVA	02	Compensable-WC	03	Compensable-Other	04	Veteran	05	Defence	06	Correctional	07	Overseas-RHCA	08	Non-Medicare	09	Private Health Insurance	10	Self-funded	11	Medicare	12	Other Hosp or Public Authority	13	No charge raised
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11	Medicare																												
12	Other Hosp or Public Authority																												
13	No charge raised																												
<i>Supplementary values:</i>																													

### Collection and usage attributes

*Guide for use:*      **Compensable - Additional Information**

A Compensable patient is one who will have the hospital fees paid for because the patient is, or may be, entitled to payment, or have received payment by way of compensation or damages under a law in force in a State or internal Territory of the Commonwealth, in respect of the injury, illness or disease for which the patient receives care and treatment.

This category includes a person who:

- Has an entitlement for damages under Motor Vehicle Third Party Insurance; or
- Has an entitlement for damages under Workers' Rehabilitation and Compensation Act, 1986; or
- Has or may have an entitlement to claim damages under public liability insurance;
- Is a Seaman under the Navigation Act.
- Is a resident of the Northern Territory, and is hospitalised as a result of an injury (including motor vehicle), illness or disease for which they are,

or may be, entitled to payment or compensation (including compensation from the Territory Insurance Office).

Only patients with these entitlements can be classified as *Compensable*. *Compensable* status dominates all other types of status. If the patient is *Compensable*, this determines classification for statistical purposes, no matter what other characteristics are possessed. **Exceptions** to this rule are Defence Force Personnel who should be recorded 05-Defence, irrespective of their compensable status.

All *compensable* patients must be admitted as *compensable private* in country hospitals which do not employ full-time medical specialists. Certification of a *compensable* patient as a *compensable private* patient cannot be overridden by the patient wishing to be classified as a *compensable hospital* patient. *Compensable* patients admitted to a metropolitan hospital can be admitted as either *private* or *hospital*.

However, if the patient's status reverts to non-compensable, then the patient is classified as *private*, if the patient has private health insurance and does not elect to be *hospital*.

Please refer to the [Patient Fees & Charges Manual](#) for further information on Compensable election.

### **Veteran - Additional Information**

- In cases where a patient with DVA status presents for admission with a condition covered by workers compensation, motor vehicle accident, or other compensable claim, the patient should be classified as compensable (not veteran).
- Admissions of all eligible Veterans should also have *data item 31, Veteran Card Type* and *data item 69, Veteran Card Number* recorded.
- If an eligible *Veteran's Affairs* patient is admitted to your hospital (i.e. DVA will pay the bill), it is mandatory that the *Admission Election* is recorded as *private*.

### **Eligibility**

Most patients entitled to treatment through DVA have been issued with a plastic treatment entitlement card indicating their eligibility status. Occasionally, a patient may only have a written authorisation from DVA. You should ask to see the card or written authorisation when admitting the patient and use the card to copy the patient's details. There are two types of cards issued:

- Repatriation Health Card - for all conditions (gold)
- Repatriation Health Card - for specific conditions (white)

For patients only entitled to treatment for specific injuries or diseases for which DVA has accepted financial responsibility - contact DVA to confirm authorisation for treatment.

All *Veterans' Affairs* patients should complete a Hospital Admission Voucher (D652C). Such a form should be completed at time of admission, or as soon afterwards as possible. A copy of this form should be retained in either the patient's casenotes or in the Finance Department. These will need to be retrieved should the Department of Veteran's Affairs decide to audit casenotes.

Each admission of a *Veterans' Affairs* patient must be considered separately. Any requirement for approval or prior approval applies, whether or not the treatment is related to previous admissions which may have been approved. Department of Veterans' Affairs will only recognise a financial responsibility

for public hospital treatment of veterans if these approval procedures are followed.

Refer to *Technical Bulletin 99:25 Department of Veteran Affairs Patient Funding* for further information.

### **RHCA - Additional Information**

Australia has signed Reciprocal Health Care Agreements (RHCA) with:

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

Visitors to Australia from these countries are eligible to receive limited health services through Medicare.

### **Period of Cover**

- Visitors residing in the United Kingdom, New Zealand, Sweden, Ireland, Finland, Belgium, Norway and the Netherlands are covered for the duration of their approved visit to Australia.
- Visitors residing in Malta and Italy are covered for a period of six months from the date of their arrival.

### **Cover**

Visitors are covered for services of immediate medical necessity only. This is ill health or injury which occurs in Australia and which requires medical treatment before returning home.

### **Medical services not covered under the RCHA**

- Medicines not subsidised under the Pharmaceutical Benefits Scheme
- Dental and allied health services
- Care or treatment arranged prior to visiting Australia
- Accommodation and treatment in a private hospital
- Accommodation and treatment as a private patient in a public hospital
- Ambulance costs
- Medical evacuation to home country
- Elective treatment

*Up-to-date information on overseas patient's eligibility is available from Medicare Australia*

<http://www.medicareaustralia.gov.au/public/migrants/visitors/index.jsp>

Collection methods:

<b>01 Compensable- MVA</b>	Use this value when a patient is eligible to make a claim for damages under Motor Vehicle Third Party insurance.
<b>02 Compensable- WC</b>	Use this value when a patient is eligible to make a claim for damages under Worker's Compensation.
<b>03 Compensable- Other</b>	Use this value when a patient has an entitlement to claim under public liability or common law damages.
<b>04 Veteran</b>	A <i>Veteran's Affairs</i> patient is a person who holds a current Department of Veteran's Affairs Health entitlement card AND has approval from the Department

	of Veteran's Affairs for admission as a Veteran's Affairs patient.
<b>05 Defence</b>	<p>Use for any patient admitted who is currently a member of the Australian Defence Force.</p> <p>In cases where Defence Force Personnel present for admission with a condition covered by workers compensation, motor vehicle accident, or other compensable claim, the patient should be admitted as <i>private</i> and classified as <i>Defence</i> (not compensable)</p>
<b>06 Correctional</b>	Use for any patient admitted who is currently being held in a correctional facility. Does not include patients being held in a secure ward of a public hospital.
<b>07 Overseas with RHCA</b>	Use for any patient admitted who is an overseas visitor who resides in a country which has a Reciprocal Health Care Agreement (RHCA) with Australia.
<b>08 Non-Medicare</b>	<p>I. Use for any patient admitted who is an overseas visitor who resides in a country which does not have a Reciprocal Health Care Agreement (RHCA) with Australia.</p> <p>II. Patients for whom travel insurance is the major funding source should be recorded in this category.</p> <p>III. For eligible RHCA patients who do not choose to be admitted under RCHA.</p>
<b>09 Private Health Insurance Fund</b>	Use for any patient admitted who is privately insured with a health insurance fund and elects to be a private patient.
<b>10 Self-funded</b>	Use for any patient admitted who is funding their own admission or whose stay is funded by the patient's family, friends or by other benefactors.
<b>11 Medicare</b>	<p>Use for any patient admitted whose funding will be sourced from the public health care system.</p> <p>These are patients who elect to be a public patient and who do not have any other source of funding for their admission.</p> <p>People who reside in Australia are eligible to receive services under Medicare if they meet any of the following four criteria:</p> <ul style="list-style-type: none"> <li>• Hold Australian citizenship;</li> <li>• Have been issued with a permanent visa;</li> <li>• Hold New Zealand citizenship; OR</li> <li>• Have applied for a permanent visa, restrictions apply to persons who have applied for a parent visa (other requirements apply).</li> </ul> <p>The Commonwealth Government has signed RHCA with some countries. Residents of these countries are entitled to restricted access to health cover while visiting Australia. <i>Refer to data element '07-Overseas-RHCA'.</i></p>
<b>12 Other Hosp or Public Authority</b>	<p>Use for any patient receiving treatment under contracted care or partial service provision arrangement (interhospital contracted patient) with another hospital.</p> <p>This is to be recorded by the hospital providing the Contract Service or Component of Care.</p>

<b>13</b> <b>No charge</b> <b>raised</b>	Use when the fee for a Medicare eligible patient receiving public hospital services is waived.
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**Data element attributes**

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**Collection and usage attributes**

*Collection methods:*

**Related ISAAC Edits**

- #2280 – Veteran card number required
- #2295 – Veteran card No and Card Type not req'd
- #2320 – Incorrect Election for Fund Source type
- #2585 – Elec Type not valid with sub F/S type
- #2610 – Funding source invalid
- #2611 – Funding source must be Other Hospital for Contracted Service

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## Hospital code

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### Identifying and definitional attributes

<i>Technical name:</i>	Hospital—Administrative identifier, hospital code NNNN
<i>Synonymous names:</i>	ISAAC Data Item 1
<i>SAHMR identifier:</i>	SA1053
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The treating hospital.

Data Element Concept: Hospital—Administrative identifier

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

#### Collection and usage attributes

*Guide for use:* A code list for all hospitals in South Australia is available on the ISAAC website [www.sahealth.sa.gov.au/isaac](http://www.sahealth.sa.gov.au/isaac), click on 'Integrated SA Activity Collection (ISAAC) Resources' tab: *Hospital Listing – alpha* and *Hospital Listing – numeric*. Public hospitals have three digit codes and require a leading zero. The number should be entered as follows:

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

Private hospitals, including day surgery facilities, have four digit codes beginning with a '4', and should be entered as follows:

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

*Collection methods:*

### Data element attributes

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#### Collection and usage attributes

*Collection methods:* Enter the code number for your hospital in the box provided and the hospital name immediately to the right. **This is a mandatory item.**

#### Related ISAAC Edits

#1000 - Hospital code invalid

#2010 - Dated admissions after hospital closure

## Hospital Insurance

### Identifying and definitional attributes

<i>Technical name:</i>	Patient—insurance flag, status code N
<i>Synonymous names:</i>	ISAAC Data Item 17
<i>SAHMR identifier:</i>	SA1107
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The insurance status of the patient. To determine if the patient has private health insurance. Does not indicate method of payment for the episode (i.e. Is independent of Patient Election and Funding Source).

Data Element Concept: Patient—Insurance flag

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table> <thead> <tr> <th>Value</th><th>Meaning</th></tr> </thead> <tbody> <tr> <td>1</td><td>Hospital insurance</td></tr> <tr> <td>2</td><td>No hospital insurance</td></tr> <tr> <td>9</td><td>Unknown (Default value)</td></tr> </tbody> </table>	Value	Meaning	1	Hospital insurance	2	No hospital insurance	9	Unknown (Default value)
Value	Meaning								
1	Hospital insurance								
2	No hospital insurance								
9	Unknown (Default value)								
<i>Supplementary values:</i>									

#### Collection and usage attributes

- Guide for use:*
- This data item indicates the patient's level of private health insurance. That is, insurance with a health insurance fund (e.g. Medical Benefits Fund, Medibank Private) providing benefits related to charges for private accommodation in a hospital. This data item is independent from the patient's election.
  - For example, a patient may elect to be admitted as a hospital patient (data item 19, Admission Election = 1, Hospital), even though the patient may have private health insurance. In this case Hospital Insurance would be recorded as a '1, Hospital).
  - If a patient does have private health insurance but is unsure of the insurance level, record this as "9-Unknown".
  - If patient has a qualified funding source of "04-Veterans", "05-Defence" or compensable then their Hospital Insurance should be recorded as "02-No Hospital Insurance".

<b>1-Hospital Insurance</b>	<p>Patient is insured with a health fund for private admitted patient hospital accommodation.</p> <p>Hospital insurance is either with a:</p> <ul style="list-style-type: none"> <li>• Health insurance fund registered under the National Health Act 1953 (Commonwealth) or is with a</li> <li>• General insurance company and or a guaranteed renewable policy providing benefits similar to those available under registered insurance.</li> </ul>
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	This category includes patients covered by health insurance plus extras or ancillary benefits or with excess arrangements. It <u>does not</u> include patients covered by extras or ancillary benefits only.
<b>2- No Hospital Insurance</b>	Patient has: <ul style="list-style-type: none"> <li>• No health insurance; <b>or</b></li> <li>• Extras or ancillary cover only.</li> </ul>
<b>9- Unknown</b>	The patient's level of health insurance cover is unknown.

*Collection methods:*

**Related ISAAC Edits**

#4210 - Insurance invalid

#2330 – Incorrect Hosp Insur with Fund Srce Type

## Hospital transferred from

### Identifying and definitional attributes

<i>Technical name:</i>	Hospital—transferring hospital name, code NNNN
<i>Synonymous names:</i>	ISAAC Data Item 18
<i>SAHMR identifier:</i>	SA1064
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Identifies, by code, the hospital from which the patient was transferred. Use the hospital codes in SA Hospital Codes Reference Table.
Data Element Concept:	Hospital—Transferring Hospital Name

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

#### Collection and usage attributes

<i>Guide for use:</i>	A code list for all hospitals in South Australia is available on the ISAAC website <a href="http://www.sahealth.sa.gov.au/isaac">www.sahealth.sa.gov.au/isaac</a> , click on 'Integrated SA Activity Collection (ISAAC) Resources' tab: <i>Hospital Listing – alpha</i> and <i>Hospital Listing – numeric</i> . Public hospitals have three digit codes and require a leading zero. The number should be entered as follows:
-----------------------	--

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

Private hospitals, including day surgery facilities, have four digit codes beginning with a '4', and should be entered as follows:

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

*Collection methods:*

### Data element attributes

#### Collection and usage attributes

*Guide for use:*

#### Related Data Items

If on admission, a patient's Source of Referral (data item 16) is: 4 - Inter-hospital Transfer then *Hospital Transferred From* must be completed with the hospital code that identifies the hospital from which the patient was transferred. If the Source of Referral (data item 16) is not equal to '4' then leave the data item blank.

*Collection methods:*

#### Related ISAAC Edits

#4290 – Hospital transferred from code invalid  
 #4300 – Hospital transferred from not required  
 #4310 – Hospital transferred from required  
 #4320 – Hospital transferred from same as admission hospital

## Hospital transferred to

### Identifying and definitional attributes

<i>Technical name:</i>	Hospital—receiving hospital name, code NNNN
<i>Synonymous names:</i>	ISAAC Data Item 44
<i>SAHMR identifier:</i>	SA1063
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Identifies, by code, the hospital to which the patient was transferred. Use the hospital codes in SA Hospital Codes Reference Table.
Data Element Concept:	Hospital—Receiving hospital name

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

#### Collection and usage attributes

<i>Guide for use:</i>	Enter the code number for your hospital in the box provided and the hospital name immediately to the right. <b>This is a mandatory data item.</b>
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A code list for all hospitals in South Australia is available on the ISAAC website [www.sahealth.sa.gov.au/isaac](http://www.sahealth.sa.gov.au/isaac), click on 'Integrated SA Activity Collection (ISAAC) Resources' tab: *Hospital Listing – alpha* and *Hospital Listing – numeric*. Public hospitals have three digit codes and require a leading zero. The number should be entered as follows:

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

Private hospitals, including day surgery facilities, have four digit codes beginning with a '4', and should be entered as follows:

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

### Data element attributes

#### Collection and usage attributes

*Guide for use:*

#### Related Data Items

If on discharge, a patient's Nature of Separation (data item 42) is either:

- 2 Other Hospital - up transfer
- 7 Other Hospital - down transfer

then *Hospital Transferred To* must be completed with the hospital code that identifies the hospital to which the patient was transferred. If Nature of Separation is not equal to '2' or '7' then leave the data item blank.

### Exclusions

- Patients discharged to a residential aged care facility. Hospital transferred to is NOT required. In this case record Nature of Separation as 3-discharged to residential aged care facility or hostel.

*Collection methods:*

### Related ISAAC Edits

#4250 – Hospital transferred to code invalid

#4260 – Hospital transferred to not required

#4270 – Hospital transferred to required

#4280 – Hospital transferred to same as admission hospital

## Hours in ICU

### Identifying and definitional attributes

<i>Technical name:</i>	Intensive care unit—Time spent, Time Total Hours NNNNN
<i>Synonymous names:</i>	ISAAC Data Item 40
<i>SAHMR identifier:</i>	SA1065
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The number of hours spent in a designated intensive care bed during an episode of care in a hospital, rounded to the nearest hour. Includes paediatric intensive care beds.

<b>Definition - PICU (Paediatric Intensive Care Unit)</b>	An appropriately staffed and equipped unit providing specialised care for critically ill children (i.e. generally less than 19 years of age). Admissions include neonatal aged patients (i.e. less than 29 days of age) who require specialised care for congenital, surgical or cardiac disease; or readmission following discharge from birth hospital.
<b>Definition - NICU (Neonate Intensive Care Unit)</b>	An appropriately staffed and equipped unit providing specialised care for critically ill neonates (i.e. less than 29 days of age) whose problems are primarily related to the late antenatal and intrapartum period. These problems result in difficulties adjusting from intrauterine to extrauterine life.

Data Element Concept: Intensive care unit—Time spent

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNNNN
<i>Maximum character length:</i>	5

#### Collection and usage attributes

<i>Guide for use:</i>	Round up or down the total hours.
	If 0 – 29 min round down to 0 hour
	If 30 – 59 min round up to 1 hour
	<ul style="list-style-type: none"> <li>For example, if a patient spent 18.5 hours in a location, if appropriate, the information is entered with leading zeros as follows:</li> </ul>

Hours	0	0	0	1	9
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### Data element attributes

#### Collection and usage attributes

<i>Guide for use:</i>	<b>Exclusions</b> Hours spent in the following units are <u>excluded</u> from this data item: Coronary care High dependency
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### Neonatal intensive care

#### **Additional Notes**

- Public hospitals can clarify any uncertainty about a bed designated as intensive care by contacting the Funding Models Unit, SA Health.
- Accumulate hours in a designated ICU bed for each individual episode of care. DO NOT accumulate hours across different episodes of care and DO NOT report the total ICU hours on the final formal discharge.
- Leave this data item blank if no time is spent in a designated intensive care bed during an episode of care. Electronic media submissions should fill this field with zeros (00000). Leave the field blank if submitting by paper.
- Round up or down the total hours.

#### *Collection methods:*

#### **Related ISAAC Edits**

#2260 – Hours in ICU is length of stay

#2300 – Hours in ICU is invalid

#2301 - ICU Hours incompatible with episode of care

## Hours on mechanical ventilation

### Identifying and definitional attributes

<i>Technical name:</i>	Mechanical ventilation—time spent, total hours NNNN
<i>Synonymous names:</i>	ISAAC Data Item 41
<i>SAHMR identifier:</i>	SA1066
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The number of hours of continuous mechanical ventilation during an episode of care in a hospital, rounded to the nearest hour.
Data Element Concept:	Mechanical ventilation—Time spent

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Total
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

#### Collection and usage attributes

<i>Guide for use:</i>	Round up or down the total hours.
	If 0 – 29 min round down to 0 hour
	If 30 – 59 min round up to 1 hour
	<ul style="list-style-type: none"> <li>For example, if a patient spent 18.5 hours in a location, if appropriate, the information is entered with leading zeros as follows:</li> </ul>

Hours	0	0	1	9
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### Data element attributes

#### Collection and usage attributes

*Guide for use:*

#### Additional Notes

- To calculate the number of hours (duration) of continuous mechanical ventilation during a hospitalisation, begin the count from the start of the (endotracheal) intubation. The duration ends with (endotracheal) extubation.
- If a patient is intubated prior to admission, begin counting the duration from the time of the admission. If a patient is transferred (discharged) while intubated, the duration would end at the time of transfer (discharge).
- For patients who begin on (endotracheal) intubation and subsequently have a tracheostomy performed for mechanical ventilation, the duration begins with the endotracheal intubation, and ends when the mechanical ventilation is turned off (after the weaning period).
- If a patient has received a tracheostomy prior to admission and is on mechanical ventilation at the time of admission, begin counting the duration from the time of admission.
- If a patient is transferred (discharged) while still on mechanical ventilation via tracheostomy, the duration would end at the time of the transfer (discharge).

- Accumulate hours for continuous mechanical ventilation during an episode of care. Report the total number of hours spent on mechanical ventilation during each episode on that episode's record. DO NOT accumulate hours for the total hospital stay and report on the final formal discharge record.
- Leave this data item blank if no time is spent on continuous mechanical ventilation during an episode of care. Electronic media submissions should fill this field with zeros (0000).
- Leave the field blank if submitting by paper.

*Collection methods:*

**Related ISAAC Edits**

#2270 – Hours on mechanical ventilation cannot be > than length of stay

#2180 – Hours on mechanical ventilation invalid

#2302 - HMTV hours incompatible with episode of care type



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## Indigenous status

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—indigenous status, code N
<i>Synonymous names:</i>	ISAAC Data Item 13
<i>SAHMR identifier:</i>	SA1104
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Indicates whether or not a person identifies themselves as being of Aboriginal and/or Torres Strait Islander origin. An Indigenous person is a person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander person.

Data Element Concept: Patient—Indigenous categorisation

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code												
<i>Data type:</i>	Number												
<i>Format:</i>	N												
<i>Maximum character length:</i>	1												
<i>Permissible values:</i>	<table> <thead> <tr> <th>Value</th><th>Meaning</th></tr> </thead> <tbody> <tr> <td>1</td><td>Aboriginal but not Torres Strait Islander origin</td></tr> <tr> <td>2</td><td>Torres Strait Islander but not Aboriginal origin</td></tr> <tr> <td>3</td><td>Both Aboriginal and Torres Strait Islander origin</td></tr> <tr> <td>4</td><td>Neither Aboriginal nor Torres Strait Islander origin</td></tr> <tr> <td>9</td><td>Not stated/inadequately described</td></tr> </tbody> </table>	Value	Meaning	1	Aboriginal but not Torres Strait Islander origin	2	Torres Strait Islander but not Aboriginal origin	3	Both Aboriginal and Torres Strait Islander origin	4	Neither Aboriginal nor Torres Strait Islander origin	9	Not stated/inadequately described
Value	Meaning												
1	Aboriginal but not Torres Strait Islander origin												
2	Torres Strait Islander but not Aboriginal origin												
3	Both Aboriginal and Torres Strait Islander origin												
4	Neither Aboriginal nor Torres Strait Islander origin												
9	Not stated/inadequately described												
<i>Supplementary values:</i>													

#### Collection and usage attributes

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

The classification for Indigenous status has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. There is one supplementary category for 'not stated' responses. The classification is as follows:

Indigenous:

- Aboriginal but not Torres Strait Islander origin.
- Torres Strait Islander but not Aboriginal origin.
- Both Aboriginal and Torres Strait Islander origin.

Non-Indigenous:

- Neither Aboriginal nor Torres Strait Islander origin.

Not stated/ inadequately described:

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

- Primarily when importing data from other data collections that do not contain mappable data.
- Where an answer was refused.

- Where the question was not able to be asked prior to completion of admission because the client was unable to communicate or a person who knows the client was not available.

Only in the last two situations may the tick boxes on the questionnaire be left blank.

1 Aboriginal but not Torres Strait Islander origin	An Aboriginal is a person of Aboriginal descent who identifies as an Australian Aboriginal.
2 Torres Strait Islander but not Aboriginal origin	A Torres Strait Islander is a person of Torres Strait Island descent who identifies as Torres Strait Islander.
3 Both Aboriginal & Torres Strait Islander origin	A person who identifies as both an Australian Aboriginal and Torres Strait Islander.
4 Neither Aboriginal nor Torres Strait Islander origin	A person who identifies as neither an Australian Aboriginal nor Torres Strait Islander. Termed non-indigenous.
9 Not Stated	Use this category if the indigenous status of the patient cannot be accurately established (not stated).

#### Data element attributes

#### Collection and usage attributes

##### Collection methods:

##### Additional Notes

When requesting information on Indigenous Status the following question structure is recommended: [Are you] [Is the person] [is (name)] of Aboriginal or Torres Strait Islander origin?

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander

For persons of both Aboriginal and Torres Strait Islander origin, mark both 'Yes' boxes.

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend or another member of the household is answering on behalf of the subject.

When someone is not present, the person answering for them should be in a position to do so i.e. this person must know the person about whom the question is being asked well and feel confident to provide accurate information about them. However, it is strongly recommended that this question be asked directly wherever possible.

In circumstances where it is impossible to ask the person directly, such as in the case of death, the question should be asked of a close relative or friend, and only if a relative or friend is not available should the undertaker or other such person answer.

**This element should always be asked even if the person does not 'look' like they are Aboriginal or Torres Strait Islander origin.**

#### Related ISAAC Edits

- #4205 -Aboriginal or TSI patient-check country of birth
- #4206 - Indigenous Status has changed since last Episode of Care
- #4395 - Indigenous status invalid

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## Leave - date of leaving service

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### Identifying and definitional attributes

<i>Short name:</i>	Patient's leave from service—date of leaving service, date DDMMYYYY
<i>Synonymous names:</i>	ISAAC Data Items 32, 34, 36, 38
<i>SAHMR identifier:</i>	SA1118
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	A temporary absence from hospital, with medical approval, for a period of not greater than 7 consecutive days, where there is an intended return to hospital for continuation of care or treatment.
<i>Data Element Concept:</i>	Patient's leave from service—Date of leaving service

### Value domain attributes

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### Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

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### Collection and usage attributes

*Guide for use:* A patient can have numerous periods of leave within the one episode of care, but the duration of an individual leave period must not exceed seven (7) consecutive days.  
A patient qualifies for leave if they meet the following criteria:

Is to remain under the responsibility of the primary Hospital whilst on leave.

Actual duration of a single leave period is less than or equal to seven (7) consecutive days.

There is intention at the start of the leave period that the patient will return to Hospital for continued treatment. (If they do not return they should be discharged on leave effective from the date and time the hospital was notified by the patient).

Requires absence from Hospital A to undertake only an outpatient service at Hospital B.

- Leave periods must be reported in chronological order i.e. date and time order as it occurred.
- When a patient is on leave, the Hospital is responsible for the patient for the duration of leave as they are still deemed an inpatient and have not been officially discharged.
- Use the day, month and year and leading zeros where necessary.
- 2400 is not considered a valid time.
- For auditing purposes, the hospital's medical record and internal computer system should reflect the true dates and times of periods of leave so that these can be matched with ISAAC.
- No patient days or charges are generated while the patient is on leave.
- The admission type for the 'admission from leave' will most often be the same as the original admission, but it depends on the circumstances of the admission from leave.
- If the patient is on leave overnight, the data submitted to ISAAC should indicate

that the patient is on leave on both days.

- Mental health patients under legal orders (treatment orders) may be authorised to take 'trial leave' for extended periods of time in excess of seven (7) consecutive days. Where this occurs an edit will be triggered. Sites should verify that the trial leave occurred and no further correction or adjustment to the record will be necessary.

#### **Example Scenarios**

- If a patient goes on leave following cardiac bypass surgery, and after a period of 72 hours the patient notifies hospital staff of his intention not to return, the patient is then discharged onto leave. If the patient then returns to Emergency Department complaining of chest pain three days later and is admitted, this admission will be an emergency admission type. It is the responsibility of the admitting medical officer to indicate if the reason for admission is related to the previous episode, and therefore the source of referral can be entered as "0=admit from leave".
- A Patient is an inpatient at Hospital A and needs to have a planned outpatient services at Hospital B as part of the Hospital A treatment protocol. The patient should be placed on leave at Hospital A for the duration of the time required to transport and complete the CT Scan. The patient should not be discharged from Hospital A and re-admitted following the CT Scan.
- If a Patient is admitted at Hospital A and sent to Hospital B for an admitted contracted service or Component of Care. Leave must not be used to capture absence for contracted services. Refer to the Appendix 3: Contract Service and Component of Care data standard.
- If a patient is an inpatient at Hospital A and is transferred to Hospital B for treatment that requires admission at Hospital B and there is no contractual service agreement between Hospital A and B, nor is the service considered a partial service provision, then the patient should be discharged from Hospital A and admitted to Hospital B.

#### **Additional Information**

It is mandatory to report all leave with a duration greater than or equal to five (5) hours and less than or equal to seven (7) consecutive days to ISAAC. A patient can still be placed on leave if the duration of leave is less than five (5) hours. Leave less than five (5) hours in duration should be captured in internal hospital systems (e.g. documented in the medical record), but it is not required to be reported to ISAAC.

If a patient fails to return from leave within seven (7) consecutive days and the patient notifies the hospital that they will not return, then the patient should be discharged on the date and time the hospital was notified by the patient. The period from the point of leaving the hospital to the point of the patient contacting the hospital should be recorded as leave.

If the patient is on leave for seven (7) consecutive days and fails to notify the hospital that they will not return, then the patient should be discharged on the date and time the seven (7) consecutive days expired. If for example the approved leave was for 2 days and they failed to return and not advise the hospital, then at the end of 2 days they are formally discharged with a '0'.

#### **Requires a contracted inpatient service or partial service provision at another hospital**

i.e. Patient is admitted at Hospital A and sent to Hospital B for an admitted contracted service or Component of Care. Leave must not be used to capture absence for contracted services. Refer to the Appendix 3: Contract Service and Component of Care data standard.

#### **Requires a non-contractual inpatient service at another hospital during the leave period**

If the patient requires absence from Hospital A to undertake an inpatient stay at Hospital B and there is no contractual agreement in place, then the patient must be formally discharged from Hospital A and formally admitted at Hospital B i.e. a patient cannot be formally admitted at 2 individual Hospitals at the same time.

**Data Entry Examples**

A period of leave of one day would be entered as:

Leave from Date								Leave to Date							
0	4	0	3	2	0	1	0	0	5	0	3	2	0	1	0
Leave from Time				Leave to Time											
1	4	0	0	0	9	0	0								

A period of weekend leave (from Friday to Monday) would be entered as:

Leave from Date								Leave to Date							
0	6	0	3	2	0	1	0	0	9	0	3	2	0	1	0
Leave from Time				Leave to Time											
1	8	3	0	0	8	1	5								

A patient who had the following periods of leave:

	Leave from Date	Leave from time	Leave to Date	Leave to Time	Length (hours)
1	01/12/2010	10:00 am	02/12/2010	10:00 am	24 hours
2	05/12/2010	14:00 pm	06/12/2010	12:00 pm	46 hours
3	08/12/2010	18:00 pm	10/12/2010	18:00 pm	48 hours
4	15/12/2010	13:00 pm	17/12/2010	09:00 am	44 hours
5	25/12/2010	11:00 am	27/12/2010	11:00 am	48 hours
6	31/12/2010	09:00 am	02/01/2011	09:00 am	48 hours
7	04/01/2011	14:00 pm	06/01/2011	14:00 pm	48 hours
8	10/01/2011	10:00 am	11/01/2011	15:00 pm	29 hours

These periods of leave would be recorded on ISAAC as follows:

	Leave from Date								Time				Leave to Date								Time			
1st	0	1	1	2	2	0	1	0	1	0	0	0	0	2	1	2	2	0	1	0	1	0	0	0
2nd	0	5	1	2	2	0	1	0	1	4	0	0	0	6	1	2	2	0	1	0	1	2	0	0
3rd	0	8	1	2	2	0	1	0	1	8	0	0	1	0	1	2	2	0	1	0	1	8	0	0
4th	1	5	1	2	2	0	1	0	1	3	0	0	1	1	0	1	2	0	1	1	1	5	0	0

Note the 4<sup>th</sup> period of leave represents the total 9 days of leave the patient took from 15<sup>th</sup> December 2010 to 11<sup>th</sup> January 2011.

Collection  
methods:

**Related ISAAC Edits**

- #2190 – Periods of leave from date/time invalid
- #2200 – Periods of leave to date/time invalid
- #2210 – Periods of leave invalid
- #2220 – Periods of leave from date invalid
- #2230 – Periods of leave to date invalid
- #4610 – Periods of leave - from time required
- #4620 – Periods of leave - to time required
- #4625 – Leave > 7 consecutive days

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## Leave - date of resuming service

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### Identifying and definitional attributes

<i>Short name:</i>	Patient's leave from service—date of resuming service, date DDMMYYYY
<i>Synonymous names:</i>	ISAAC Data Items 33, 35, 37, 39
<i>SAHMR identifier:</i>	SA1119
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	A temporary absence from hospital, with medical approval, for a period of not greater than 7 consecutive days, where there is an intended return to hospital for continuation of care or treatment.
<i>Data Element Concept:</i>	Patient's leave from service—Date of resuming service

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	Used with date Items 32,34,36,38 A patient can have numerous periods of leave within the one episode of care, but the duration of an individual leave period must not exceed seven (7) consecutive days.
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A patient qualifies for leave if they meet the following criteria:

- Is to remain under the responsibility of the primary Hospital whilst on leave.
- Actual duration of a single leave period is less than or equal to seven (7) consecutive days.
- There is intention at the start of the leave period that the patient will return to Hospital for continued treatment. (If they do not return they should be discharged on leave effective from the date and time the hospital was notified by the patient).
- Requires absence from Hospital A to undertake only an outpatient service at Hospital B.

Leave periods must be reported in chronological order i.e. date and time order as it occurred. When a patient is on leave, the Hospital is responsible for the patient for the duration of leave as they are still deemed an inpatient and have not been officially discharged.

Use the day, month and year and leading zeros where necessary. 2400 is not considered a valid time. For auditing purposes, the hospital's medical record and internal computer system should reflect the true dates and times of periods of leave so that these can be matched with ISAAC.

No patient days or charges are generated while the patient is on leave. The admission type for the 'admission from leave' will most often be the same as the original admission, but it depends on the circumstances of the admission from leave. If the patient is on leave overnight, the data submitted to ISAAC should indicate that the patient is on leave on both days.

Mental health patients under legal orders (treatment orders) may be authorised to take 'trial leave' for extended periods of time in excess of seven (7) consecutive days. Where this occurs an edit will be triggered. Sites should verify that the trial leave occurred and no further correction or adjustment to the record will be necessary.

#### Example Scenarios

- The admission type for the 'admission from leave' will most often be the same as

the original admission, but it depends on the circumstances of the admission from leave.

- If a patient is on leave overnight, the data submitted to ISAAC should indicate that the patient is on leave on both days.
- For example, if a patient goes on leave following cardiac bypass surgery, and after a period of 72 hours the patient notifies hospital staff of his intention not to return, the patient is then discharged onto leave. If the patient then returns to Emergency Department complaining of chest pain three days later and is admitted, this admission will be an emergency admission type. It is the responsibility of the admitting medical officer to indicate if the reason for admission is related to the previous episode, and therefore the source of referral can be entered as "0=admit from leave".
- A Patient is an inpatient at Hospital A and needs to have a planned outpatient services at Hospital B as part of the Hospital A treatment protocol. The patient should be placed on leave at Hospital A for the duration of the time required to transport and complete the CT Scan. The patient should not be discharged from Hospital A and re-admitted following the CT Scan.
- If a Patient is admitted at Hospital A and sent to Hospital B for an admitted contracted service or Component of Care. Leave must not be used to capture absence for contracted services. Refer to the Appendix 3: Contract Service and Component of Care data standard.
- If a patient is an inpatient at Hospital A and is transferred to Hospital B for treatment that requires admission at Hospital B and there is no contractual service agreement between Hospital A and B, nor is the service considered a partial service provision, then the patient should be discharged from Hospital A and admitted to Hospital B.

### *Collection methods:*

### **Related ISAAC Edits**

#2190 – Periods of leave from date/time invalid  
 #2200 – Periods of leave to date/time invalid  
 #2210 – Periods of leave invalid  
 #2220 – Periods of leave from date invalid  
 #2230 – Periods of leave to date invalid  
 #4610 – Periods of leave - from time required  
 #4620 – Periods of leave - to time required  
 #4625 – Leave > 7 consecutive days



---

## Leave - time of leaving service

---

### Identifying and definitional attributes

<i>Short name:</i>	Patient's leave from service—time of leaving service, hhmm
<i>Synonymous names:</i>	ISAAC Data Items 73, 75, 77, 79
<i>SAHMR identifier:</i>	SA1120
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	A temporary absence from hospital, with medical approval, for a period of not greater than 7 consecutive days, where there is an intended return to hospital for continuation of care or treatment.
Data Element Concept:	Patient's leave from service—Time of leaving service

### Value domain attributes

---

#### Representational attributes

<i>Representation class:</i>	Time
<i>Data type:</i>	Date/Time
<i>Format:</i>	hhmm
<i>Maximum character length:</i>	4

#### Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	Used with Data Items 32-39. A patient can have numerous periods of leave within the one episode of care, but the duration of an individual leave period must not exceed seven (7) consecutive days.
-----------------------	--

A patient qualifies for leave if they meet the following criteria:

- Is to remain under the responsibility of the primary Hospital whilst on leave.
- Actual duration of a single leave period is less than or equal to seven (7) consecutive days.
- There is intention at the start of the leave period that the patient will return to Hospital for continued treatment. (If they do not return they should be discharged on leave effective from the date and time the hospital was notified by the patient).
- Requires absence from Hospital A to undertake only an outpatient service at Hospital B.

Leave periods must be reported in chronological order i.e. date and time order as it occurred. When a patient is on leave, the Hospital is responsible for the patient for the duration of leave as they are still deemed an inpatient and have not been officially discharged.

Use the day, month and year and leading zeros where necessary. 2400 is not considered a valid time. For auditing purposes, the hospital's medical record and internal computer system should reflect the true dates and times of periods of leave so that these can be matched with ISAAC.

No patient days or charges are generated while the patient is on leave. The admission type for the 'admission from leave' will most often be the same as the original admission, but it depends on the circumstances of the admission from leave. If the patient is on leave overnight, the data submitted to ISAAC should indicate that the patient is on leave on both days.

Mental health patients under legal orders (treatment orders) may be authorised to take 'trial leave' for extended periods of time in excess of seven (7) consecutive days. Where this occurs an edit will be triggered. Sites should verify that the trial leave occurred and no further correction or adjustment to the record will be necessary.

### Example Scenarios

- The admission type for the 'admission from leave' will most often be the same as the original admission, but it depends on the circumstances of the admission from leave.
- If a patient is on leave overnight, the data submitted to ISAAC should indicate that the patient is on leave on both days.
- For example, if a patient goes on leave following cardiac bypass surgery, and after a period of 72 hours the patient notifies hospital staff of his intention not to return, the patient is then discharged onto leave. If the patient then returns to Emergency Department complaining of chest pain three days later and is admitted, this admission will be an emergency admission type. It is the responsibility of the admitting medical officer to indicate if the reason for admission is related to the previous episode, and therefore the source of referral can be entered as "0=admit from leave".
- A Patient is an inpatient at Hospital A and needs to have a planned outpatient services at Hospital B as part of the Hospital A treatment protocol. The patient should be placed on leave at Hospital A for the duration of the time required to transport and complete the CT Scan. The patient should not be discharged from Hospital A and re-admitted following the CT Scan.
- If a Patient is admitted at Hospital A and sent to Hospital B for an admitted contracted service or Component of Care. Leave must not be used to capture absence for contracted services. Refer to the Appendix 3: Contract Service and Component of Care data standard.
- If a patient is an inpatient at Hospital A and is transferred to Hospital B for treatment that requires admission at Hospital B and there is no contractual service agreement between Hospital A and B, nor is the service considered a partial service provision, then the patient should be discharged from Hospital A and admitted to Hospital B.
- .

### Collection methods:

#### Related ISAAC Edits

- #2190 – Periods of leave from date/time invalid
- #2200 – Periods of leave to date/time invalid
- #2210 – Periods of leave invalid
- #2220 – Periods of leave from date invalid
- #2230 – Periods of leave to date invalid
- #4610 – Periods of leave - from time required
- #4620 – Periods of leave - to time required
- #4625 – Leave > 7 consecutive days

---

## Leave - time of resuming service

---

### Identifying and definitional attributes

<i>Short name:</i>	Patient's leave from service—time of resuming service, hhmm
<i>Synonymous names:</i>	ISAAC Data Items 74, 76, 78, 80
<i>SAHMR identifier:</i>	SA1121
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	A temporary absence from hospital, with medical approval, for a period of not greater than 7 consecutive days, where there is an intended return to hospital for continuation of care or treatment.
Data Element Concept:	Patient's leave from service—Time of resuming service

### Value domain attributes

---

#### Representational attributes

<i>Representation class:</i>	Time
<i>Data type:</i>	Date/Time
<i>Format:</i>	hhmm
<i>Maximum character length:</i>	4

#### Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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### Data element attributes

---

#### Collection and usage attributes

<i>Guide for use:</i>	Used with Data Items 32-39 & 73,75,77,79. A patient can have numerous periods of leave within the one episode of care, but the duration of an individual leave period must not exceed seven (7) consecutive days.
-----------------------	--

A patient qualifies for leave if they meet the following criteria:

- Is to remain under the responsibility of the primary Hospital whilst on leave.
- Actual duration of a single leave period is less than or equal to seven (7) consecutive days.
- There is intention at the start of the leave period that the patient will return to Hospital for continued treatment. (If they do not return they should be discharged on leave effective from the date and time the hospital was notified by the patient).
- Requires absence from Hospital A to undertake only an outpatient service at Hospital B.

Leave periods must be reported in chronological order i.e. date and time order as they occurred. When a patient is on leave, the Hospital is responsible for the patient for the duration of leave as they are still deemed an inpatient and have not been officially discharged.

Use the day, month and year and leading zeros where necessary. 2400 is not considered a valid time. For auditing purposes, the hospital's medical record and internal computer system should reflect the true dates and times of periods of leave so that these can be matched with ISAAC.

No patient days or charges are generated while the patient is on leave. The admission type for the 'admission from leave' will most often be the same as the original admission, but it depends on the circumstances of the admission from leave. If the patient is on leave overnight, the data submitted to ISAAC should indicate that the patient is on leave on both days.

Mental health patients under legal orders (detention orders) may be authorised to take 'trial leave' for extended periods of time in excess of seven (7) consecutive days. Where this occurs an edit will be triggered. Sites should verify that the trial leave occurred and no further correction or adjustment to the record will be necessary.

### Example Scenarios

- The admission type for the 'admission from leave' will most often be the same as the original admission, but it depends on the circumstances of the admission from leave.
- If a patient is on leave overnight, the data submitted to ISAAC should indicate that the patient is on leave on both days.
- For example, if a patient goes on leave following cardiac bypass surgery, and after a period of 72 hours the patient notifies hospital staff of his intention not to return, the patient is then discharged onto leave. If the patient then returns to Emergency Department complaining of chest pain three days later and is admitted, this admission will be an emergency admission type. It is the responsibility of the admitting medical officer to indicate if the reason for admission is related to the previous episode, and therefore the source of referral can be entered as "0=admit from leave".
- A patient is an inpatient at Hospital A and needs to have a planned outpatient service (eg. CT Scan) at Hospital B as part of the Hospital A treatment protocol. The patient should be placed on leave at Hospital A for the duration of the time required to transport and complete the CT Scan. The patient should not be discharged from Hospital A and re-admitted following the CT Scan.
- If a Patient is admitted at Hospital A and sent to Hospital B for an admitted contracted service or Component of Care. Leave must not be used to capture absence for contracted services. Refer to the Appendix 3: Contract Service and Component of Care data standard.
- If a patient is an inpatient at Hospital A and is transferred to Hospital B for treatment that requires admission at Hospital B and there is no contractual service agreement between Hospital A and B, nor is the service considered a partial service provision, then the patient should be discharged from Hospital A and admitted to Hospital B.

#### *Collection methods:*

#### **Related ISAAC Edits**

- #2190 – Periods of leave from date/time invalid
- #2200 – Periods of leave to date/time invalid
- #2210 – Periods of leave invalid
- #2220 – Periods of leave from date invalid
- #2230 – Periods of leave to date invalid
- #4610 – Periods of leave - from time required
- #4620 – Periods of leave - to time required
- #4625 – Leave > 7 consecutive days

## Legal status

### Identifying and definitional attributes

<i>Technical name:</i>	Patient— Mental Health Legal Status, code N
<i>Synonymous names:</i>	ISAAC Data Item 71
<i>SAHMR identifier:</i>	SA1626
<i>Registration status:</i>	SA Health, Candidate 01/07/2015
<i>Definition:</i>	The mental health <i>Legal status</i> of a patient under relevant Acts of Parliament. <i>Legal status</i> is to be collected on separation indicating whether <u>any part</u> of a patient's stay in hospital was <i>involuntary</i> .

Data Element      Patient—Mental Health Legal Status  
Concept:

### Value domain attributes

#### Representational attributes

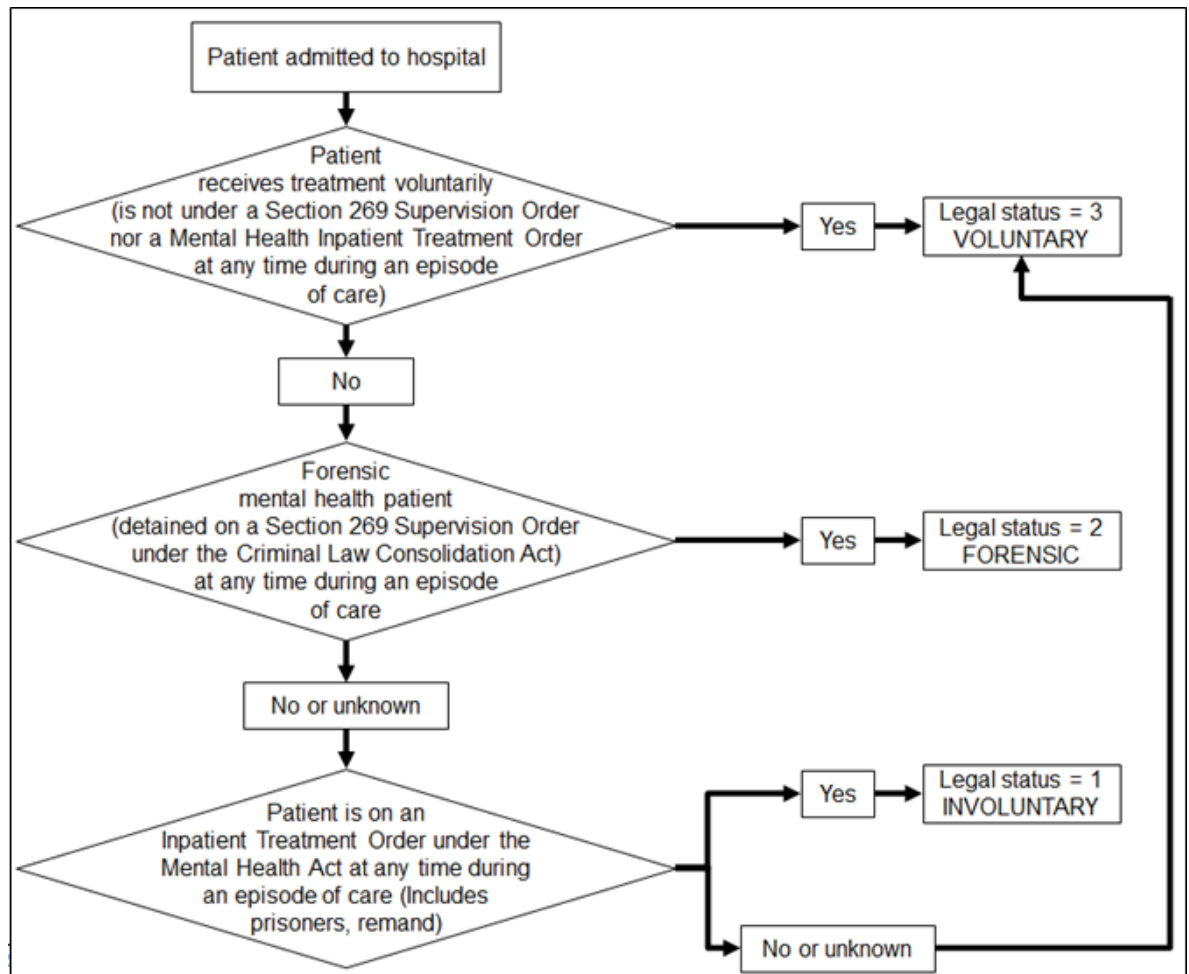
<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table> <thead> <tr> <th>Value</th><th>Meaning</th></tr> </thead> <tbody> <tr> <td>1</td><td>Involuntary</td></tr> <tr> <td>2</td><td>Forensic</td></tr> <tr> <td>3</td><td>Voluntary</td></tr> </tbody> </table>	Value	Meaning	1	Involuntary	2	Forensic	3	Voluntary
Value	Meaning								
1	Involuntary								
2	Forensic								
3	Voluntary								

### Data element attributes

#### Collection and usage attributes

<i>Guide for use:</i>	<table> <tr> <td>1 Involuntary</td><td>Patients on an Inpatient Treatment Order under the Mental Health Act (MH ITO) at any time during an episode of care. Includes patients who are prisoners or remanded in custody treated compulsorily under a MH ITO and are <u>not</u> under an S269 O, U or X order.</td></tr> <tr> <td>2 Forensic</td><td>Patients who are under a Section 269 O, U or X Order under the Criminal Law Consolidation Act at any time during an episode of care. A MH ITO is <u>not</u> also required in order to code a patient's episode as having a Forensic Legal Status; where a patient is under both a MH ITO and a Section 269 O, U or X Order during an episode the patient should be coded as Forensic.</td></tr> <tr> <td>3 Voluntary</td><td>All other patients who are not Involuntary or Forensic. This category will apply to the majority of patients. Includes prisoners receiving mental health care under neither an MH ITO nor an S269 Supervision Order.</td></tr> </table>	1 Involuntary	Patients on an Inpatient Treatment Order under the Mental Health Act (MH ITO) at any time during an episode of care. Includes patients who are prisoners or remanded in custody treated compulsorily under a MH ITO and are <u>not</u> under an S269 O, U or X order.	2 Forensic	Patients who are under a Section 269 O, U or X Order under the Criminal Law Consolidation Act at any time during an episode of care. A MH ITO is <u>not</u> also required in order to code a patient's episode as having a Forensic Legal Status; where a patient is under both a MH ITO and a Section 269 O, U or X Order during an episode the patient should be coded as Forensic.	3 Voluntary	All other patients who are not Involuntary or Forensic. This category will apply to the majority of patients. Includes prisoners receiving mental health care under neither an MH ITO nor an S269 Supervision Order.
1 Involuntary	Patients on an Inpatient Treatment Order under the Mental Health Act (MH ITO) at any time during an episode of care. Includes patients who are prisoners or remanded in custody treated compulsorily under a MH ITO and are <u>not</u> under an S269 O, U or X order.						
2 Forensic	Patients who are under a Section 269 O, U or X Order under the Criminal Law Consolidation Act at any time during an episode of care. A MH ITO is <u>not</u> also required in order to code a patient's episode as having a Forensic Legal Status; where a patient is under both a MH ITO and a Section 269 O, U or X Order during an episode the patient should be coded as Forensic.						
3 Voluntary	All other patients who are not Involuntary or Forensic. This category will apply to the majority of patients. Includes prisoners receiving mental health care under neither an MH ITO nor an S269 Supervision Order.						

*Collection methods:*      The following diagram shows the process for correct assignment of Legal Status:

**Related ISAAC Edits**

#4220 - Legal status invalid

## Marital status

### Identifying and definitional attributes

<i>Technical name:</i>	Patient—marital status, code N
<i>Synonymous names:</i>	ISAAC Data Item 12
<i>SAHMR identifier:</i>	SA1109
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.

Data Element Concept: Patient—Marital status

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code														
<i>Data type:</i>	Number														
<i>Format:</i>	N														
<i>Maximum character length:</i>	1														
<i>Permissible values:</i>	<table> <thead> <tr> <th>Value</th><th>Meaning</th></tr> </thead> <tbody> <tr> <td>1</td><td>Never married</td></tr> <tr> <td>2</td><td>Married / De Facto</td></tr> <tr> <td>3</td><td>Widowed</td></tr> <tr> <td>4</td><td>Divorced</td></tr> <tr> <td>5</td><td>Separated</td></tr> <tr> <td>9</td><td>Unknown / Not stated</td></tr> </tbody> </table>	Value	Meaning	1	Never married	2	Married / De Facto	3	Widowed	4	Divorced	5	Separated	9	Unknown / Not stated
Value	Meaning														
1	Never married														
2	Married / De Facto														
3	Widowed														
4	Divorced														
5	Separated														
9	Unknown / Not stated														
<i>Supplementary values:</i>															

### Data element attributes

#### Collection and usage attributes

*Guide for use:*

<b>1 Never married</b>	A person who has not entered into a couple relationship. If the patient is less than 16 years of age, then default to '1-Never Married'.
<b>2 Married/De Facto</b>	This refers to registered marriages and de facto marriages. Includes people who have been divorced or widowed but have since re-married, and should be generally accepted as applicable to all de facto couples, including couples of the same sex.
<b>3 Widowed</b>	This code usually refers to registered marriages but when self-reported may refer to de facto marriages.
<b>4 Divorced</b>	This code usually refers to registered marriages but when self-reported may refer to de facto marriages.
<b>5 Separated</b>	This code usually refers to registered marriages but when self-reported may refer to de facto marriages.
<b>9 Unknown / Not Stated</b>	This code is not for use on primary collection forms. This code is primarily for use in administrative collections when transferring data from data sets where the item has not been collected.

*Collection methods:*

#### **Related ISAAC Edit**

#4190 – Marital status invalid

## Medicare IRN

### Identifying and definitional attributes

*Technical name:* Patient—Medicare Individual reference number, identifier N(1)  
*Synonymous names:* ISAAC Data Item 100  
*SAHMR identifier:* SA1374  
*Registration status:* No registration status  
*Definition:* The 2012 ISAAC collection received 10 digits for the Medicare number from the hospitals. It is now a requirement that as of July 1 2013 11 digits are captured. This is to include the identifier for the family member called Individual Reference Number (IRN) on the Medicare card which appears a single digit.

Data Element Concept: Patient—Medicare Individual Reference Number

### Value domain attributes

#### Representational attributes

*Representation class:* Identifier  
*Data type:* Number  
*Format:* N(1)  
*Maximum character length:* 1  
*Permissible values:*

Value	Meaning
1-9	representing each family member on the Medicare card

### Data element attributes

#### Collection and usage attributes

*Guide for use:* Once the information has been obtained, or the patient's eligibility for Medicare has been ascertained, make the entries for the Medicare number and IRN as follows:

Medicare No. 4961991871, IRN 2:

4	9	6	1	9	9	1	8	7	1	IRN
										2

If the patient is eligible for Medicare, but is not yet registered:

0	0	0	0	0	0	0	0	0	0	IRN
										0

If the patient is ineligible for Medicare:

0	0	0	0	0	0	0	0	0	9	IRN
										0

If the patient is registered, but after considerable attempts, the hospital is unable to obtain the Medicare number:

0	0	0	0	0	0	0	0	0	0	IRN
										0

*Collection methods:*

#### **Related ISAAC Edits**

#4382 - Medicare number IRN invalid for Medicare number

#4382a – Medicare number IRN invalid for supplementary Medicare number



*Comments:*

**Additional Notes**

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

**Reciprocal Health Care Agreements (RCHA)**

The following countries have Reciprocal Health Care Agreements with Australia:

Belgium, Finland, Italy\*, Malta\*, New Zealand, Norway, Slovenia, Sweden, the Netherlands, the Republic of Ireland, the United Kingdom

**\*only eligible when visa is for 6 months or less**

Up to date information on overseas patient's eligibility is available from Medicare Australia:

<http://www.medicareaustralia.gov.au/public/migrants/visitors/index.jsp>

## Medicare Number

### Identifying and definitional attributes

<i>Technical name:</i>	Patient—Medicare number, identifier N(10)
<i>Synonymous names:</i>	ISAAC Data Item 4
<i>SAHMR identifier:</i>	SA1110
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The main ten digits of the patient's Medicare number.

Data Element Concept: Patient—Medicare Number

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Identifier								
<i>Data type:</i>	Number								
<i>Format:</i>	N(10)								
<i>Maximum character length:</i>	10								
<i>Permissible values:</i>	<table> <tr> <th>Value</th><th>Meaning</th></tr> <tr> <td>NNNNNNNNNN</td><td>A valid Medicare number (refer Medicare number check digit below)</td></tr> <tr> <td>0000000009</td><td>Ineligible for Medicare</td></tr> <tr> <td>0000000000</td><td>Eligible but number unavailable</td></tr> </table>	Value	Meaning	NNNNNNNNNN	A valid Medicare number (refer Medicare number check digit below)	0000000009	Ineligible for Medicare	0000000000	Eligible but number unavailable
Value	Meaning								
NNNNNNNNNN	A valid Medicare number (refer Medicare number check digit below)								
0000000009	Ineligible for Medicare								
0000000000	Eligible but number unavailable								

#### Collection and usage attributes

*Guide for use:* Once the information has been obtained, or the patient's eligibility for Medicare has been ascertained, make the entries for the Medicare number as follows:

##### Medicare No. 4961991871:

4	9	6	1	9	9	1	8	7	1
---	---	---	---	---	---	---	---	---	---

If the patient is eligible for Medicare, but is not yet registered:

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

If the patient is ineligible for Medicare:

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

If the patient is registered, but after considerable attempts, the hospital is unable to obtain the Medicare number:

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

#### Medicare Check Algorithm

Hospitals are urged to implement an edit check on their local systems to ensure the

Medicare Number reported to ISAAC is accurate. Those hospitals submitting paper records are reminded to ensure Medicare Numbers are recorded carefully.

#### Technical Specification

Format: 10 digit field, numeric

Check Digit: value in 9th position

Card Issue Number: value in 10th position

### **Algorithm**

(DIGIT 1 + (DIGIT 2 \* 3)

+ (DIGIT 3 \* 7) + (DIGIT 4 \* 9)

+ (DIGIT 5) + (DIGIT 6 \* 3)

+ (DIGIT 7 \* 7) + (DIGIT 8 \* 9)

DIVIDE THE ANSWER BY 10. THE RESULT GIVES AN AMOUNT AND A REMAINDER. THE REMAINDER SHOULD BE THE SAME AS THE CHECK DIGIT.

### **Example**

Medicare Card Number: 2428 77813 2. The Check Digit is (3) and the card has been issued twice (2).

(2) + (4 \* 3) 12

+ (2 \* 7) 14 + (8 \* 9) 72

+ (7) + (7 \* 3) 21

+ (8 \* 7) 56 + (1 \* 9) 9

Divide the ANSWER (193) by 10. The RESULT (19.3) gives an AMOUNT (19) and a REMAINDER (3). The REMAINDER (3) should be same as the CHECK DIGIT (3).

## **Data element attributes**

### **Collection and usage attributes**

*Guide for use:*

<b>Eligibility for Medicare</b>	<p>The majority of patients will be eligible for Medicare. Therefore, only rarely will checking for eligibility be necessary. Eligible but number not available, unknown, unidentified include:</p> <ul style="list-style-type: none"> <li>• Overseas visitors who usually reside in a country with a Reciprocal Health Care Agreement (RHCA).</li> <li>• Card number not able to be provided by a permanent resident who is an Australian or New Zealand citizen.</li> <li>• Card number not able to be provided by a temporary resident who has applied for permanent residency.</li> <li>• Unable to ascertain Medicare eligibility (i.e. card not available, unconscious, unable to identify patient).</li> </ul> <p>(Refer also Data Item 95, Funding Source).</p>
<b>Ineligible for Medicare</b>	<p>Ineligible patients include:</p> <ul style="list-style-type: none"> <li>• Overseas visitors who come from a country without reciprocal health care arrangements.</li> </ul>

	<ul style="list-style-type: none"> <li>• Temporary residents.</li> <li>• Overseas visitors travelling on a student visa (Baby born in Australia to o/s parents not Medicare eligible are not automatically an Aust. citizen, therefore Medicare number would be 0000000009).</li> <li>• Overseas visitors who reside in Malta and Italy whose visa is greater than 6 months.</li> </ul> <p>(Refer also Data Item 95, Funding Source).</p>
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Collection methods:

**Related ISAAC Edits**

#4380 – Medicare number invalid

Comments:

**Additional Notes**

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

**Reciprocal Health Care Agreements (RCHA)**

The following countries have Reciprocal Health Care Agreements with Australia:

Belgium, Finland, Italy\*, Malta\*, New Zealand, Norway, Slovenia, Sweden, the Netherlands, the Republic of Ireland, the United Kingdom

**\*only eligible when visa is for 6 months or less**

Up to date information on overseas patient's eligibility is available from Medicare Australia:

<http://www.medicareaustralia.gov.au/public/migrants/visitors/index.jsp>

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## Mental health linking number

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—mental health linking number, identifier N(10)
<i>Synonymous names:</i>	ISAAC Data Item 83
<i>SAHMR identifier:</i>	SA1112
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The Mental Health Services has a "state wide" service number for their patients.
Data Element Concept:	Patient—Mental health linking number

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	N(10)
<i>Maximum character length:</i>	10

### Data element attributes

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#### Collection and usage attributes

<i>Guide for use:</i>	Hospitals will be advised when this data item is relevant for their hospital.
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<i>Collection methods:</i>	<b><u>Related ISAAC Edits</u></b> #4640 – Mental health linking number invalid same as patient UR
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## Nature of separation

### Identifying and definitional attributes

<i>Technical name:</i>	Patient's separation from service—nature of separation, code X
<i>Synonymous names:</i>	ISAAC Data Item 42
<i>SAHMR identifier:</i>	SA1086
<i>Registration status:</i>	SA Health, Standard 21/10/2011
<i>Definition:</i>	The status on separation of the patient (discharge/transfer/death) and where they were released (if applicable).

Data Element Concept: Patient's separation from service—Nature of separation

### Value domain attributes

#### Representational attributes

Representation class:	Code	
Data type:	String	
Format:	X	
Maximum character length:	1	
Permissible values:	Value	Meaning
	0	Discharge on leave
	1	Home
	2	Other hospital - up transfer
	3	Residential aged care facility
	4	Other health care accommodation
	5	Died - no autopsy
	6	Died - autopsy
	7	Other hospital - down transfer
	8	Self discharge
	A	Administrative discharge
	E	End of quarter reporting
	X	Retrieval
Supplementary values:	9	Unknown

### Data element attributes

#### Collection and usage attributes

*Guide for use:*

<b>0 Discharge on Leave</b>	<p>Patients who were initially sent on leave, with medical approval for a period not greater than seven (7) consecutive days and there was an intent to return to hospital for continuation of care or treatment i.e. for a period less than seven (7) consecutive days e.g. 48 hrs, but failed to return within 48 hours. These patients must be formally discharged when they fail to return, by recording the Nature of Separation as 0-discharge on leave.</p> <p><b>Additional Notes</b></p> <ul style="list-style-type: none"> <li>Record the Separation Date and Time as the date/time when the medically approved leave e.g. 48 hours have elapsed.</li> <li>If a patient is on leave and advises that they will not return from leave, record the Separation Date and Time as the date/time the patient communicated their non-return.</li> <li>If the patient is discharged and to be readmitted in 5 days time, for example, this is not considered a period of leave. In this case the Nature of Separation should be NOT be equal to 0-discharge on leave. Do not record Nature of Separation as 0-discharge on leave.</li> <li>Do not record Nature of Separation as 0-discharge on leave if a patient is sent to another hospital for admission as a day stay</li> </ul>
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	patient. A <u>patient cannot be placed on leave at one hospital, while an in-patient at another.</u>
<b>1 Home</b>	<p>Patient returning home or to their usual residence, or being transferred to other facilities where health care is not available.</p> <p><b>Additional Notes</b> Home <u>includes</u> patients:</p> <ul style="list-style-type: none"> <li>• Transferred to jail;</li> <li>• Discharged to accommodation facilities that do not provide medical/nursing care i.e. backpackers hostels and hotels/motels.</li> <li>• Discharged/transferred to a residential aged care facility if this is their usual residence.</li> </ul> <p>Home <u>excludes</u> patients:</p> <ul style="list-style-type: none"> <li>• Discharged to a residential aged care facility for the first time (i.e. not their usual place of residence).</li> </ul>
<b>2 Other Hospital – Up Transfer</b>	<p>Patient transferred to another hospital for the purpose of receiving an EQUIVALENT OR INCREASED LEVEL OF CARE relative to that just received. Patients must be transferred directly from your hospital, for admission to the destination hospital.</p> <p><b>Additional Notes</b></p> <ul style="list-style-type: none"> <li>• When using this value Hospital Transferred To must be completed with a valid Hospital Code.</li> <li>• For an inter-hospital transfer, the patient does not necessarily need to be transferred in an ambulance. There are instances where a friend or family member actually drives the patient between the hospitals. These should still be considered as inter-hospital transfers if undertaken within 24 hours, and travel is directly to the other hospital, i.e. excludes an overnight stay elsewhere.</li> </ul> <p>Other Hospital-up transfer includes:</p> <ul style="list-style-type: none"> <li>• A sick baby transferred to a hospital to receive specialist neonatal care after undergoing stabilisation would represent an up transfer.</li> <li>• A patient transferred from a country hospital to a metropolitan hospital for rehabilitation, i.e. for specialist care.</li> </ul> <p>Excludes patients:</p> <ul style="list-style-type: none"> <li>• Discharged to residential aged care facility. In this case record "2 Discharged to residential aged care facility".</li> <li>• Discharged to Julia Farr - record "3- Residential Aged Care Facility".</li> </ul>
<b>3 Residential Aged Care Facility or Hostel</b>	<p>Patient discharged to a residential aged care facility or hostel (which is not the patient's usual residence) <b>providing medical or nursing care.</b></p> <p><b>Exclusions:</b></p> <ul style="list-style-type: none"> <li>• If the residential aged care facility or hostel is their usual place of residence record as 1=Home.</li> <li>• 'Youth hostels' and 'backpackers hostels' are considered accommodation only hostels and do not provide medical or nursing care. For data collection purposes, patients discharged to accommodation only hostels are to be considered as "1=Home".</li> </ul>
<b>4 Other Health Care Accommodation</b>	Patient discharged to other accommodation providing medical/nursing care not specified in other Nature of Separation categories.
<b>5 Died - No Autopsy</b>	Patient who died in hospital and no autopsy will be/was performed. <i>Use this category if you do not know whether an autopsy is being performed.</i>

<b>6 Died – Autopsy</b>	Patient who died in hospital and an autopsy will be/was performed.
<b>7 Other Hospital - Down Transfer</b>	<p>Patient transferred to another hospital for the purpose of receiving a REDUCED LEVEL OF CARE relative to that just received. Patients must be transferred directly from your hospital, for admission to the destination hospital.</p> <p><b>Additional Notes</b></p> <ul style="list-style-type: none"> <li>When using this value Hospital Transferred From must be completed with a valid Hospital Code.</li> <li>For an inter-hospital transfer, the patient does not necessarily need to be transferred in an ambulance. There are instances where a friend or family member actually drives the patient between the hospitals. These should still be considered as inter-hospital transfers if undertaken within 24 hours, and travel is directly to the other hospital, i.e. excludes an overnight stay elsewhere.</li> </ul> <p>Other Hospital-down transfer includes:</p> <ul style="list-style-type: none"> <li>Patient transferred to a hospital close to home for convalescence, after receiving specialist burns care in a teaching hospital.</li> </ul> <p>Excludes:</p> <ul style="list-style-type: none"> <li>Discharges to residential aged care facility. In this case record "3- Discharge to residential aged care facility".</li> <li>Patients discharged to Julia Farr are to be recorded "3- Residential Aged Care Facility".</li> </ul>
<b>8 Self Discharge</b>	Patient who has discharged themselves or left against medical advice.
<b>9 Unknown</b>	When it is unknown to where the patient is discharged. There should be minimal incidents of this category.
<b>A Administrative Discharge</b>	<p>This category is for reporting changes in episodes of care. When a patient's clinical intent changes from one type of care to another, an administrative discharge is required i.e. the patient is NOT formally discharged, but remains in hospital and changes their care type. Commencement of an administrative admission is then required. (Refer also to Source of Referral and Episodes of Care.)</p> <p><b>Additional Notes</b></p> <ul style="list-style-type: none"> <li>Administrative Discharge is required whenever a patient begins a new episode type of care, including Hospital at Home.</li> <li>A patient who is discharged home or transferred cannot be recorded as an administrative discharge.</li> </ul>
<b>E End of Quarter Reporting</b>	<p>Used to report patients who are still in hospital at the end of the quarter.</p> <p>This value is only applicable for public hospitals and only for Maintenance Care patients and some specific mental health patients at specific sites.</p> <p>Refer also Source of Referral and Episode of Care.</p> <p><b>Additional Notes</b></p> <p>Used to report patients who are still in hospital at the end of the quarter.</p> <ul style="list-style-type: none"> <li>All data items on the ISAAC form must be completed prior to submission to ISAAC Unit i.e. for both formal discharges and administrative discharges.</li> <li>A Hospital at Home episode may not have a Nature of Separation code equal to E - End of Quarter Reporting. When a patient leaves a hospital at home episode it is a formal discharge. Use the appropriate Nature of Separation code, e.g. 0,1, 3-6, 8, 9. When a patient leaves the hospital at home episode to return to inpatient care the patient is also formally discharged - use "1 = Home".</li> </ul>



<b>X Retrieval</b>	<p>A retrieval involves the transportation of seriously ill or injured person/s under the specialist care of a recognised retrieval team. The seriously ill or injured person/s requires specialised monitoring and treatment in transit to the retrieving hospital. A retrieval team is formally recognised by the hospital and usually consists of two staff, a medical officer and a nurse. On some occasions the team may include a second medical officer and/or nurse.</p> <p><b>Additional Notes</b></p> <ul style="list-style-type: none"> <li>• If the retrieval is to another South Australian hospital, the four (4) digit hospital code must be recorded in "Hospital Transferred To" (data item 44).</li> <li>• "X-Retrieval" must only be assigned when the nature of separation is consistent with the domain definition as detailed above.</li> </ul>
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## Data element attributes

### Collection and usage attributes

#### *Collection methods*

#### **Related ISAAC Edits**

- #2080 – Nature of separation invalid
- #2085 – Wrong nature of separation for H@H/R@H
- #4740 – E invalid for private hospitals - set to 9
- #2720 – Referral to H@H – Nature of Sep Incorrect
- #2750 – Incorrect NOS & Ref for Ep of Care Type
- #4985 – Unqualified newborn with NOS=death
- #4995 – Nature of Separation invalid without leave

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## OACIS Linking Variable

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—OACIS linking variable, identifier N(10)
<i>Synonymous names:</i>	ISAAC Data Item 84
<i>SAHMR identifier:</i>	SA1114
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	<p>The implementation of OACIS (Open Architecture Clinical Information System) has resulted in the development of a linking variable for admitted patients across OACIS sites.</p> <p>Note this data item has been included in the ISAAC submission format specifications but not on the ISAAC form. Refer to Appendix 1: File Submission Format – 746 (effective from 1 July 2013, applies 2015-16)</p>
<i>Data Element Concept:</i>	Patient—OACIS identifier

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	N(10)
<i>Maximum character length:</i>	10

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## Operating theatre – Date of first procedure (DFOTP)

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### Identifying and definitional attributes

<i>Technical name:</i>	Operating theatre procedure—date of event (first performed), DDMMYYYY
<i>Synonymous names:</i>	ISAAC Data Item 96
<i>SAHMR identifier:</i>	SA1068
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Date of the first procedure performed in an Operating Theatre for an episode of care.
 Data Element Concept:	 Operating theatre procedure—Date of event (first performed)

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

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#### Collection and usage attributes

*Guide for use:* The Date of First Operating Theatre Procedure Performed only needs to be collected by the following designated public hospitals:

- Flinders Medical Centre
- Lyell McEwin Hospital
- Modbury Public Hospital
- Noarlunga Public Hospital
- Repatriation General Hospital
- Royal Adelaide Hospital
- The Queen Elizabeth Hospital
- Women's and Children's Hospital

#### Additional Notes

- The Date of First Operating Theatre Procedure Performed is collected in conjunction with the Time of First Operating Theatre Procedure Performed to facilitate the monitoring of time between admission and first operating theatre procedure performed.
- Where the date of admission is the same as the procedure date this would facilitate the derivation of the Day of Surgery Admission (DOSa) Indicator.
- See also Time of First Operating Theatre Procedure Performed - data item 81.

*Collection methods:*

#### **Related ISAAC Edits**

- #2001 – DFOTP before Admission Date
- #2002 – DFOTP after Separation Date
- #2005 – DFOTP must be accompanied by TFOTP

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## Operating theatre – Time of first procedure (TFOTP)

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### Identifying and definitional attributes

<i>Technical name:</i>	Operating theatre procedure—time first performed, hhmm
<i>Synonymous names:</i>	ISAAC Data Item 81
<i>SAHMR identifier:</i>	SA1069
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The time the first procedure (in 24 hour clock), performed in an operating theatre, actually commenced for an episode of care.
Data Element Concept:	Operating theatre procedure—Time first performed

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Time
<i>Data type:</i>	Date/Time
<i>Format:</i>	Hhmm
<i>Maximum character length:</i>	4

#### Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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### Data element attributes

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#### Collection and usage attributes

<i>Guide for use:</i>	<p>The Time of First Operating Theatre Procedure Performed only needs to be collected by the following designated public hospitals:</p> <ul style="list-style-type: none"> <li>Flinders Medical Centre</li> <li>Lyell McEwin Hospital</li> <li>Modbury Public Hospital</li> <li>Noarlunga Public Hospital</li> <li>Repatriation General Hospital</li> <li>Royal Adelaide Hospital</li> <li>The Queen Elizabeth Hospital</li> <li>Women's and Children's Hospital</li> </ul>
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#### Additional Notes

- The Time of First Operating Theatre Procedure Performed is collected in conjunction with the Date of First Operating Theatre Procedure Performed.
- Both items facilitate the monitoring of time between admission and first operating theatre procedure performed i.e. Day of Surgery Admission (DOSA) Indicator.

#### Collection methods:

#### Related ISAAC Edits

#2003 TFOTP before Admission Time  
 #2004 TFOTP after Separation Time  
 #2006 TFOTP must be accompanied by DFOTP

## Patient Category - Intent

### Identifying and definitional attributes

<i>Technical name:</i>	Patient admission—admission intention (stay type), code N
<i>Synonymous names:</i>	ISAAC Data Item 14
<i>SAHMR identifier:</i>	SA1074
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	<p>This field indicates the admission intention at the time of admission.</p> <p>The definition of this data item should be applied to each individual episode of care. It facilitates the validation of hospital utilisation in relation to the Casemix reporting requirements. Refer Casemix Funding Technical Bulletin 95:17.</p> <p>Minimum criteria established by the Commonwealth Government must be applied to all patient (public and private) admissions. The minimum criteria which must be met before a patient can be admitted is that the patient receives one of the services described.</p>

Data Element Concept: Patient admission—Admission intention - stay type

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code										
<i>Data type:</i>	Number										
<i>Format:</i>	N										
<i>Maximum character length:</i>	1										
<i>Permissible values:</i>	<table> <thead> <tr> <th>Value</th><th>Meaning</th></tr> </thead> <tbody> <tr> <td>1</td><td>Overnight stay</td></tr> <tr> <td>2</td><td>Day only Type C professional attention procedures</td></tr> <tr> <td>3</td><td>Boarder</td></tr> <tr> <td>4</td><td>Day Only surgical bands 1A, 1B, 2, 3 and 4</td></tr> </tbody> </table>	Value	Meaning	1	Overnight stay	2	Day only Type C professional attention procedures	3	Boarder	4	Day Only surgical bands 1A, 1B, 2, 3 and 4
Value	Meaning										
1	Overnight stay										
2	Day only Type C professional attention procedures										
3	Boarder										
4	Day Only surgical bands 1A, 1B, 2, 3 and 4										

#### Collection and usage attributes

##### Collection methods

1 <b>Overnight Stay - Intent</b>	<p>An overnight stay patient is a person who:</p> <ul style="list-style-type: none"> <li>Registered as a patient at your hospital; and</li> <li>Undergone your admission procedure; and</li> <li>Occupies an approved bed for the purpose of treatment, and</li> <li>Admitted with the <b>intention of discharge after a minimum of one night</b> in hospital. This includes patients who subsequently leave on their own accord, die or are transferred on their first day in hospital.</li> </ul> <p>It excludes persons who are NOT sick i.e. healthy mothers accompanying sick children.</p>
2 <b>Day Only Type C Professional Attention Procedures - Intent</b>	<p>A day only (or same-day) Type C patient is a person who:</p> <ul style="list-style-type: none"> <li>Registered as a patient at your hospital;</li> <li>Undergone your admission procedure; and</li> <li>Admitted with the <b>intention of discharge</b> on the same day; and</li> <li>Will receive professional attention according to the Day Only Type C exclusion list.</li> </ul>

	<p><b>Additional Notes - Type C</b></p> <p>Day Only Type C professional attention includes those procedures that do NOT normally require hospital treatment.</p> <p>The Type C exclusion list is a list of services for which basic table benefits will <u>not</u> normally be paid. However, there will be occasions when admission is warranted and completion of a <i>Day Only Procedure Certification</i> (component of form 1830) will enable the payment of a Band 1 accommodation benefit.</p> <p>The certifications that are part of the arrangements are requirements under subsection 4C(1), 4C(2) and 4C(3) of the National Health Act 1953.</p> <p>FOR FURTHER INFORMATION REFER TO THE COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE DAY ONLY PROCEDURES MANUAL (SEPTEMBER 1999), AVAILABLE FOR DOWNLOAD FROM:</p> <p><a href="http://www.sahealth.sa.gov.au/isaac">www.sahealth.sa.gov.au/isaac</a>, click on Integrated South Australian Activity Collection (ISAAC) Resources and select 'Day Only Procedures Manual 1999'</p> <p>ALTERNATIVELY CONTACT YOUR HOSPITAL FINANCE DEPARTMENT FOR SPECIFIC DEFINITIONS OF THE ABOVE SAME DAY SERVICES.</p>
<p><b>3</b> <b>Boarders</b> <b>(not</b> <b>Reported</b> <b>to ISAAC)</b></p>	<p>A boarder is a person who does not receive any medical treatment and/or care. ISAAC does not collect data on boarders.</p> <p><b>Additional Notes</b></p> <ul style="list-style-type: none"> <li>• A boarder thus defined is not admitted to the hospital. However, a hospital may register a boarder.</li> <li>• Babies in hospital at age 9 days or less cannot be boarders.</li> <li>• Morbidity details should only relate to persons who are formally admitted as inpatients. The status of boarders may be recorded in Item 14 Patient Category, if it is hospital policy to complete an ISAAC form, however, this data must not be submitted to ISAAC.</li> </ul>
<p><b>4</b> <b>Day Only -</b> <b>Other</b></p>	<p>A day only (or same-day) patient is a person:</p> <ul style="list-style-type: none"> <li>• Registered as a patient at your hospital;</li> <li>• Undergone your admission procedure; and</li> <li>• Admitted with the <b>intention of discharge</b> on the same day. This includes patients who are subsequently required to stay in hospital for one night or more.</li> </ul> <p>The day arrangements are part of the health insurance "basic table" which is defined in the National Health Act 1953. The certifications that are part of the arrangements are requirements, for both public and private patients, under sub-section 4C(1), 4C(2) and 4C(3) of the National Health Act 1953. Patients who present for a procedure listed in the Type C Exclusions, but who have no certificate completed, are to be recorded as outpatients, and not admitted patients.</p> <p>As specified in Bands 1A, 1B, 2, 3 and 4, but excluding uncertified type C professional attention procedures of the Health</p>

	<p>Insurance Basic Table as defined in Subsection 4(1) of the National Health Act 1953.</p> <p><b>Band 1</b></p> <p>A categorisation of Day Only patients which includes gastrointestinal endoscopy, certain minor surgical items and non-surgical procedures that do not normally require anaesthetic. A list of Medicare Benefit Schedule (MBS) item numbers included within band 1 is provided in the Commonwealth Department of Health and Aged Care Day Only Procedures Manual, issued March 1999, available on disk.</p> <p>A certification, the <i>Overnight Stay Certification</i> (component of form 1830), is to be completed when a designated Band 1 patient is admitted to an overnight stay in hospital. It should be noted that the Band 1 list is comprised essentially of minor procedures and overnight admission should not be a common occurrence.</p> <p><b>Band 2</b></p> <p>A categorisation of Day Only Patients which includes procedures (other than band 1) carried out under local anaesthetic with no sedation.</p> <p><b>Band 3</b></p> <p>A categorisation of Day Only Patients which includes procedures (other than band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time (actual time in theatre) is less than one hour.</p> <p><b>Band 4</b></p> <p>A categorisation of Day Only Patients which includes procedures (other than band 1) carried out under general or regional anaesthesia or intravenous sedation. Theatre time (actual time in theatre) is one hour or more.</p> <p>Dialysis patients should be reported each time they are admitted for dialysis. Dialysis patients are not handled any differently to other admissions.</p> <p>FOR FURTHER INFORMATION REFER TO THE COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE DAY ONLY PROCEDURES MANUAL (SEPTEMBER 1999), AVAILABLE FOR DOWNLOAD FROM:</p> <p><a href="http://www.sahealth.sa.gov.au/isaac">www.sahealth.sa.gov.au/isaac</a>, click on Integrated South Australian Activity Collection (ISAAC) Resources and select 'Day Only Procedures Manual 1999'</p> <p>ALTERNATIVELY CONTACT YOUR HOSPITAL FINANCE DEPARTMENT FOR SPECIFIC DEFINITIONS OF THE ABOVE SAME DAY SERVICES.</p> <p><b>Non-admitted</b></p> <p>A non-admitted patient is a person who:</p>
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	<ul style="list-style-type: none"> <li>• Receives health care from a member of your hospital staff, OR receives health care at your hospital; and</li> <li>• Receives a service which is normally charged at Emergency Department/Outpatient rates; and</li> <li>• Is not registered as an admitted patient at your hospital on this occasion.</li> </ul> <p><b>Boundary between sameday inpatients and non-admitted patients</b></p> <p>The sameday patient is receiving care which involves a prolonged procedure or a post-procedural recovery period. The non-inpatient is receiving simpler and less prolonged treatment. Whether or not a patient actually occupies a bed (approved, staffed, or otherwise) is not relevant to the classification as sameday patient or non-inpatient. For statistical purposes, the classification used must coincide with that used for billing.</p>
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#### Data element attributes

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#### Collection and usage attributes

*Collection methods:*

#### Related ISAAC Edits

#1300 – Boarder deleted

#4000 – Inappropriate Sameday Admission

#4009 – Inappropriate Admission: Diabetes Education

#4390 – Patient category invalid



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## Patient unit record number

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient admission—patient unit record number, identifier N(10)
<i>Synonymous names:</i>	ISAAC Data Item 3
<i>SAHMR identifier:</i>	SA1078
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The Patient Unit Record Number, also known as the Unit Record Number (or URN), is a unique identifying number which is allocated to a patient on the first visit or admission to the hospital/health care service and retained for all subsequent admissions and treatments at that hospital.

Data Element Concept: Patient admission—Patient unit record number

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	N(10)
<i>Maximum character length:</i>	10

#### Collection and usage attributes

<i>Guide for use:</i>	<ul style="list-style-type: none"> <li>The use of a unit record numbering system is a prerequisite of the system.</li> <li>Any one patient should have only one Unit Record Number at any one hospital. Conversely, the issuing of the same number to more than one patient should not occur.</li> <li>The same number should be used for the same patient on all admissions; the number should not be allocated to any other patient.</li> <li>Though a patient may die or not receive treatment for a considerable period of time, with the medical record being moved to an inactive filing area, the Unit Record Number should NOT be reused for any other patient.</li> <li>Enter the number assigned to the patient by your hospital. A maximum of 10 digits is allowed. Use numbers only. The unit record number should be entered as follows, using leading zeros where necessary:</li> </ul>
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eg. UR No. 537859

0	0	0	5	3	7	8	5	9
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eg UR No. 76543210

0	7	6	5	4	3	2	1	0
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### Data element attributes

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#### Collection and usage attributes

<i>Collection methods:</i>	<b><u>Related ISAAC Edits</u></b> #1060 - Invalid patient UR number
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## Pension Status

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—pension status, code N
<i>Synonymous names:</i>	ISAAC Data Item 89
<i>SAHMR identifier:</i>	SA1115
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Identifies whether or not a person is in receipt of a pension and the nature of that pension (note that this does not mean the pension is necessarily the recipient's main source of income).

Data Element Concept: Patient—Pension status

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code																
<i>Data type:</i>	Number																
<i>Format:</i>	N																
<i>Maximum character length:</i>	1																
<i>Permissible values:</i>	<table> <thead> <tr> <th>Value</th><th>Meaning</th></tr> </thead> <tbody> <tr> <td>1</td><td>Aged</td></tr> <tr> <td>2</td><td>Repatriation</td></tr> <tr> <td>3</td><td>Invalid</td></tr> <tr> <td>4</td><td>Unemployment Benefit</td></tr> <tr> <td>5</td><td>Sickness Benefit</td></tr> <tr> <td>0</td><td>Not Applicable</td></tr> <tr> <td>9</td><td>Other/Unknown (Default Value)</td></tr> </tbody> </table>	Value	Meaning	1	Aged	2	Repatriation	3	Invalid	4	Unemployment Benefit	5	Sickness Benefit	0	Not Applicable	9	Other/Unknown (Default Value)
Value	Meaning																
1	Aged																
2	Repatriation																
3	Invalid																
4	Unemployment Benefit																
5	Sickness Benefit																
0	Not Applicable																
9	Other/Unknown (Default Value)																
<i>Supplementary values:</i>																	

### Data element attributes

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#### Collection and usage attributes

*Guide for use:*

#### Additional Notes

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

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

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

Record the appropriate value as reported by the patient.

If on repatriation pension and unemployed select highest on list i.e. Repatriation .

Overseas pension to be recorded as other '9'.

*Collection methods:*

#### Related ISAAC Edits

#4770 – Pension status invalid

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## Place of occurrence

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**Identifying and definitional attributes**

<i>Technical name:</i>	Event leading to hospitalisation— place of occurrence, code AN[NNN]
<i>Synonymous names:</i>	ISAAC Data Item 94
<i>SAHMR identifier:</i>	SA1059
<i>Registration status:</i>	SA Health, Standard 24/04/2013

Data Element Concept: Event leading to hospitalisation—Place of occurrence

**Value domain attributes****Representational attributes**

<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	AN[NNN]
<i>Maximum character length:</i>	5

**Collection and usage attributes**

<i>Guide for use:</i>	Format for Clinical Data Submission	The submission of ICD-10-AM codes must be recorded in the following format: Without decimal points Include lead alpha characters Record codes in sequence order Left justify, blank fill Where there is no 4th digit, but a 5th digit is required use "0" as a filler
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For example, secondary conditions are entered as:

P 1 2 3                      M 2 3 4 5                      S 4 5 0 1

Hospitals submitting information to ISAAC electronically must refer to ISAAC reference table - record format for magnetic media for the correct format of the data.

**Data element attributes****Collection and usage attributes**

<i>Guide for use:</i>	Place of occurrence code is required for any case with an external cause code in the range as defined by the current TOME from Medical Records.  The place of occurrence code should be placed in the Additional Diagnosis. ISAAC will locate it and store it in a separate field. This will enable us to still produce reports by Place of Occurrence..
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*Collection methods:***Related ISAAC Edits**

#2680 – Place of occurrence code invalid  
 #4940 – External cause must accompany place of occurrence code  
 #4950 – Place of occurrence code not required  
 #4960 – Place of occurrence code required

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## Postcode

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—home postcode, code NNNN
<i>Synonymous names:</i>	ISAAC Data Item 6
<i>SAHMR identifier:</i>	SA431
<i>Registration status:</i>	SA Health, Standard 01/07/1985
<i>Definition:</i>	The postcode where the patient usually resides.
<i>Data Element Concept:</i>	Patient—Home postcode

### Value domain attributes

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### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

### Data element attributes

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### Collection and usage attributes

<i>Guide for use:</i>	Enter the postcode of the patient's residential address
	.
	Refer to the ISAAC REFERENCE TABLE - LOCALITY NAMES, POSTCODES AND SLAS.

As of 1 July 2014:-

A postcode of '0999' should be entered for the following:

- Babies for Adoption
- Unconscious patients
- No Fixed Abode
- Not Known

A postcode of '9999' should be entered for the following:

- Overseas

### Related ISAAC Edits

#4010 - Postcode invalid

#2310 – Interstate postcode does not match with SLA or vice versa

#4215 – SLA & Postcode do not match

## Previous specialised treatment

### Identifying and definitional attributes

<i>Technical name:</i>	Patient—previous specialised treatment, code N
<i>METeOR identifier:</i>	270374
<i>Registration status:</i>	AIHW Health, Standard 01/03/2005
<i>Definition:</i>	Whether a patient has had a previous <b>admission</b> or service contact for treatment in the specialty area within which treatment is now being provided, as represented by a code.

Data Element Concept: Patient—previous specialised treatment

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	N
<i>Maximum character length:</i>	1
<i>Permissible values:</i>	

Value	Meaning
1	Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided
2	Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided
3	Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided
4	Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided
5	Unknown/not stated

*Supplementary values:*

#### Collection and usage attributes

<i>Guide for use:</i>	<p>CODE 1 Patient has no previous admission(s) or service contact(s) for the specialised treatment now being provided Use this code for admitted patients, whose only prior specialised treatment contact was the service contact that referred the patient for admission.</p> <p>CODES 2-4 These codes include patients who have been seen at any time in the past within the speciality within which the patient is currently being treated (mental health or palliative care), regardless of whether it was part of the current episode or a previous admission/service contact many years in the past. Use these codes regardless of whether the previous treatment was provided within the service in which the person is now being treated, or another equivalent specialised service (either institutional or community-based).</p> <p>CODE 2 Patient has previous hospital admission(s) but no service contact(s) for the specialised treatment now being provided</p> <p>CODE 3 Patient has previous service contact(s) but no hospital admission(s) for the specialised treatment now being provided</p> <p>CODE 4 Patient has both previous hospital admission(s) and service contact(s) for the specialised treatment now being provided</p>
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## Data element attributes

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### Collection and usage attributes

*Comments:*

This metadata item was originally developed in the context of mental health institutional care data development (originally metadata item Problem status and later First admission for psychiatric treatment). More recent data development work, particularly in the area of palliative care, led to the need for this item to be re-worded in more generic terms for inclusion in other data sets.

For palliative care, the value of this data element is in its use in enabling approximate identification of the number of new palliative care patients receiving specialised treatment. The use of this data element in this way would be improved by the reporting of this data by community-based services.

*Collection methods:*

**Related ISAAC Edits**

#4755 – Previous Specialised Treatment invalid

## Procedure location indicator

### Identifying and definitional attributes

<i>Technical name:</i>	Episode of care—procedure location, code N
<i>Synonymous names:</i>	ISAAC Data Item 85
<i>SAHMR identifier:</i>	SA472
<i>Registration status:</i>	SA Health, Standard 01/07/1996
<i>Definition:</i>	The Procedure Indicator refers to the location in which a procedure was performed, as represented by a code.

Data Element Concept: Episode of care—Procedure location (hospital)

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code						
<i>Data type:</i>	Number						
<i>Format:</i>	N						
<i>Maximum character length:</i>	1						
<i>Permissible values:</i>	<table> <tr> <th>Value</th><th>Meaning</th></tr> <tr> <td>1</td><td>Procedure performed at this hospital</td></tr> <tr> <td>2</td><td>Procedure performed at another hospital</td></tr> </table>	Value	Meaning	1	Procedure performed at this hospital	2	Procedure performed at another hospital
Value	Meaning						
1	Procedure performed at this hospital						
2	Procedure performed at another hospital						

### Data element attributes

#### Collection and usage attributes

<i>Guide for use:</i>	<table> <tr> <td><b>1 Procedure performed at this Hospital</b></td><td>The ICD-10-AM coded procedure was performed at your hospital</td></tr> <tr> <td><b>2 Procedure performed at another Hospital</b></td><td> <p>The ICD-10-AM coded procedure was performed at another hospital, under a Hospital Contracted Service Agreement or is a Component of Care.</p> <p>A contracted service or Component of Care is one where the hospital pays for the service, not the patient. Refer to 'Source of Referral = 7', Contracted Service, for further details. Therefore, do not record procedures as a contracted service if the patient will be billed privately, i.e. radiology and pathology services provided and billed to the patient by Gribbles, Perrett Harrison &amp; Partners, Jones &amp; Partners, Clinpath, etc.</p> </td></tr> </table>	<b>1 Procedure performed at this Hospital</b>	The ICD-10-AM coded procedure was performed at your hospital	<b>2 Procedure performed at another Hospital</b>	<p>The ICD-10-AM coded procedure was performed at another hospital, under a Hospital Contracted Service Agreement or is a Component of Care.</p> <p>A contracted service or Component of Care is one where the hospital pays for the service, not the patient. Refer to 'Source of Referral = 7', Contracted Service, for further details. Therefore, do not record procedures as a contracted service if the patient will be billed privately, i.e. radiology and pathology services provided and billed to the patient by Gribbles, Perrett Harrison &amp; Partners, Jones &amp; Partners, Clinpath, etc.</p>
<b>1 Procedure performed at this Hospital</b>	The ICD-10-AM coded procedure was performed at your hospital				
<b>2 Procedure performed at another Hospital</b>	<p>The ICD-10-AM coded procedure was performed at another hospital, under a Hospital Contracted Service Agreement or is a Component of Care.</p> <p>A contracted service or Component of Care is one where the hospital pays for the service, not the patient. Refer to 'Source of Referral = 7', Contracted Service, for further details. Therefore, do not record procedures as a contracted service if the patient will be billed privately, i.e. radiology and pathology services provided and billed to the patient by Gribbles, Perrett Harrison &amp; Partners, Jones &amp; Partners, Clinpath, etc.</p>				

*Collection methods:*

#### Related ISAAC Edits

#4930 – Contracted patient, no contract procedure indicator recorded  
 #4910 – Procedure indicator required  
 #4920 – Procedure indicator not required - no procedure

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## Procedures

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### Identifying and definitional attributes

<i>Technical name:</i>	Episode of care—procedure type, code N(7)
<i>Synonymous names:</i>	ISAAC Data Item 49
<i>SAHMR identifier:</i>	SA474
<i>Registration status:</i>	SA Health, Standard 01/07/1985
<i>Definition:</i>	A maximum of 25 ICD-10-AM procedure codes from the appropriate code version, in accordance with the SA and Australian Coding Standards, may be entered in data item 49
Data Element Concept:	Episode of care—Procedure type

### Data element attributes

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#### Related ISAAC Edits

- #2530 – Procedure code invalid
- #2550 – Princ proc blank but at least one other proc not blank
- #2560 – Operative intervention with normal delivery
- #4820 – Procedure not compatible with sex
- #4830 – Procedure not compatible with age
- #4832 – Procedure unacceptable as 1<sup>st</sup> proc code



## Referral for further health care

### Identifying and definitional attributes

<i>Technical name:</i>	Patient's separation from service—type of further health care referred to, code N
<i>Synonymous names:</i>	ISAAC Data Item 72
<i>SAHMR identifier:</i>	SA1088
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Indicate if the patient is referred to further health care, excluding admitted patient care at the same or another hospital.

Data Element Concept: Patient's separation from service—Type of health care referred to

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	N
<i>Maximum character length:</i>	1

<i>Permissible values:</i>	Value	Meaning
	01	Not referred
	02	Private Medical Specialist (excluding private psychiatrist)
	03	Other Private Health Practitioner
	04	Outpatient/Emergency Department (Acute hospital)
	05	Community mental health service
	06	Other community health service
	07	Hospital at Home / Rehab at Home
	08	Disability SA
	10	Healthcare @ Home
	11	Residential Mental Health Service
	12	Transition to Residential Aged Care (TRAC)
	13	Transition Care Package
	14	Other residential health service
	15	Private psychiatrist
	16	Drug and Alcohol inpatient facility
	17	Drug and Alcohol non-inpatient facility
	18	Outpatient /Emergency Department (Psychiatric hospital)
<i>Supplementary values:</i>	99	Other/Unknown

### Collection and usage attributes

#### Guide for use:

*Collection methods:*

<b>01 Not Referred</b>	If on discharge, there has been no arrangement made for further health care for continuing care/treatment of a condition which relates to the current admission. Includes all transfers to another hospital including transfers to Glenside/Oakden and specialised mental health wards in acute hospitals.
<b>02 Private Medical Specialist (excluding private psychiatrist)</b>	Patients referred for further care to a private medical specialist or general practitioner. Includes patients who are referred back to their private specialist for a post-surgery follow-up appointment.
<b>03 Other Private Health Practitioner</b>	Includes referrals to allied health professionals, psychologists, social workers, other health professionals such as chiropractor, physiotherapist, dentist, dietician and homeopath.
<b>04 Hospital Outpatient</b>	Patients referred to any hospital

<b>/Emergency Department (Acute hospital)</b>	outpatient/emergency department for further care. This includes patients who are referred back to an outpatient department or emergency service for removal of stitches, dressings of wounds and removal of plaster, for example.
<b>05 Community Mental Health Service</b>	Includes referrals to all South Australian Mental Health Service, GROW, COPE and similar self-help groups, northern and southern CAMHS.
<b>06 Other Community Health Service</b>	Patients referred for further care to a community health service. For example visits by the community welfare nurse or RDNS.
<b>07 Hospital at Home /Rehab at Home</b>	Includes referrals to a qualified Rehab at Home or Hospital at Home program, as covered under the Casemix Funding Technical Bulletins 95:16 and 97:20 respectively. Important Note: When transferring a patient from an admitted patient episode to a Hospital at Home or Rehab at Home episode, use the Referral for Further Health Care field (7-Hospital at Home), even though the Nature of Separation is 'A- Administrative Discharge'. This should only be done when transferring a patient to an immediate home based program.
<b>08 Disability SA</b>	SA Health Response to the Every Patient Every Service Policy which states: PROVISION OF INVESTMENT TO SUPPORT TRANSITION OF PATIENTS WITH A DISABILITY INTO THE COMMUNITY Providing additional resources to support transition of patients with a disability into the community. Will enable more rapid discharge of patients with a disability from the hospital setting when clinically appropriate in collaboration with Disability SA. <ul style="list-style-type: none"> <li>Enables earlier discharge of patients with a disability into the community earlier when clinically appropriate</li> <li>Increases hospital bed capacity to more readily enable admission of patients when clinically appropriate</li> </ul>
<b>10 Healthcare @ Home (HC@H)</b>	HC@H provides a rapid, short term response to either avoid a presentation to an Emergency Department or an admission to a metropolitan public hospital and/or support a safe and timely discharge from a metropolitan public hospital. The service is contracted to or provided by a community based organisation and is a specifically funded program called "Health Care @ Home. It is separate and distinct from 07 – Hospital at Home / Rehabilitation at Home where a hospital (as opposed to a community organisation) provides care for the patient in their home that would otherwise have been provided at hospital.
<b>11 Residential mental health service</b>	Should be used in conjunction with Nature of Separation code 4 = Other Health Care Accommodation. Should be used for hospital separations where patient/consumer is being transferred to a Residential Mental Health Care service such as a Community Rehabilitation Centre (CRC) or an Intermediate Care
<b>12 Transition to Residential Aged Care (TRAC)</b>	The Transition to Residential Aged Care pilot is a State funded initiative that runs across metropolitan

	Adelaide and aims to support the safe and timely transition of older people who are medically stable and waiting a residential care placement but remain in acute care due to a range of complex circumstances.”
<b>13 Transition Care Package</b>	Community Transitional Care Programme (TCP) and a Residential TCP and other aged care services. The TCP program is primarily focused on reducing the transition of people from acute hospitals directly into residential aged care. It does this by providing services and supports that allow people at risk of such transition to return home instead.
<b>14 Other residential health service</b>	Other residential health service that is not adequately described by any other code in this value domain
<b>15 Private psychiatrist</b>	If a patient is referred to a private psychiatrist
<b>16 Drug and Alcohol inpatient facility</b>	For patients referred to any specialist drug & alcohol inpatient facility
<b>17 Drug and Alcohol non-inpatient facility</b>	For patients referred to non-inpatient facilities including such services operating on Glenside Health Services campus as well as community-based services
<b>18 Outpatient /Emergency Department (Psychiatric hospital)</b>	for referrals to an Outpatient clinic or an ED care of a psychiatric hospital (ie, Glenside and Oakden).
<b>99 Other /Unknown</b>	If, on discharge, arrangements not covered in the above categories, have been made for further care/treatment of a condition that relates to the current condition.

#### Data element attributes

#### Collection and usage attributes

##### Guide for use:

- Referral for further health care must be formally organised at the discharging hospital. With the exception of H@H/R@H care, this item is only be used when the patient will be leaving the in-patient care of a hospital.
- If a patient is discharged with referrals to multiple organisations, assign the lowest number value.
- Transfers and intention to re-admit to health facilities are NOT considered a referral for further health care. For example, transfers to residential aged care facilities, hostels and other health care are not considered a referral for further health care. In these examples, ‘1-not referred’ should be recorded.

**Exclusions** Referral to social welfare agencies like Meals on Wheels or the Central Mission are considered social services, not health services and should be recorded as ‘1-Not Referred’.

##### Collection methods:

##### **Related ISAAC Edits**

- #4230 – Referral for further health care invalid
- #4240 – Referral for further should be ‘not referred’
- #2720 – Referral to H@H – Nature of Sep Incorrect
- #2730 – Incorrect Referral – patient already H@H
- #2750 – Incorrect NOS & Ref for Ep of Care Type

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## Separation Date

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient's separation from service—date of event, DDMMYYYY
<i>Synonymous names:</i>	ISAAC Data Item 43
<i>SAHMR identifier:</i>	SA1085
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The date on which an admitted patient completes an episode of care. A separation is the process by which an admitted patient completes an episode of care. A separation may be formal or administrative.

Data Element Concept: Patient's separation from service—Date of event

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

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#### Collection and usage attributes

<i>Guide for use:</i>	<p><b>Formal separation</b> - The administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient. Includes:</p> <ul style="list-style-type: none"> <li>• Discharges to return home.</li> <li>• Transfers to other hospitals, nursing homes and other forms of congregate living.</li> <li>• Deaths of persons who were in-patients at the time of death.</li> <li>• Patients who discharge themselves against medical advice</li> </ul> <p><b>Administrative separation</b> - The administrative process by which a hospital records the completion of an episode of care occurring within the one hospital stay.</p> <ul style="list-style-type: none"> <li>• Enter the full date of separation in the box provided using the day, month and year and leading zeros where necessary.</li> <li>• For example, if a patient was discharged on 6 March 2011, the date would be entered as follows:</li> </ul>
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0	6	0	3	2	0	1	1
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#### Additional Notes

For patients who die in hospital and donate organs, record the Separation Date as Date of Death. ISAAC does not have provision for organ procurement episodes.

#### Collection methods:

#### Related ISAAC Edits

#1010 - Date of separation invalid  
 #1030 - Separation date pre admit date  
 #1040 - Date of separation after current date  
 #4710 - Separation date > 1 year old  
 #4160 - LOS > 92 days  
 #4170 - LOS > 1 day in a day hospital

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## Separation Time

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient's separation from service—time, hhmm
<i>Synonymous names:</i>	ISAAC Data Item 70
<i>SAHMR identifier:</i>	SA1087
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The time at which an overnight stay or sameday patient completes an episode of care by one of the following processes: <b>Formal separation</b> - The administrative process by which a hospital records the completion of treatment and/or care and accommodation of a patient (discharge, transfer or death). <b>Administrative separation</b> - The administrative process by which a hospital records the completion of an episode of care occurring within a hospital stay.

Data Element Concept: Patient's separation from service—Time of first event

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Time
<i>Data type:</i>	Date/Time
<i>Format:</i>	hhmm
<i>Maximum character length:</i>	4

#### Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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### Data element attributes

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#### Collection and usage attributes

<i>Guide for use:</i>	<b>Additional Notes</b> <b>2400 is NOT a valid time</b> Any time submitted as 2400 will have the following action taken: <ul style="list-style-type: none"> <li>• Separation Time will be changed to 0000; and</li> <li>• Separation Date will be incremented by 1.</li> </ul>
	<i>Example</i> Record submitted with: Separation Time = 2400 Separation Date = 30/09/2010  Record is changed to: Separation Time = 0000 Separation Date = 01/10/2010
<i>Collection methods:</i>	<b>Related ISAAC Edits</b> #1030 – Separation time invalid. #4700 – 2400 reset to 0000 and date increased by 1 day

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## Sex

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**Identifying and definitional attributes**

<i>Technical name:</i>	Patient—sex, code N
<i>Synonymous names:</i>	ISAAC Data Item 8
<i>SAHMR identifier:</i>	SA1116
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The sex of the person.

Data Element Concept: Patient—Sex

**Value domain attributes****Representational attributes**

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table> <tr> <th>Value</th><th>Meaning</th></tr> <tr> <td>1</td><td>Male</td></tr> <tr> <td>2</td><td>Female</td></tr> <tr> <td>3</td><td>Indeterminate</td></tr> </table>	Value	Meaning	1	Male	2	Female	3	Indeterminate
Value	Meaning								
1	Male								
2	Female								
3	Indeterminate								

**Data element attributes****Collection and usage attributes***Guide for use:*

- The term 'sex' refers to the anatomical differences between males and females, while the term 'gender' refers to the socially expected/perceived dimensions of behaviour associated with males and females – masculinity and femininity.
- The indeterminate sex category should be used to classify patients aged less than 90 days when it is not possible for the sex to be determined.
- It is recognised that collecting the sex of a transsexual or transgender person can be very sensitive. Wherever possible, it is preferred that transsexuals and people with transgender issues have their sex at the time of hospital admission recorded and not their preferred gender i.e. Sex status may change post reassignment but should remain biological till then. This avoids problems with edits and in allocation of some DRGs.
- Where uncertainty exists about the sex of the person, the sex to be recorded is to be based on the sex nominated by the person themselves or on the observations or judgement of the interviewer. Although this may lead to some error, it is considered preferable to any offence that may be caused by a question that suggests that there is some doubt about the person's sex or sexuality.
- Hospitals should endeavour to resolve the sex of a patient within the current hospital admission.

*Collection methods:***Related ISAAC Edit**

#2160 – Sex invalid

#4505 – Indeterminate sex invalid for age 90 days+, pls check

#4506 - Sex has changed since last episode of care

## Source of referral

### Identifying and definitional attributes

<i>Short name:</i>	Patient admission - source of referral, code X
<i>Synonymous names:</i>	ISAAC Data Item 16
<i>SAHMR identifier:</i>	SA1080
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Records the source of where the patient was referred / transferred from for an admission to this hospital. <b>This is a mandatory item.</b>
Data Element Concept:	Patient admission—Source of referral

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code																																		
<i>Data type:</i>	String																																		
<i>Format:</i>	X																																		
<i>Maximum character length:</i>	1																																		
<i>Permissible values:</i>	<table> <thead> <tr> <th>Value</th><th>Meaning</th></tr> </thead> <tbody> <tr><td>0</td><td>Admit from leave</td></tr> <tr><td>1</td><td>Other Private medical practice (excluding psychiatrist)</td></tr> <tr><td>2</td><td>Residential Aged Care Facility</td></tr> <tr><td>3</td><td>Community health service</td></tr> <tr><td>4</td><td>Inter-hospital transfer</td></tr> <tr><td>5</td><td>Outpatient department</td></tr> <tr><td>6</td><td>Casualty/ Emergency</td></tr> <tr><td>7</td><td>Contracted service</td></tr> <tr><td>8</td><td>Other</td></tr> <tr><td>A</td><td>Administrative admission</td></tr> <tr><td>E</td><td>End of quarter reporting</td></tr> <tr><td>X</td><td>Retrieval</td></tr> <tr><td>L</td><td>Law enforcement agency</td></tr> <tr><td>P</td><td>Private psychiatric practice</td></tr> <tr><td>R</td><td>Residential Mental Health Service</td></tr> <tr><td>9</td><td>Unknown</td></tr> </tbody> </table>	Value	Meaning	0	Admit from leave	1	Other Private medical practice (excluding psychiatrist)	2	Residential Aged Care Facility	3	Community health service	4	Inter-hospital transfer	5	Outpatient department	6	Casualty/ Emergency	7	Contracted service	8	Other	A	Administrative admission	E	End of quarter reporting	X	Retrieval	L	Law enforcement agency	P	Private psychiatric practice	R	Residential Mental Health Service	9	Unknown
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<i>Supplementary values:</i>																																			

### Collection and usage attributes

*Guide for use:*

### Data element attributes

#### Collection and usage attributes

<i>Guide for use:</i>	<b>0 Admit from Leave</b>	Those patients who were discharged on short term leave, i.e. less than 72 hours, but who did not return until <b>after a period greater than 72 hours</b> . The patient's return to hospital must be related to the initial episode of care from which the patient went on short-term leave.
	<b>1 Private Medical Practice</b>	Patients referred to the hospital for admission by their medical practitioner, GP or specialist.
	<b>2 Residential Aged Care Facility</b>	Patients admitted to hospital directly from a residential aged care facility. If the residential aged care facility is the patient's normal place of residence, and patient has been admitted by their private medical practitioner, record source of referral = Residential Aged Care Facility.
	<b>3 Community Health Service</b>	Patients admitted to hospital from a community health service.
	<b>4 Inter-Hospital</b>	Patients transferred directly to your hospital, from another

<b>Transfer</b>	<p>hospital. Patients must have been admitted at the first hospital to be classified as an inter-hospital transfer.</p> <p><b>When using this value the field Hospital Transferred To must also be completed with a valid ISAAC Hospital Code.</b></p> <p>EXCLUSION: a non-admitted patient (i.e. Outpatients or Accident &amp; Emergency Department) transferred from another hospital, and admitted at your hospital. In these situations record the Source of Referral as 8=Other.</p> <p>For an <i>inter-hospital transfer</i>, the patient does not necessarily need to be transferred in an ambulance. There are instances where a friend or family member actually drives the patient between the hospitals. These should still be considered as inter-hospital transfers if undertaken within 24 hours, and travel is directly to the other hospital i.e. excludes an overnight stay elsewhere.</p>
<b>5 Outpatient Department</b>	<p>Patients admitted from the outpatient department of that hospital.</p> <p>Excludes an outpatient department at another hospital. These should have <i>Source of Referral</i> recorded as 8=Other.</p>
<b>6 Casualty/Emergency</b>	<p>Patients admitted to hospital through the hospital's Accident &amp; Emergency or Casualty Service.</p> <p>Excludes an Accident &amp; Emergency department at another hospital. These should have <i>Source of Referral</i> recorded as 8=Other.</p>
<b>7 Contracted Service</b>	<p>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) or for Component of Care.</p> <p>This value is only applicable to <i>hospitals providing the contracted service i.e. the destination hospital</i>.</p> <p>The destination hospital must record the patient as a contracted patient in the source of referral category, thus distinguishing that patient from other patients. Refer Appendix 3: Contract Service and Component of Care</p>
<b>8 Other</b>	<p>Any patient admitted to hospital through other avenues not listed in this data item.</p> <ul style="list-style-type: none"> <li>Includes newborns born during the reported episode.</li> <li>Patient's admitted from another hospital's Accident &amp; Emergency or Outpatient department.</li> <li>Police referrals</li> </ul>
<b>9 Unknown</b>	<p>There should be minimal incidents of cases where the Source of Referral is unknown.</p>
<b>A Administrative Admission</b>	<p>This category is for reporting changes in episodes of care. When a patient's clinical intent changes from one type of care to another, an <i>administrative discharge</i> is required, and commencement of an <i>administrative admission</i>. The patient is NOT formally discharged and formally readmitted, but remains in hospital and changes their care type. Refer also episodes of care</p> <ul style="list-style-type: none"> <li>A formal admission implies that source of referral will have a value not equal to 'A=Administrative'.</li> <li>An administrative admission implies that the source of referral will be equal to either 'A=Administrative' or 'E= End of Quarter' reporting.</li> </ul>
<b>E End of Quarter Reporting</b>	<p><b>This value is only applicable for public hospitals.</b> It is to be used to report patients who are still in-patients at the end of the quarter or as formally approved in writing by the Funding Models Unit.</p> <p>Refer also Nature of separation = E=End of quarter.</p>



If the patient is on leave at the end of quarter, an end of quarter separation is still required. Enter the following data items as:

Last <b>leave to</b> date	30/09/2008	Last <b>leave to</b> time	2358
Separation date	30/09/2008	Separation time	2358
Nature of separation	E		
<b>New admission record:</b>			
First <b>leave from</b> date	30/09/2008	First <b>leave from</b> time	2359
Admission date	30/09/2008	Admission time	2359
Source of referral	E		

EPAS sites are not to report End of Quarter discharges

### X Retrieval

A retrieval involves the transportation of seriously ill or injured person/s under the specialist care of a recognised retrieval team. The seriously ill or injured person/s requires specialised monitoring and treatment in transit to the retrieving hospital. A retrieval team is formally recognised by the hospital and usually consists of two staff, a medical officer and a nurse. On some occasions the team may include a second medical officer and/or nurse.

If the retrieval is from another South Australian hospital, the 4-digit hospital code must be recorded in data item 18, Hospital transferred from.

### L Law enforcement agency

Includes police and correctional services officers

### P Private psychiatric practice

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

### R - Residential Mental Health Service

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

Includes Intermediate Care Centres, Community Rehabilitation Centres and 24-hour staffed NGO-managed services

### Hospital at Home Patients

- When a patient starts a Hospital at Home episode without having been a formally admitted in-patient (e.g. on to the Hospital at Home episode through Emergency or Outpatients) use the appropriate Source of Referral code e.g. 6 = Casualty / Emergency.
- When a patient commences a Hospital at home episode after an in-patient episode, an administrative discharge is required and commencement of an administrative admission for the Hospital at Home episode.
- A Hospital at Home episode may not have a Source of Referral code equal to 'E - End of Quarter Reporting'.

### Collection methods:

#### **Related ISAAC Edits**

#4030 – Source of referral invalid

#4310 – Hospital transferred from required

#4740 – E invalid for private hospital-set to 9

#2740 – Incorrect SOR for H@H/R@H Ep of Care

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## Statistical local area

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—home SLA, code NNNN
<i>Synonymous names:</i>	ISAAC Data Item 7
<i>SAHMR identifier:</i>	SA1102
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Complete this at the time of the patient's admission. Assign a code to the statistical local area according to the postcode and locality by referring to ISAAC REFERENCE TABLE - INDEX TO LOCALITY NAMES, POSTCODES AND SLAS.

Data Element Concept: Patient—Home SLA

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	NNNN
<i>Maximum character length:</i>	4

### Data element attributes

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#### Collection and usage attributes

- Guide for use:*
- Only the patient's suburb, not the patient's name and full address appears on the ISAAC form submitted to SA Health. Therefore, it is critical that both Postcode and SLA are entered at the time of the patient's admission and before the three part form is separated.
  - Use the value **0999** for: Unknown address, No fixed abode, Babies for adoption, Unconscious patients
  - Use the value **0009** for patients usually residing overseas.
  - Enter the statistical local area codes as follows, using leading zeros where necessary:

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

Or

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

*Collection methods:*

#### **Related ISAAC Edits**

#2310 – Interstate postcode or SLA invalid  
 #4215 – SLA & postcode do not match

## Status Change – Date Effective From

### Identifying and definitional attributes

<i>Technical name:</i>	Patient status—date of change event, DDMMYYYY
<i>Synonymous names:</i>	ISAAC Data Items 24, 27, 30
<i>SAHMR identifier:</i>	SA1083
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Records the date a change of Election or Type is effective from
<i>Data Element Concept:</i>	Patient status—Date of change event

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Date
<i>Data type:</i>	Date/Time
<i>Format:</i>	DDMMYYYY
<i>Maximum character length:</i>	8

### Data element attributes

#### Collection and usage attributes

- Guide for use:*
- Enter the full date of the Status change in the box provided using the day, month and year and leading zeros where necessary.
  - If a status change date is submitted, there must also be a status change type and status change election submitted, even though these other data items have not been altered.
  - For example, the following details would be entered if the patient changed from a Private, Ordinary patient to a Hospital, Long Stay - Acute patient on 6 March 2011:

Election	Type	Effective From
1	2	06032011

#### Related Data Items

Status Change – Election (data items 22, 25, 28). Refer also to Admission Election (data item 19). Status Change – Type (data items 23, 26, 29). Refer also to Admission Type (data item 20).

#### Collection methods:

#### Related ISAAC Edits

- #4470 – Status change date invalid
- #4474 – Status change details not required
- #4500 – Status change date missing

## Status Change - Election

### Identifying and definitional attributes

<i>Technical name:</i>	Patient status—admission election status change, code N
<i>Synonymous names:</i>	ISAAC Data Items 22, 25, 28
<i>SAHMR identifier:</i>	SA1082
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Records whether the patient has changed Election Status i.e. changed from a Hospital to a Private patient, or from a Private to a Hospital patient.

Data Element Concept: Patient status—Admission election (care type) (change)

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code	
<i>Data type:</i>	Number	
<i>Format:</i>	N	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	1	Hospital
	2	Private

#### Collection and usage attributes

- Guide for use:*
- If election by that patient or a responsible relative cannot be made at the time of admission, or where the patient's private health insurance status cannot be determined, the patient's election may be made retrospectively to the date of admission.
  - At the time that the patient makes an election to be a private or a hospital patient, hospital staff should ensure that the patient is fully aware of the implications of this election choice. Hospital staff may advise patients regarding election, but should not bias the choice.
  - When ascertaining whether the patient has private health insurance, ensure that the patient is covered for "hospital treatment" and not just "extras".
  - This data item is independent from the patient's insurance status. For example, a patient may elect to be admitted as a hospital (Admission Election = 1, Hospital), but the patient may have private health insurance (data item 17, Hospital insurance = 3, Other private health insurance).
  - If a patient election form is not signed by the patient, then the default admission election should be 1 = Hospital.
  - Refer to the [Patient Fees and Charges Manual](#) for further detail on the appropriate admission election for patients with certain types of Funding Source.
  - Admission Election is closely connected with data item 95 Funding Source. Refer to Funding Source for additional information

Collection

<b>1 Hospital</b>	A Hospital Patient is a person who, on
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methods:

	<p>admission to a recognised hospital or soon after, elects to be a public patient treated by a <b>medical practitioner nominated by your hospital</b>.</p> <p>Additionally:</p> <ul style="list-style-type: none"> <li>• A public patient shall be entitled to receive the care and treatment referred to in accordance with the Australian Health Care Agreement without charge.</li> <li>• Public patients admitted to private hospitals for contracted services, should be recorded with an election of '1-Hospital'.</li> <li>• A patient who is eligible for under a Reciprocal Health Care Agreement should be admitted with an election of '1-Hospital'.</li> </ul> <p>Persons visiting Australia who are ordinarily resident in the following countries are covered by reciprocal health care agreements (RHCA's): United Kingdom, Ireland, New Zealand, Sweden, Netherlands, Finland, Malta*, Italy*.</p> <p>* Only covered when visa is for six months or less.</p> <p>Refer to the Patient Health Care Services Fees and Charges Manual for further information on RHCA's.</p>
<b>2 Private</b>	<p>A Private Patient is a person who:</p> <ul style="list-style-type: none"> <li>• On admission to a public hospital or soon after, elects to be a private patient treated by a medical practitioner of his or her choice.</li> <li>• Who chooses to be admitted to a private hospital.</li> </ul> <p>Where either of these choices are made, the patient is responsible for meeting all hospital charges as well as the professional charges raised by any treating medical or dental practitioner.</p>
<b>Compensable &amp; Non-Medicare Patients</b>	<p><u>Country Hospitals</u> All Compensable and Non-Medicare patients must be admitted as private in country hospitals which do not employ full-time medical specialists. (Refer Funding Source data item for further definition.)</p> <p><u>Metropolitan Hospitals</u> Compensable and Non-Medicare patients admitted to a metropolitan hospital must be admitted as private. (Refer Funding Source data item for further definition.)</p>

#### Data element attributes

### Collection and usage attributes

#### *Guide for use:*

- Record whether the patient has changed Election Status i.e. changed from a Hospital to a Private patient or from a Private to a Hospital patient, by entering one of the above valid codes.
- If a *status change election* is submitted, there must also be a *status change type* and *status change date* submitted, even though these other data items have not been altered.
- Refer to above sections for data items 19 and 20 for further information regarding the definition of admission type and admission election.

#### **Related Data Items**

Status Change – Date Effective From (data items 24, 27, 30). Status Change – Type (data items 23, 26, 29). Refer also to Admission Type (data item 20).

#### *Collection methods:*

#### **Related ISAAC Edits**

- #4450 – Status change election invalid
- #4474 – Status change details not required
- #4480 – Status change election missing

## Status Change - Type

### Identifying and definitional attributes

<i>Technical name:</i>	Patient status—stay type status change, code N
<i>Synonymous names:</i>	ISAAC Data Items 23, 26, 29
<i>SAHMR identifier:</i>	SA1084
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Indicates that the type and duration of care that the patient has been receiving has changed.

Data Element Concept: Patient status—Stay type (Change)

### Value domain attributes

#### Representational attributes

<i>Representation class:</i>	Code								
<i>Data type:</i>	Number								
<i>Format:</i>	N								
<i>Maximum character length:</i>	1								
<i>Permissible values:</i>	<table> <tr> <th>Value</th><th>Meaning</th></tr> <tr> <td>1</td><td>Ordinary</td></tr> <tr> <td>2</td><td>Long Stay - Acute</td></tr> <tr> <td>3</td><td>Long Stay - Maintenance Care Type</td></tr> </table>	Value	Meaning	1	Ordinary	2	Long Stay - Acute	3	Long Stay - Maintenance Care Type
Value	Meaning								
1	Ordinary								
2	Long Stay - Acute								
3	Long Stay - Maintenance Care Type								

#### Collection and usage attributes

##### Guide for use:

<b>Qualifying Period</b>	<ul style="list-style-type: none"> <li>The qualifying period may accrue in a single hospital or two or more hospitals but not in a residential aged care facility. Hospitals in which the qualifying period is accrued may be public or private.</li> <li>Transferring between hospitals has no effect on the qualifying period.</li> <li>Periods of less than seven days out of hospital do not break the qualifying period.</li> <li>If a patient does not enter another hospital within 7 days, their qualifying period restarts on the day of the next admission.</li> <li>Days spent on leave or between separations do not count e.g. a patient who has accrued 20 days then takes three days of leave will start day 21 on return to the hospital.</li> </ul>
<b>Transferring to Long Stay Status</b>	Following the completion of the 35-day qualifying period, a status change is to be recorded for the patient, from Ordinary to either a Long Stay-Acute, or Long Stay-Maintenance Care Type. This reclassification is based on medical diagnosis.
<b>Acute Care Certificates</b>	<ul style="list-style-type: none"> <li>Although completion of the Acute Care Certificate is no longer legislatively mandated by the Commonwealth, SA Health have mandated that clinicians must continue to complete an Acute Care Certificate or similar documentation if they consider the patient to be acute and the patient has met the 35 day long stay, qualifying period. In the event that a dispute should arise between the hospital and health fund in relation to payment of benefits for long stay acute patients, some medical evidence will be available.</li> </ul>

	<ul style="list-style-type: none"> <li>SA Health have produced generic Acute Care Certificates which are available for purchase via the SA Health Distribution Centre</li> <li>Ph (08) 8350 4160 Fax: (08) 8350 4161.</li> </ul>
<b>Maintenance Care Type Patients</b>	<p>This judgement is made in respect to the principal condition i.e. the main cause of hospitalisation. Thus, an elderly infirm patient not expected to recover sufficiently to leave the hospital must be classed as Maintenance Care. If a secondary condition requiring medical attention from a doctor (such as a broken limb) the Maintenance care patient can be reclassified as long stay acute. See section Transferring to Long Stay Acute.</p> <p>If a patient is classified as Acute Type, a portion of the fees (the "patient contribution") is automatically waived for the duration of the certificate. This does not affect the Board of Management's authority to remit all or part of any other patient's fees in cases of hardship - refer to the Monthly Management Summary Guidelines for further details on remission of fees.</p> <p>It should be noted that classification as Acute Type relates to the present and expected future prognosis of the patient, and cannot be made retrospectively, nor taken as altering any past liability of the patient to pay fees.</p> <p><b>Transferring to long stay acute</b> The only circumstance in which a Maintenance care patient can be re-classified as Acute Type is when there is a revision of the doctor's opinion regarding prognosis. This may occur under two circumstances:</p> <ul style="list-style-type: none"> <li>Where the doctor's original opinion regarding the main cause of the patient's hospitalisation is revised; or</li> <li>Where a secondary condition requiring medical attention develops. This may occur within the hospital where the patient is currently admitted, or within transfers between hospitals.</li> </ul> <p>When a patient transfers from Long Stay Maintenance Care Type to Long Stay Acute, it is also a change in episode of care. Refer also 'episodes of care'.</p> <p>Every effort should be made to source more suitable community based accommodation for patients who are not acute after 35 days.</p> <p><b>Example 1</b></p> <p>A patient is admitted to hospital and after the 35 day qualifying period, is classified as a <i>Long Stay Maintenance Care</i> Type patient. The patient is not expected to recover sufficiently to be discharged from hospital. During hospitalisation the patient develops bronchopneumonia (which due to the patient's age has complications). The doctor may issue an Acute Care Certificate and authorise the patient to be transferred to <i>Long Stay Acute</i> classification.</p> <p>Once the patient has recovered from the bronchopneumonia (i.e. they are no longer in need of acute</p>



	<p>care), they will revert back to the <i>Long Stay Maintenance Care Type</i> classification.</p> <p><b>Example 2</b></p> <p>A patient is admitted to hospital and after the 35 day qualifying period is classified as a <i>Long Stay Maintenance Care Type</i> patient. During their hospitalisation at Hospital A, the patient falls, breaking their hip, necessitating a transfer to Hospital B for a hip replacement. Hospital B may admit the patient as a <i>Long Stay Acute</i> and issue an Acute Care Certificate. If the patient still requires post-operative care on return to Hospital A, then Hospital A may admit them as Long Stay-Acute. When the patient is deemed no longer acute, they should return to <i>Maintenance Care Type</i>.</p>
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### Data element attributes

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#### Collection and usage attributes

##### *Guide for use:*

If a Status Change Type is submitted, there must also be a Status Change Election and Status Change Date submitted, even though these other data items have not been altered. Refer to ISAAC data items 19 and 20 for further information regarding the definition of admission type and admission election.

##### **Related Data Items**

Status Change – Date Effective From (data items 24, 27, 30).  
 Status Change – Election (data items 22, 25, 28). Refer also to Admission Election (data item 19).

##### *Collection methods:*

##### **Related ISAAC Edits**

#4460 – Status change type invalid  
 #4474 – Status change details not required  
 #4490 – Status change type missing

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## Suburb / Locality

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—home suburb/locality, identifier X[20]
<i>Synonymous names:</i>	ISAAC Data Item 5
<i>SAHMR identifier:</i>	SA1103
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The suburb/town of the patient's usual residence.

Data Element Concept: Patient—Home suburb/locality

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	X[20]
<i>Maximum character length:</i>	20

### Data element attributes

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#### Collection and usage attributes

*Guide for use:* Enter the name of the suburb/town of the patient's usual residence.

If the patient is from interstate, enter the patient's usual (permanent) address and NOT their holiday (temporary) address.

Ensure that the spelling of the Suburb or Locality is consistent with Australia Post listings or the ISAAC Reference File 'Locality / Suburb Listing' available on the ISAAC Resources web page at [www.sahealth.sa.gov.au/isaac](http://www.sahealth.sa.gov.au/isaac), click on 'Integrated SA Activity Collection (ISAAC) Resources' tab.

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## TOTDDL

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### Identifying and definitional attributes

<i>Short name:</i>	Episode of care - transfer to discharge lounge, time hhmm
<i>Synonymous names:</i>	ISAAC Data Item 53
<i>SAHMR identifier:</i>	SA1011
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The time a patient was transferred to the Discharge/Transit Lounge during their hospital admission.
<i>Context:</i>	Admitted Activity
<i>Data Element Concept:</i>	Episode of care - transfer to discharge lounge

### Value domain attributes

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### Representational attributes

<i>Representation class:</i>	Time
<i>Data type:</i>	Date/Time
<i>Format:</i>	hhmm
<i>Maximum character length:</i>	4

### Source and reference attributes

<i>Reference documents:</i>	ISO 8601:2000 : Data elements and interchange formats - Information interchange - Representation of dates and times
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### Data element attributes

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### Collection and usage attributes

<i>Guide for use:</i>	<ul style="list-style-type: none"> <li>• This information is used to calculate the percentage of overnight stay separations that occur before 11am as a proportion of all overnight stay separations.</li> <li>• The percentage serves as a key performance indicator for hospitals and is reported to the Portfolio Performance Review Committee and the Emergency Access Taskforce as per the Health Performance Agreements between SA Health and the Regions.</li> </ul>
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### Collection methods:

#### Related ISAAC Edits

- #2760 – TOTDDL Invalid
- #2761 – DOTDDL must be accompanied by TOTDDL
- #2762 – TOTDDL must be accompanied by DOTDDL
- #2765 – Transfer to Discharge Lounge before Admission Time
- #2766 - Transfer to Discharge Lounge After Separation Time

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## Type of Usual Accommodation

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—type of usual accommodation, code N
<i>Synonymous names:</i>	ISAAC Data Item 90
<i>SAHMR identifier:</i>	SA1117
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	Indicates the self-described usual type of physical accommodation the patient lived in prior to admission.

Data Element Concept: Patient—Accommodation type

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code																																		
<i>Data type:</i>	Number																																		
<i>Format:</i>	N																																		
<i>Maximum character length:</i>	1																																		
<i>Permissible values:</i>	<table> <tr><td>1</td><td>House, Flat or other private residence</td></tr> <tr><td>2</td><td>Independent unit as part of retirement village or similar</td></tr> <tr><td>4</td><td>Psychiatric Hospital</td></tr> <tr><td>5</td><td>Homeless – boarding/rooming house</td></tr> <tr><td>6</td><td>Other Accommodation</td></tr> <tr><td>7</td><td>Homeless - no usual residence</td></tr> <tr><td>8</td><td>Homeless – shelter/refuge</td></tr> <tr><td>A</td><td>Specialised alcohol/other drug treatment residence</td></tr> <tr><td>B</td><td>Boarding/rooming house (not homeless)</td></tr> <tr><td>C</td><td>Residential aged care service</td></tr> <tr><td>D</td><td>Domestic scale supported living facility</td></tr> <tr><td>H</td><td>Hostel or hostel type accommodation</td></tr> <tr><td>M</td><td>Specialised mental health community based - residential</td></tr> <tr><td>O</td><td>Other supported accommodation</td></tr> <tr><td>P</td><td>Prison/remand centre/youth training centre</td></tr> <tr><td>S</td><td>Shelter/refuge (not homeless persons' shelter)</td></tr> <tr><td>9</td><td>Unknown (Default Value)</td></tr> </table>	1	House, Flat or other private residence	2	Independent unit as part of retirement village or similar	4	Psychiatric Hospital	5	Homeless – boarding/rooming house	6	Other Accommodation	7	Homeless - no usual residence	8	Homeless – shelter/refuge	A	Specialised alcohol/other drug treatment residence	B	Boarding/rooming house (not homeless)	C	Residential aged care service	D	Domestic scale supported living facility	H	Hostel or hostel type accommodation	M	Specialised mental health community based - residential	O	Other supported accommodation	P	Prison/remand centre/youth training centre	S	Shelter/refuge (not homeless persons' shelter)	9	Unknown (Default Value)
1	House, Flat or other private residence																																		
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S	Shelter/refuge (not homeless persons' shelter)																																		
9	Unknown (Default Value)																																		
<i>Supplementary values:</i>																																			

### Data element attributes

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#### Collection and usage attributes

*Guide for use:* **Collection and usage attributes**

- 'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to admission to institutional health care or first contact with a community service setting. If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation. In practice, receiving an answer to questioning about a person's usual accommodation setting may be difficult to achieve. The place the person perceives as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.
- All hospitals are required to report the Type of Usual Accommodation for

each patient on admission.

- Record the appropriate value as reported by the patient.

Collection  
methods:

<b>1 House or Flat</b>	People who usually reside in a private residence (e.g. house, flat, unit, caravan, boat, including private and public rented homes). Includes caravans and boats used as a private residence.
<b>2 Independent unit as part of a retirement village or similar</b>	Includes independent units in a retirement village. Implies that the resident does not require full time care.
<b>4 Psychiatric Hospital</b>	People who reside long term in a psychiatric health care facility.
<b>5 Homeless –boarding/rooming house</b>	People in marginal accommodation, who live in single rooms in private boarding or rooming houses, without their own bathroom, kitchen or security of tenure, on a medium or long term basis.
<b>6 Other Accommodation</b>	Other accommodation not elsewhere classified under the other domains. Includes: hotel/motel, specialised mental health community based residential support, shelter/refuge (other than homeless shelter or refuge).
<b>7 Homeless – no usual residence</b>	People without conventional or usual accommodation, such as people living on the streets, sleeping in parks, squats, cars or makeshift dwellings for temporary shelter.
<b>8 Homeless – shelter/refuge</b>	People who move frequently between various forms of temporary shelter e.g. friends, emergency accommodation, hostels and boarding houses.
<b>9 Unknown</b>	Details of type of usual accommodation is not stated or unknown.
<b>A Specialised alcohol/other drug treatment residence</b>	Includes alcohol/other drug treatment units in psychiatric hospitals.
<b>C Residential aged care service</b>	Includes nursing home beds in acute care hospitals
<b>D Domestic scale supported living facility</b>	(e.g. group home for people with disability): Domestic-scale supported living facilities include group homes for people with disability, cluster apartments where a support worker lives on-site, community residential apartments (except mental health), congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care.
<b>M Specialised mental health community based - residential</b>	Specialised mental health community-based residential support services are defined as community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provides 24-hour support/rehabilitation on a residential basis.
<b>O Other supported accommodation</b>	Includes other supported accommodation facilities such as hostels for people with

	disability, aged people and residential services/facilities (Victoria and South Australia only). These facilities provide board and lodging and rostered care workers provide client support services.
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### **Related ISAAC Edit**

- #4780 - Type of usual accommodation invalid

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## Veteran Card Number

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient—DVA card number, identifier X(9)
<i>Synonymous names:</i>	ISAAC Data Item 69
<i>SAHMR identifier:</i>	SA1098
<i>Registration status:</i>	SA Health, Standard 24/04/2013

Data Element Concept: Patient—DVA card number

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	String
<i>Format:</i>	X(9)
<i>Maximum character length:</i>	9

#### Collection and usage attributes

*Guide for use:* Note the Treatment Entitlement Cards contain two numbers: Alphanumeric, up to 9 digits, mostly prefixed with 'SX' and ending with an alpha character indicating the whether the patient is a veteran or spouse of a veteran, and a 13 digit number.

### Data element attributes

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#### Collection and usage attributes

*Guide for use:* Record the card number which appears on the patient's Department of Veterans' Affairs (DVA) Treatment Entitlement Card for all patients whose cost of hospital stay will be covered by DVA.  
PLEASE NOTE: These prefixes will appear on the card. There is no need to add them.

<b>S</b>	<b>South Australia</b>
<b>V</b>	<b>Victoria</b>
<b>N</b>	<b>New South Wales</b>
<b>W</b>	<b>Western Australia</b>
<b>Q</b>	<b>Queensland</b>
<b>T</b>	<b>Tasmania</b>

#### Additional Notes

An Alphanumeric number (up to 9 digits) is the information which **must** be recorded for ISAAC. Collection of the Veteran Card Number enables SA Health to recoup costs from DVA.

Record the Veteran Card Number from the DVA Entitlement Card if the patient is an eligible Veteran.

If in any doubt about the eligibility of a patient, record the card details.

These details must always be recorded on all episodes of care for that hospital stay.

Please note that a critical error will result if veteran card number is not supplied but is required. A critical error implies no funding for the affected record if the record is not corrected.

#### Related Data Items

- Funding Source (data item 95)
- Veteran Card Type (data item 31)

*Collection methods:*

**Related ISAAC Edits**

- #2280 – Veteran card number required
- #2290 – Veteran card number invalid
- #2295 – Veteran card number and card type no required
- #4530 – Veteran card type required
- #4540 – Veteran card type invalid
- #4521 - DVA Status has changed since last Episode of Care



---

## Veteran Card Type

---

**Identifying and definitional attributes**

<i>Technical name:</i>	Patient—DVA card type, code A
<i>Synonymous names:</i>	ISAAC data Item 31
<i>SAHMR identifier:</i>	SA433
<i>Registration status:</i>	SA Health, Standard 01/07/1996

Data Element Concept: Patient—DVA card type

**Value domain attributes****Representational attributes**

<i>Representation class:</i>	Code	
<i>Data type:</i>	String	
<i>Format:</i>	A	
<i>Maximum character length:</i>	1	
<i>Permissible values:</i>	Value	Meaning
	G	Treatment entitlement card - all conditions (gold)
	W	Treatment entitlement card- specific (white)
<i>Supplementary values:</i>	N	Not available

**Collection and usage attributes**

*Guide for use:*

**Data element attributes****Collection and usage attributes**

*Guide for use:*

**Additional Notes**

- The yellow, red and mauve cards were phased out from 1st January 1996 and have been replaced with a gold card. Any Veterans who present with these old cards should have their card type recorded as 'G'.
- An eligible Veteran is a patient who holds a current Department of Veteran's Affairs (DVA) entitlement card, and the cost of the hospital stay is funded by DVA.
- On admission, ascertain whether the patient holds a current DVA entitlement card. If a patient claims to be a cardholder but cannot present the card for sighting, the patient should be asked to arrange for a friend or relative to bring the card into hospital. Card type should be recorded for all eligible Veterans.
- Enter "N" (not available) for a patient who claims to be an eligible Veteran, but whose card cannot be sighted before discharge. Leave this data item blank when a patient is not an eligible Veteran.
- Only record the card details for those eligible Veteran patients whose cost of hospital stay will be covered by DVA. This applies for Veterans who are classified as Long Stay. These details must also be recorded on their subsequent episodes of care for that hospital stay.
- All Gold card eligible Veterans should have their Veteran Card Type recorded as G, Gold, as such patients are covered for all conditions, except if their admission is as a compensable patient - i.e., traffic accident. If in doubt of the

Veteran's eligibility, record the Veteran Card Type and Veteran Card Number.

- All White card eligible Veterans should have their Veteran Card Type recorded as W, White. White card holders are eligible to receive, for specific conditions, treatment from medical, hospital, pharmaceutical, dental and allied health care providers with whom DVA have arrangements.

*Collection methods:*

### **Related ISAAC Edits**

#2280 – Veteran card number required

#2290 – Veteran card number invalid

#2295 – Veteran card number and card type no required

#4530 – Veteran card type required

#4540 – Veteran card type invalid

#4521 - DVA Status has changed since last Episode of Care

---

## Ward on admission

---

### Identifying and definitional attributes

<i>Technical name:</i>	Patient admission - Ward on admission, code X[10]
<i>SAHMR identifier:</i>	SA1008
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The first ward the patient was admitted to at the beginning of their episode of care.

Data Element Concept	Patient Admission – Ward name
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### Value domain attributes

---

### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	N(10)
<i>Maximum character length:</i>	10

### Collection and usage attributes

*Guide for use:*

### Data element attributes

---

### Collection and usage attributes

*Guide for use:*

- This item is to be reported by all public country and metropolitan hospitals that capture ward information.
- One of the key purposes of capturing Ward on Admission is to assist in the accurate identification and monitoring the effectiveness of the Acute Medical Units through a range of performance indicators.
- Currently, there is no ISAAC Reference Table for wards by hospital.
- It is envisaged that capturing this information will not require any additional data entry. The Ward on Admission can be extracted from the patient administration system and included in the submission file that is sent to ISAAC.

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## Ward on Discharge

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### Identifying and definitional attributes

<i>Technical name:</i>	Patient's separation from service—ward on discharge, code X[10]
<i>Synonymous names:</i>	ISAAC Data item 66
<i>SAHMR identifier:</i>	SA1089
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	The last ward the patient was located in immediately prior to completion of their episode of care.

Data Element Concept: Patient's separation from service—Ward name

### Value domain attributes

---

#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	String
<i>Format:</i>	N(10)
<i>Maximum character length:</i>	10

#### Collection and usage attributes

*Guide for use:*

### Data element attributes

---

#### Collection and usage attributes

*Guide for use:*

- This item is to be reported by all public country and metropolitan hospitals that capture ward information.
- One of the key purposes of capturing Ward on Discharge is to assist in the identification inpatient activity through designated, specialist mental health beds.
- Administrative separations should have Ward on Discharge submitted.
- Currently, there is no ISAAC Reference Table for wards by hospital.

## Clinical Data Submission

### IMPORTANT NOTE

Refer to SA Morbidity Coding Standards and Guidelines for concise details on Clinical Coding. The guidelines also highlight additional Clinical Edits not covered in this manual.

### ICD CODE VERSIONS IMPLEMENTED IN SA

ICD Version	Implemented in SA	Book colour
October 1979 (inc errata through Aug 1983)	1 January 1985	Green
AIDS codes effective 1 October 1986	1 July 1987	Green
October 1986 (including AIDS) 1987 & 1988	1 July 1989	Red
October 1989 and 1990	1 January 1992	Black
October 1991 and 1992	1 March 1993	Blue
Australian ICD-9-CM codes	1 July 1994	
1995 Australian ICD-9-CM	1 July 1995	
1996 Australian ICD-9-CM	1 July 1996	
1999 Australian ICD-10-AM (1 <sup>st</sup> Edition)	1 July 1999	Blue
2000 Australian ICD-10-AM (2 <sup>nd</sup> Edition)	1 July 2000	Silver
2000 Australian ICD-10-AM (2 <sup>nd</sup> Edition)	1 July 2001	Silver
2002 ICD-10-AM (3 <sup>rd</sup> Edition)	1 July 2002	Purple
2004 ICD-10-AM (4 <sup>th</sup> Edition)	1 July 2004	Blue
2006 ICD-10-AM (5 <sup>th</sup> Edition)	1 July 2006	Navy-Blue
2008 ICD-10-AM (6 <sup>th</sup> Edition)	1 July 2008	Teal
2010 ICD-10-AM (7 <sup>th</sup> Edition)	1 July 2010	Black
2013 ICD_10_AM (8 <sup>th</sup> Edition)	1 July 2013	Multi coloured
2015 ICD-10-AM (9 <sup>th</sup> Edition)	1 July 2015	Grey

### Format for Clinical Data Submission

#### The submission of ICD-10-AM codes must be recorded in the following format:

- Without decimal points
- Include lead alpha characters
- Record codes in sequence order
- Left justify, blank fill
- Where there is no 4th digit, but a 5th digit is required use "0" as a filler

For example, secondary conditions are entered as:

P	1	2	3			M	2	3	4	5		S	4	5	0	1
---	---	---	---	--	--	---	---	---	---	---	--	---	---	---	---	---

Hospitals submitting information to ISAAC electronically must refer to ISAAC REFERENCE TABLE – FILE SUBMISSION FORMAT for the correct format of the data.

## **SECTION 5: Reports & Data Extraction**

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## Reports & Data Extraction

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### ISAAC Error reports

#### ISAAC Hospital Error Reports

The ISAAC unit currently sends each submitting hospital a report of errors in their monthly ISAAC submissions identified by the ISAAC data quality edits. EPAS hospitals will have access to real time reports of errors in their daily feed of data to ISAAC on LARS (currently under development).

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### Analysis and Reporting Services

SA Admitted activity data has been collected since 1985.

ISAAC data from 2000/2001 onwards is available to authorised SA Health personnel through the Health Information Portal (HIP). Contact HIP Operations for training in HIP reporting and access to HIP.

#### Contact HIP Operations

[HealthHealthInformationPortalOperations@sa.gov.au](mailto:HealthHealthInformationPortalOperations@sa.gov.au)

Reports on ISAAC data and near-real time data (eg OBI), or assistance with HIP can be requested from the Data Analysis and Corporate Reporting team, contact details below. Data may be subject to conditions of release and confidentiality.

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### Other reports on admitted activity

There are many health statistic resources. Below are some suggestions of commonly accessed health websites:

OBI dashboards (SA Health only)

[SA Health statistics](#) (public)

[SA Health website OBI dashboards](#) (public)

[My Hospitals website](#) (public)

[Australian Institute of Health and Welfare \(AIHW\)](#) (public)

For any other information on reporting and analysis services please contact the Data Analysis and Corporate Reporting team.

### Data Analysis and Corporate Reporting Team:

**Phone:** (08) 8226 6126

**Fax:** (08) 8226 8150

**E-mail:** [HealthDACRDataRequests@sa.gov.au](mailto:HealthDACRDataRequests@sa.gov.au)

## **SECTION 6: ISAAC Non-Clinical Data Quality Edits –**

ISAAC Clinical Data Quality Edits are published in '2016 SA Morbidity Coding Standards and Guidelines' available from Medical Record Advisory Unit, contact details [page 17](#).



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## ISAAC Data Quality Edits

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### Reject Edits

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**0990**      **MORE THAN ONE RECORD WITH SAME SEPARATION DATE & TIME IN FILE  
BOTH RECORDS REJECTED**

**Effect**      Rejected

**Details**      More than 1 rec with this Separation Date and Time in the file submission

**Logic**      If the Separation Date & Time (Data Item Numbers 43+70) is the same as the  
Separation Date & Time for another record for this patient in the file  
THEN REJECT record  
AND PRINT error message #0990 MORE THAN 1 REC WITH THE SAME SEP DATE  
& TIME IN FILE BOTH RECORDS REJECTED

---

**0991**      **RECORD WITH THIS SEPARATION DATE & TIME ALREADY EXISTS**

**Effect**      Rejected

**Details**      Record with this Separation Date and Time already exists in the database

**Logic**      If the Separation Date & Time (Data Item Numbers 43+70) is the same as the  
Separation Date & Time for another record for this patient in the database  
THEN REJECT record  
AND PRINT error message #0991 REC WITH THE SAME SEP DATE & TIME  
ALREADY EXISTS IN DATABASE

---

**1000**      **HOSPITAL CODE INVALID**

**Effect**      Rejected

**Details**      The Hospital Code is not recognised in the ISAAC Reference List of Hospitals.

**Logic**      IF Hospital Code (data item 1) is invalid  
THEN REJECT the record  
AND PRINT error message #1000 HOSPITAL CODE INVALID

---

**1010**      **DATE OF SEPARATION INVALID**

**Effect**      Rejected

**Details**      The Separation Date is not valid.

**Logic**      IF Separation date (data item 43) is an invalid date  
THEN REJECT record  
AND PRINT error message #1010 DATE OF SEPARATION INVALID

---

**1020**      **SEPARATION DATE PRE-ADMIT DATE**

**Effect**      Rejected

**Details**      The Separation Date must not be before the Admission Date.

**Logic**      IF Separation Date (data item 43) is < Admission Date (data item 21)  
THEN REJECT record  
AND PRINT error message #1020 SEPARATION DATE PRE ADMIT DATE

---

<b>1030</b>	<b>SEPARATION TIME INVALID</b>
<b>Effect</b>	Rejected
<b>Details</b>	The Separation Time is not valid.
<b>Logic</b>	IF Separation Time (data item 70) is ≠ a valid value between 0000 and 2359 THEN REJECT record AND PRINT error message #1030 SEPARATION TIME INVALID
<b>1040</b>	<b>DATE OF SEPARATION AFTER CURRENT DATE</b>
<b>Effect</b>	Rejected
<b>Details</b>	The Separation Date is after today's date. This is not possible. Revise Separation Date.
<b>Logic</b>	IF Separation Date (data item 43) is > [TODAY] THEN REJECT record AND PRINT error message #1040 DATE OF SEPARATION AFTER CURRENT DATE
<b>1050</b>	<b>DATE OF ADMISSION AFTER CURRENT DATE</b>
<b>Effect</b>	Rejected
<b>Details</b>	The Admission Date is after today's date. This is not possible. Revise Admission Date.
<b>Logic</b>	IF Admission Date (data item 21) is > today THEN REJECT record AND PRINT error message #1050 DATE OF ADMISSION AFTER CURRENT DATE
<b>1060</b>	<b>INVALID PATIENT UR NUMBER</b>
<b>Effect</b>	Rejected
<b>Details</b>	UR number must be in a 10 digit format and greater than 0.  IF Patient Unit Number (data item 3) is invalid THEN REJECT record AND PRINT error message #1060 INVALID PATIENT UR NUMBER
<b>1100</b>	<b>INVALID ITEM NUMBER</b>
<b>Effect</b>	Rejected
<b>Details</b>	Valid record submitted with invalid Item number
<b>Logic</b>	If Item Number not found on Data Item Number List Then REJECT record AND PRINT error message #1100-Invalid Item Number
<b>1110</b>	<b>INVALID DELETE CODE</b>
<b>Effect</b>	Rejected
<b>Details</b>	Delete code on rejection record must be 0 or 1
<b>Logic</b>	If record type = '5' and If Delete Code not equal to '0' or '1' REJECT record AND PRINT error message #1110-Invalid Delete Code

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## ISAAC Data Quality Edits (continued)

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### **1130 MORE THAN ONE RECORD WITH THIS ADMISSION DATE & TIME IN FILE BOTH RECORDS REJECTED**

**Effect** Rejected

**Details** More than 1 rec with this Admission Date and Time in the file submission

**Logic** If the Admission Date & Time (Data Item Numbers 21+67) is the same as the Admission Date & Time for another record for this patient in the file  
THEN REJECT record  
AND PRINT error message #1130 MORE THAN 1 REC WITH THIS ADMISSION DATE & TIME IN FILE BOTH RECORDS REJECTED

---

### **1140 2 OR MORE DELETION RECORDS FOR SAME PATIENT** (deactivated July 2015)

**Effect** Rejected

**Details** 2 or more deletion records for same patient

**Logic** If duplicate key found AND Delete\_Indicator = '1' in matching records within the same correction file then  
THEN REJECT record  
AND PRINT error message #1140 2 OR MORE DELETION RECORDS FOR SAME PATIENT

---

### **1150 DELETION AND CORRECTION EXISTS**

**Effect** Rejected

**Details** Can't request a deletion and a correction of the same record in the same correction file

**Logic** If duplicate key found AND Delete\_Indicator = '1' in 1 of the matching records AND Delete\_Indicator = '0' in another matching record within the same correction file  
THEN REJECT record  
AND PRINT error message #1150 DELETION AND CORRECTION EXISTS

---

### **1300 BOARDER DELETED**

**Effect** Rejected

**Details** Attempted to submit a boarder – record deleted.

**Logic** IF Patient Category (data item 14) = 3-Boarder  
OR Principal Diagnosis (data item 45) = Z763 or Z764  
THEN REJECT record  
AND PRINT error message #1300 BOARDER DELETED

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## ISAAC Data Quality Edits (continued)

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### 1310 BOARDER REJECTED

<b>Effect</b>	Rejected
<b>Details</b>	A correction to change a record into a boarder is not allowed
<b>Logic</b>	IF Patient Category (data item 14) has new value = 3-Boarder OR Principal Diagnosis (data item 45) has new value = Z763 or Z764 THEN REJECT record AND PRINT error message #1310 BOARDER REJECTED

---

### 1340 OVERLAPPING RECORD – SEP DATE/TIME BETWEEN ADM DATE/TIME & SEP DATE/TIME OF ANOTHER RECORD IN FILE BOTH RECORDS REJECTED

<b>Effect</b>	Rejected
<b>Details</b>	Separation date/time in between the Admission date/time & Separation date/time of another record for this patient in the file. This will create an overlapping record in the database.
<b>Logic</b>	If Separation Date & Time (Data Item Numbers 43 + 70) is in-between the Admission Date/Time (Data Item Numbers 21+67) and Separation Date/Time of another record for this patient in the file THEN REJECT record AND PRINT error message #1340 OVERLAPPING – SEP DATE/TIME BETWEEN ADM DATE/TIME & SEP DATE/TIME OF ANOTHER RECORD IN FILE BOTH RECORDS REJECTED

---

### 1350 OVERLAPPING RECORD – ADMISSION DATE/TIME BETWEEN ADM DATE/TIME & SEP DATE/TIME OF ANOTHER RECORD IN FILE BOTH RECORDS REJECTED

<b>Effect</b>	Rejected
<b>Details</b>	Admission date/time in between the Admission date/time & Separation date/time of another record for this patient in the file. This will create an overlapping record in the database.
<b>Logic</b>	If Admission Date/Time (Data Item Numbers 21+67) is in-between the Admission Date/Time and Separation Date/Time (Data Item Numbers 43 + 70) of another record for this patient in the file THEN REJECT record AND PRINT error message #1350 OVERLAPPING – ADMISSION DATE/TIME BETWEEN ADM DATE/TIME & SEP DATE/TIME OF ANOTHER RECORD IN FILE BOTH RECORDS REJECTED

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## ISAAC Data Quality Edits (continued)

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### Critical Edits

---

**1131 RECORD WITH THIS ADMISSION DATE & TIME ALREADY EXISTS**

**Effect** Critical

**Details** Record with this Admission Date and Time already exists in the database

**Logic** If the Admission Date & Time (Data Item Numbers 21+67) is the same as the Admission Date & Time for another record for this patient in the database  
THEN PRINT error message #1131 REC WITH THIS ADMISSION DATE & TIME ALREADY EXISTS

---

**1341 OVERLAPPING RECORD – SEPARATION DATE/TIME BETWEEN ADM DATE/TIME & SEP DATE/TIME OF ANOTHER RECORD IN DATABASE**

**Effect** Critical

**Details** Separation date/time in between the Admission date/time & Separation date/time of another record for this patient in the database. This will create an overlapping record in the database.

**Logic** If Separation Date & Time (Data Item Numbers 43 + 70) is in-between the Admission Date/Time (Data Item Numbers 21+67) and Separation Date/Time of another record for this patient in the database  
THEN PRINT error message #1341 OVERLAPPING– SEP DATE/TIME BETWEEN ADM DATE/TIME & SEP DATE/TIME OF ANOTHER RECORD IN DATABASE

---

**1351 OVERLAPPING RECORD – ADMISSION DATE/TIME BETWEEN ADM DATE/TIME & SEP DATE/TIME OF ANOTHER RECORD IN DATABASE**

**Effect** Critical

**Details** Admission date/time in between the Admission date/time & Separation date/time of another record for this patient in the database. This will create an overlapping record in the database.

**Logic** If Admission Date/Time (Data Item Numbers 21+67) is in-between the Admission Date/Time and Separation Date/Time (Data Item Numbers 43 + 70) of another record for this patient in the database  
THEN PRINT error message #1351 OVERLAPPING – ADMISSION DATE/TIME BETWEEN ADM DATE/TIME & SEP DATE/TIME OF ANOTHER RECORD IN DATABASE

---

**1361 OVERLAPPING RECORD – ADMISSION & SEPARATION DATE/TIME FOR ANOTHER RECORD IN THE DATABASE IS BETWEEN ADM DATE/TIME & SEP DATE/TIME OF THIS RECORD**

**Effect** Critical

**Details** Admission date/time earlier than the Admission date/time and the Separation date/time later than the Separation date/time of another record for this patient in the database. This will create an overlapping record in the database.

**Logic** If Admission Date & Time (Data Item Numbers 21 + 67) are earlier than the Admission Date/Time and the Separation Date/Time (Data Item Numbers 43+70) are later than the Separation date/time of another record for this patient in the database  
THEN PRINT error message #1361 OVERLAPPING – ADMISSION & SEPARATION DATE/TIME OF ANOTHER RECORD IN THE DATABASE IS BETWEEN ADM DATE/TIME & SEP DATE/TIME OF THIS RECORD

---

## ISAAC Data Quality Edits (continued)

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### 2000 DATE OF ADMISSION INVALID

**Effect** Critical

**Details** The Admission Date is invalid. Check the format and/or characters.

**Logic** IF Admission Date (data item 21) is invalid  
THEN ACCEPT submitted date  
AND PRINT error message #2000 DATE OF ADMISSION INVALID

---

### 2001 DFOTP BEFORE ADMISSION DATE

**Effect** Critical

**Details** The Date of First Operating Theatre Procedure Performed is before the Admission Date.

**Logic** IF Hospital Code (data item 1) = 0003 or 0005 or 0014 or 0018 or 0019 or 0027 or 0030 or 0033  
AND Procedure Location (data item 85) = 1  
AND Date Of First Operating Theatre Procedure Performed (data item 96) is < Admission Date (data item 21)  
THEN ACCEPT submitted record  
AND PRINT error message #2001 DFOTP DATE BEFORE ADMISSION DATE

---

### 2002 DFOTP AFTER SEPARATION DATE

**Effect** Critical

**Details** The Date of First Operating Theatre Procedure Performed is after the Separation Date.

**Logic** IF Hospital Code (data item 1) = 0003 or 0005 or 0014 or 0018 or 0019 or 0027 or 0030 or 0033  
AND Procedure Location (data item 85) = 1  
AND Date Of First Operating Theatre Procedure Performed (data item 96) is > Separation Date (data item 43)  
THEN ACCEPT submitted record  
AND PRINT error message #2002 – DFOTP DATE AFTER SEPARATION DATE

---

### 2003 TFOTP BEFORE ADMISSION TIME

**Effect** Critical

**Details** The Time of First Operating Theatre Procedure Performed is before the Admission Time.

**Logic** IF Hospital Code (data item 1) = 0003 or 0005 or 0014 or 0018 or 0019 or 0027 or 0030 or 0033  
AND Procedure Location Indicator (data item 85) = 1  
AND Date of First Operating Theatre Procedure Performed (data item 96) = Admission Date (data item 21)  
AND Time of First Operating Theatre Procedure Performed (data item 81) is before the Admission Time (data item 67)  
PRINT error message #2003 TFOTP BEFORE ADMISSION TIME

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## ISAAC Data Quality Edits (continued)

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<b>2004</b>	<b>TFOPT AFTER SEPARATION TIME</b>
<b>Effect</b>	Critical
<b>Details</b>	The Time of First Operating Theatre Procedure Performed is after the Separation Time.
<b>Logic</b>	IF Hospital Code (data item 1) = 0003 or 0005 or 0014 or 0018 or 0019 or 0027 or 0030 or 0033 AND Procedure Location Indicator (data item 85) = 1 AND Date of First Operating Theatre Procedure Performed (data item 96) = Separation Date (data item 43) AND Time of First Operating Theatre Procedure Performed (data item 81) is after the Separation Time (data item 70) PRINT error message #2004 TFOTP AFTER SEPARATION TIME
<b>2005</b>	<b>DFOTP MUST BE ACCOMPANIED BY TFOTP</b>
<b>Effect</b>	Critical
<b>Details</b>	A Date of First Operating Theatre Procedure Performed which is 1/7/2008 or onwards has been provided without a corresponding Time of First Operating Theatre Procedure.
<b>Logic</b>	IF Hospital Code (data item 1) = 0003 or 0005 or 0014 or 0018 or 0019 or 0027 or 0030 or 0033 AND Date of First Operating Theatre Procedure Performed (data item 96) = valid date >= 01/07/2008 AND Time of First Operating Theatre Procedure Performed (data item 81) is null PRINT error message #2005 DFOTP MUST BE ACCOMPANIED BY TFOTP
<b>2006</b>	<b>TFOTP MUST BE ACCOMPANIED BY DFOTP</b>
<b>Effect</b>	Critical
<b>Details</b>	A Time of First Operating Theatre Procedure Performed has been provided without a corresponding Date of First Operating Theatre Procedure Performed.
<b>Logic</b>	IF Hospital Code (data item 1) = 0003 or 0005 or 0014 or 0018 or 0019 or 0027 or 0030 or 0033 AND Date of First Operating Theatre Procedure Performed (data item 96) is null AND Time of First Operating Theatre Procedure Performed (data item 81) = valid time PRINT error message #2006 TFOTP MUST BE ACCOMPANIED BY DFOTP
<b>2010</b>	<b>DATE OF ADMISSION AFTER HOSPITALCLOSURE</b>
<b>Effect</b>	Critical
<b>Details</b>	The Hospital has closed – cannot have admission date after Hospital Closure Date.
<b>Logic</b>	IF Hospital Code (data item 1) is a hospital which has closed AND Admission Date (data item 21) >= Hospital Closure date THEN ACCEPT submitted record AND PRINT error message #2010 DATED ADMISSIONS AFTER HOSPITAL CLOSURE

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## ISAAC Data Quality Edits (continued)

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### 2040 DATE OF BIRTH INVALID

**Effect** Critical

**Details** The Date of Birth is not recognised as a valid date. Check format and/or characters.

**Logic** IF Date of Birth (data item 9) is null or invalid  
THEN ACCEPT submitted record  
AND PRINT error message #2040 DATE OF BIRTH INVALID

---

### 2050 DATE OF BIRTH AFTER ADMISSION DATE

**Effect** Critical

**Details** The Date of Birth must be before or equal the Admission Date. A patient cannot be born after they are admitted.

**Logic** IF Date of birth (data item 9) > Admission Date (data item 21)  
AND Date of Birth < > 01/07/1890  
THEN ACCEPT submitted record  
AND PRINT error message #2050 DATE OF BIRTH AFTER ADMISSION DATE

---

### 2060 ADMISSION TIME INVALID

**Effect** Critical

**Details** The Admission Time must be between 0000 and 2359. Check format and/or characters.

**Logic** IF Admission Time (data item 67) is blank or invalid  
THEN DEFAULT Admission Time to 00:00  
AND PRINT error message #2060 ADMISSION TIME INVALID

---

### 2070 DATE OF SEPARATION IS OVER 10 YEARS AGO

**Effect** Critical

**Details** Unable to submit records for patients separated more than 10 years ago.

**Logic** IF Separation Date (data item 43) >= 10 years  
THEN ACCEPT submitted record  
AND PRINT error message #2070 DATE OF SEPARATION OVER 10 YEARS AGO

---

### 2080 NATURE OF SEPARATION INVALID

**Effect** Critical

**Details** Valid values for Nature of Separation are 0 – 9, A, E or X. Check character.

**Logic** IF Nature of Separation (data item 42) ≠ 0-9, A or E or X  
THEN ACCEPT submitted value  
AND PRINT error message #2080 NATURE OF SEPARATION INVALID

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## ISAAC Data Quality Edits (continued)

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### **2085**      **WRONG NATURE OF SEPARATION FOR H@H/R@H**

**Effect**      Critical

**Details**      Valid values for Nature of Separation are 0 – 9, A, E or X. Check character.

**Logic**      IF Episode of Care (data item 51) = 7-Hospital at Home/Rehab at Home  
AND Nature of Separation (data item 42) = 0 or A or E or X or 2 or 3 or 4 or 7  
THEN ACCEPT submitted record  
AND PRINT error message #2085 WRONG NATURE OF SEPARATION

---

### **2160**      **SEX INVALID**

**Effect**      Critical

**Details**      The sex of a patient/client can only be one of three values – 1 = Male, 2 = Female or 3 = Indeterminate.

**Logic**      IF Sex (data item 8) is null or ≠ 1, 2 or 3  
THEN ACCEPT submitted record  
AND PRINT error message #2160 SEX INVALID

---

### **2170**      **ADMISSION WEIGHT REQUIRED FOR BABY**

**Effect**      Critical

**Details**      Baby's age is <29 days and the Admission Weight is blank or 9999. Require Admission Weight for neonate.

**Logic**      IF Admission Date (data item 21) – Date of Birth (data item 9) is < 29 days  
AND Admission Weight (data item 11) = null or 9999  
THEN ACCEPT submitted record  
AND PRINT error message #2170 ADMISSION WEIGHT REQUIRED FOR BABY

---

### **2175**      **BABY ADMISSION WEIGHT DIFFERENT, CORRECT ALL EPISODES.**

**Effect**      Critical

**Details**      Baby's Admission Weight should not change between Qualified and Unqualified care type changes during episode of care (for Bundled Records)

**Logic**      If this is 'LAST' identified record for baby bundling  
Then check other records in 'bundle' AND  
If admission weight on any of the records to be bundled differs from the other records to be bundled;

THEN RETAIN VALUES and trigger ERROR message: #2175 Baby admission weight different, correct all episodes

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## ISAAC Data Quality Edits (continued)

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### 2180 HOURS ON MECHANICAL VENTILATION INVALID

<b>Effect</b>	Critical
<b>Details</b>	Hours on Mechanical Ventilation must be between 0000 hours and 9999 hours.
<b>Logic</b>	IF Hours on Mechanical Ventilation (data item 41) is < 0000 or > 9999 THEN ACCEPT submitted record AND PRINT error message #2180 HOURS ON MECHANICAL VENTILATION INVALID

---

### 2190 PERIODS OF LEAVE FROM DATE/TIME INVALID

<b>Effect</b>	Critical
<b>Details</b>	The date and time recorded for periods of leave must be greater than the Admission Date and Time and less than the Separation Date and Time.
<b>Logic</b>	IF Leave From Date/Time is < Admission Date/Time (data items 67, 21) OR > Separation Date/Time (data item 43, 70) THEN ACCEPT submitted record AND PRINT error message #2190 PERIODS OF LEAVE FROM DATE/TIME INVALID

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### 2200 PERIODS OF LEAVE TO DATE/TIME INVALID

<b>Effect</b>	Critical
<b>Details</b>	The date and time recorded for periods of leave must be greater than the Admission Date and Time and less than the Separation Date and Time.
<b>Logic</b>	IF Leave To Date/Time is < Admission Date/Time (data items 21, 67) OR > Separation Date/Time (data item 43, 70) THEN ACCEPT submitted record AND PRINT error message #2200 PERIODS OF LEAVE TO DATE/TIME INVALID

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### 2210 PERIODS OF LEAVE INVALID

<b>Effect</b>	Critical
<b>Details</b>	There is inconsistency with Leave From Date or Leave To Date.
<b>Logic</b>	IF Leave To Date is < Leave From Date OR Leave To Date is valid AND Leave From Date is null OR Leave From Date is valid AND Leave To Date is null THEN ACCEPT submitted record AND PRINT error message #2210 PERIODS OF LEAVE INVALID

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<b>2220</b>	<b>PERIODS OF LEAVE FROM DATE INVALID</b>
<b>Effect</b>	Critical
<b>Details</b>	The Leave From Date is invalid.
<b>Logic</b>	IF leave from date is an invalid date THEN ACCEPT submitted record AND PRINT error message #2220 PERIODS OF LEAVE FROM DATE INVALID
<b>2230</b>	<b>PERIODS OF LEAVE TO DATE INVALID</b>
<b>Effect</b>	Critical
<b>Details</b>	The Leave To Date is invalid.
<b>Logic</b>	IF Leave To Date is an invalid date THEN ACCEPT submitted record AND PRINT error message #2230 PERIODS OF LEAVE TO DATE INVALID
<b>2240</b>	<b>ADMISSION TIME &gt; SEPARATION TIME</b>
<b>Effect</b>	Critical
<b>Details</b>	The Admission Date and Admission Time is greater than the Separation Date and Separation Time.
<b>Logic</b>	IF Admission Date (data item 21) = Separation Date (data item 43) AND Admission Time (date item 67) > Separation Time (data item 70) THEN ACCEPT submitted record AND PRINT error message #2240 ADMISSION TIME > SEPARATION TIME
<b>2250</b>	<b>AGE &gt; 124 YEARS CHECK DOB</b>
<b>Effect</b>	Critical
<b>Details</b>	Patient's aged is over 124 years – validate date of birth.
<b>Logic</b>	IF patient's age > 124 years AND DOB Accuracy flag (data item 91) ≠ 2 AND Date of Birth (data item 9) ≠ 01/07/1890 THEN ACCEPT submitted record AND PRINT error message #2250 AGE > 124 YEARS, CHECK DOB
<b>2255</b>	<b>AGE AT ADMISSION &gt; 9 DAYS, CANNOT BE UNQUALIFIED OR QUALIFIED NEWBORN</b>
<b>Effect</b>	Critical
<b>Details</b>	Only a newborn less than or equal to nine (9) days of age can have an Episode of Care of "unqualified". Check the patient's age and the episode of care type.
<b>Logic</b>	IF Patient's age at admission > 9 days AND Episode of Care (data item 51) = 5-Unqualified Newborn or 6-Qualified Newborn THEN Accept submitted values AND print error message: #2255 AGE AT ADMISSION > 9 DAYS, CANNOT BE UNQUALIFIED OR QUALIFIED NEWBORN
<b>2260</b>	<b>HOURS IN ICU IS &gt; LENGTH OF STAY</b>
<b>Effect</b>	Critical
<b>Details</b>	Hours in Intensive Care Unit cannot be greater than the total length of stay.

**Logic** IF Hours in ICU (data item 40) is > total length of stay  
THEN ACCEPT submitted record  
AND PRINT error message #2260 HOURS IN ICU IS > LENGTH OF STAY

---

**2270 HOURS ON MECHANICAL VENTILATION CANNOT BE > THAN LENGTH OF STAY**

**Effect** Critical

**Details** Hours on mechanical ventilation cannot be > than the total length of stay.

**Logic** IF Hours on Mechanical Ventilation (data item 41) is > length of stay  
THEN ACCEPT submitted record  
AND PRINT error message #2270 HOURS ON MECHANICAL VENTILATION  
CANNOT BE > THAN LENGTH OF STAY

---

**2280 VETERAN CARD NUMBER REQUIRED**

**Effect** Critical

**Details** If Veteran Card Type is Gold, White or Not Available or the Funding Source is "Veteran"  
then a Veteran Card Number is required

**Logic** IF Veteran Care Type (data item 31) is G, W or N  
OR Funding Source (data item 95) = 4-Veteran  
AND Veteran Card Number (data item 69) is null or invalid  
THEN DEFAULT Veteran Card Number (data item 69) to 000000000  
AND PRINT error message #2280 VETERAN CARD NUMBER REQUIRED

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**2290 VETERAN CARD NUMBER INVALID**

**Effect** Critical

**Details** Veteran Card Number must have an alpha prefix.

**Logic** If Veteran Card Number (data item 69) does not have a lead alpha character  
THEN PRINT error message #2290 VETERAN CARD NUMBER INVALID

---

**2295 NOT VETERAN – VETERAN CARD NUMBER AND CARD TYPE NOT REQUIRED**

**Effect** Critical

**Details** The patient is not a veteran; therefore Veteran Card Number and Veteran Card Type  
are not required.

**Logic** IF Veteran Card Number (data item 69) ≠ null  
Or Veteran Card Type (data item 31) ≠ null  
AND Funding Source (data item 95) ≠ 4-Veteran  
THEN PRINT error message #2295-NOT VETERAN – VETERAN CARD NUMBER  
AND CARD TYPE NOT REQUIRED

---

**2300 HOURS IN ICU IS INVALID**

**Effect** Critical

**Details** Value must be between 00000 and 99999.

**Logic** IF Hours in ICD (data item 40) ≥ 00000 and ≤ 99999  
THEN ACCEPT submitted record  
AND PRINT error message #2300 HOURS IN ICU IS INVALID

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## ISAAC Data Quality Edits (continued)

<b>2301</b>	<b>ICU HOURS INCOMPATIBLE WITH EPISODE OF CARE TYPE</b>
<b>Effect</b>	Critical
<b>Details</b>	Unqualified newborns and patients admitted to Hospital at Home/Rehab at Home cannot have Intensive Care Unit (ICU) hours recorded. Check and/or correct Episode of Care Type or ICU Hours.
<b>Logic</b>	IF Episode of Care Type (data item 51) = 5 – Unqualified Newborn or 7 – Hospital at Home/ Rehab at Home AND ICU Hours (data item 40) ≠ 00000 THEN ACCEPT submitted values AND TRIGGER error message 2301 ICU HOURS INCOMPATIBLE WITH EPISODE OF CARE TYPE
<b>2302</b>	<b>HMV HOURS INCOMPATIBLE WITH EPISODE OF CARE TYPE</b>
<b>Effect</b>	Critical
<b>Details</b>	Unqualified Newborns and patients admitted to Hospital at Home/Rehab at Home cannot have Hours on Mechanical Ventilation (HMV) recorded. Check and/or correct Episode of Care Type or HMV Hours.
<b>Logic</b>	IF Episode of Care Type (data item 51) = 5 – Unqualified Newborn or 7 – Hospital at Home/ Rehab at Home AND HMV Hours (data item 41) ≠ 00000 THEN ACCEPT submitted values AND TRIGGER error message 2302 HMV HOURS INCOMPATIBLE WITH EPISODE OF CARE TYPE
<b>2310</b>	<b>INTERSTATE POSTCODE OR SLA INVALID (disabled from 01/07/2013)</b>
<b>Effect</b>	Critical
<b>Details</b>	An interstate postcode does not match with SLA or vice versa.
<b>Logic</b>	IF Statistical Local Area (data item 7) = interstate AND Postcode (data item 6) ≠ interstate OR Postcode (data item 6) = interstate AND Statistical Local Area (data item 7) ≠ interstate THEN PRINT error message #2310 INTERSTATE POSTCODE OR SLA INVALID
<b>2320</b>	<b>INCORRECT ELECTION FOR FUNDING SOURCE TYPE</b>
<b>Effect</b>	Critical
<b>Details</b>	Election must be 1- Hospital with a Funding Source of Correctional, Overseas RHCA or Medicare.
<b>Logic</b>	IF Funding Source (data item 95) = 06 or 07 or 11 AND Election (data item 19) ≠ 1 THEN ACCEPT submitted record AND PRINT error message #2320 INCORRECT ELECTION FOR FUNDING SOURCE

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## ISAAC Data Quality Edits (continued)

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### 2330 INCORRECT HOSPITAL INSURANCE WITH THIS FUNDING SOURCE TYPE

**Effect** Critical

**Details** The Funding Source and Hospital Insurance must match. If the patient has Hospital Cover then the patient must have a Funding Source of 9-Private Health Insurance.

**Logic** IF Funding Source (data item 95) = 9  
AND Hospital Insurance (data item 17) ≠ 1 THEN  
PRINT error message #2330 INCORRECT HOSPITAL INSURANCE WITH THIS  
FUNDING SOURCE TYPE

---

### 2340 LOS > 35 DAYS ENSURE PATIENT IS LONG STAY

**Effect** Critical

**Details** If length of stay is greater than 35 days the Admission Type must be Long Stay – Acute or Long Stay –Maintenance CareType.

**Logic** If Admission Type (data item 20) = 1-Ordinary  
AND Length of Stay > 35 days  
AND Status Change Type (data item 23, or 26, or 29) does not equal 2 or 3 (if a 2 or 3 exist in any of the data items 23,26,29 then do not trigger edit for this record)  
AND Funding Source ≠ 01-Compensable-MVA or 02-Compensable-WC or 03-Compensable-Other or 07-Overseas-RHCA or 08-Non-Medicare  
THEN PRINT error message #2340 – LOS>35 DAYS, ENSURE PATIENT IS LONG STAY

---

### 2341 ADMISSION OR STATUS CHANGE TYPE AND EPISODE OF CARE INCOMPATIBLE

**Effect** Critical

**Details** Episode of Care is not compatible with Admission Type or Status Type Changes.  
*Introduced 1 July 2014*

**Logic** IF Episode of Care (data item 51) ≠ 2-Maintenance  
AND Admission Type (data item 20) or Status Type Changes (data item 23,26,29) = 3 - Long Stay-Maintenance Care  
THEN PRINT error message #2341 ADMISSION TYPE OR STATUS CHANGE TYPE AND EPISODE OF CARE INCOMPATIBLE.

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### 2342 ADMISSION OR STATUS CHANGE TYPE INCOMPATIBLE WITH EPISODE OF CARE 2

**Effect** Critical

**Details** If Episode of Care is Maintenance then Admission Type or Status Change Type cannot be 2- Long Stay - Acute *Introduced 1 July 2014*

**Logic** IF Episode of Care (data item 51) = 2-Maintenance  
AND Admission Type (data item 20) or Status Type Changes (data item 23,26,29) ≠ 1-Ordinary or 3 - Long Stay-Maintenance  
THEN PRINT error message #2342 ADMISSION TYPE OR STATUS CHANGE TYPE INCOMPATIBLE WITH EPISODE OF CARE 2

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## ISAAC Data Quality Edits (continued)

### 2580 EPISODE OF CARE INVALID

**Effect** Critical

**Details** Episode of Care is invalid.

**Logic** IF Episode of Care (data item 51) = null  
OR Episode of Care (data item 51) ≠ 1 – 9 or I-Mental Health Acute or J-Mental Health Maintenance Care or K-Mental Health Rehabilitation or L-Mental Health Psychogeriatric Care or P-Posthumous Organ Procurement  
AND Age > 9 days  
THEN PRINT error message #2580 EPISODE OF CARE INVALID

### 2580a EPISODE OF CARE INVALID FOR NEWBORN

**Effect** Critical

**Details** Episode of Care is invalid.

**Logic** IF Episode of Care (data item 51) = null  
OR Episode of Care (data item 51) ≠ 5 or 6  
AND Age ≤ 9 days  
THEN PRINT error message #2580a EPISODE OF CARE INVALID FOR NEWBORN

### 2582 WRONG EPISODE OF CARE FOR PRIVATE FREESTANDING DAY FACILITY

**Effect** Critical

**Details** The Australian Institute of Health & Welfare stipulate that private freestanding day surgeries should only be reporting acute and newborn episodes

Private freestanding day facilities in South Australia that report to ISAAC include:

4311-Hartley Dialysis	4346-Sach Day Surgery
4333-Ashford Day Surgery	4347-Adelaide DermSurgery
4339-Adelaide Day Surgery	4350-North Adelaide Day Surgery
4340-Northern Endoscopy Centre	4353-Glen Osmond Surgi-centre
4341-Glenelg Day Surgery	4354-Waverley House Plastic Surgery
4343-Hamilton House Day Surgery	4359-South Terrace Urology
4345-Oxford Day Surgery	4356-Brighton Day Surgery
4358-Adelaide Eye & Laser Centre	4365-Modbury Dialysis
4361-North Adelaide Gastro Centre	4366-Repromed
4362-Baxter Renal Therapy Service	4368-West Lakes Day Surgery
4363-Parkside Cosmetic Surgery	4369-Norwood Day Surgery

**Logic** IF ISAAC Hospital Role Code = "6-Day Surgery"  
AND Episode of Care ≠ "1-Acute" or "5-Unqualified Newborn" or "6-Qualified Newborn"  
THEN ACCEPT submitted record  
AND PRINT error message #2582 WRONG EPISODE OF CARE FOR PRIVATE FREESTANDING DAY FACILITY

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## ISAAC Data Quality Edits (continued)

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### 2583 NEWBORN OUTCOME OF DELIVERY NOT COMPATIBLE WITH AGE

**Effect** Critical

**Details** The patient is more than 28 days old at the time of admission and a diagnosis code indicating birth has been recorded. Check the patient's age and the recorded morbidity diagnosis codes.

**Logic** IF Patient's Age at admission is > 28 days  
AND Principal Diagnosis (data item 45) = Z38.x  
OR Additional Diagnosis (data item 46) = Z38.x  
THEN ACCEPT submitted record  
AND PRINT error message #2583 NEWBORN OUTCOME OF DELIVERY NOT COMPATIBLE WITH AGE

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### 2585 ELECTION TYPE NOT VALID WITH SUBMITTED FUNDING SOURCE

**Effect** Critical

**Details** For country hospitals, where the patient's funding source is Veteran, Defence, Non-Medicare, Private Health Insurance or Self funded, the Admission Election should be Private.

**Logic** IF Hospital Code (data item 1) is between 0049 and 0250  
AND Funding Source (data item 95) = 4 or 5 or 8 or 9 or 10  
AND Election (data item 19) ≠ 2  
OR Status Change Election 1 (data item 22) is non blank  
AND Status Change Election 1 ≠ 2  
OR Status Change Election 2 (data item 25) is non blank  
AND Status Change Election 2 ≠ 2  
OR Status Change Election 3 (data item 28) is non blank  
AND Status Change Election 3 ≠ 2  
THEN PRINT error message #2585 ELECTION TYPE NOT VALID WITH SUBMITTED FUNDING SOURCE

---

### 2610 FUNDING SOURCE INVALID

**Effect** Critical

**Details** The Funding Source field does not have a valid value between 01 and 13.

**Logic** IF Funding Source (data item 20) is invalid or ≠ 1 or 2, or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13  
PRINT error message #2610 – FUNDING SOURCE INVALID

---

### 2611 FUNDING SOURCE MUST BE OTHER HOSPITAL FOR CONTRACT SERVICE

**Effect** Critical

**Details** The Source of Referral indicates that the patient is receiving a contracted service and the Funding Source does not reflect Other Hospital or Public Authority.

**Logic** IF Source of Referral (data item 16) = 7-Contracted Service  
AND Funding Source (data item 20) ≠ 12-Other Hospital or Public Authority  
THEN PRINT error message #2611 FUNDING SOURCE MUST BE OTHER HOSPITAL FOR CONTRACTED SERVICE

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## ISAAC Data Quality Edits (continued)

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### 2695 SEPARATION DATE TIME FOR EOQ BUT NATURE OF SEPARATION NOT E

**Effect** Critical

**Details** Nature of separation must be E when Separation date and time indicate episode is an End Of Quarter *Introduced 1 July 2014*

**Logic** IF Episode of Care (data item 51) = 2 Maintenance  
AND Nature of Separation (data item 42) ≠ E – End of Quarter  
AND Separation Date (data item 43) = 3103yyyy or 3006yyyy or 3009yyyy or 3112yyyy  
AND Separation Time (data item 70) = 2358  
THEN PRINT error message #2695 SEPARATION DATE TIME FOR EOQ BUT  
NATURE OF SEPARATION NOT E

---

### 2696 EOQ SEPARATION - INCORRECT SOURCE OF REFERRAL

**Effect** Critical

**Details** Maintenance Care End of Quarter Separations have E as source of referral *Introduced 1 July 2014*

**Logic** IF Source of Referral (data item 16) ≠ E-End of Quarter  
AND Episode of Care (data item 51) = 2-Maintenance Care  
AND Admission Date (data item 21) = 3103yyyy or 3006yyyy or 3009yyyy or 3112yyyy  
AND Admission Time (data item 67) = 2359  
THEN PRINT error message #2696 EOQ SEPARATION - INCORRECT SOURCE OF  
REFERRAL

---

### 2700 EOQ SEPARATION TIME INCORRECT – MUST BE 2358

**Effect** Critical

**Details** End of Quarter Separation Time is incorrect – must be 23:58 pm.

**Logic** IF Nature of Separation (data item 42) = E-End of Quarter  
AND Episode of Care (data item 51) = 2-Maintenance Care  
AND Separation Date (data item 43) = 3103yyyy or 3006yyyy or 3009yyyy or 3112yyyy  
AND Separation Time (data item 70) ≠ 2358  
THEN PRINT error message #2700 EOQ SEPARATION TIME INCORRECT – MUST  
BE 2358

---

### 2705 EOQ SEPARATION DATE INCORRECT

**Effect** Critical

**Details** End of Quarter Separation Date is incorrect.

**Logic** IF Nature of Separation (data item 42) = E-End of Quarter  
AND Episode of Care (data item 51) = 2-Maintenance Care  
AND Separation Date (data item 43) ≠ 3103yyyy or 3006yyyy or 3009yyyy or 3112yyyy  
THEN PRINT error message #2705 EOQ SEPARATION DATE INCORRECT

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## ISAAC Data Quality Edits (continued)

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### 2710 EOQ ADMISSION TIME INCORRECT – MUST BE 2359

**Effect** Critical

**Details** End of Quarter Admission Time is incorrect – must be 2359 pm.

**Logic** IF Source of Referral (data item 16) = E-End of Quarter  
AND Episode of Care (data item 51) = 2-Maintenance Care  
AND Admission Date (data item 21) = 3103yyyy or 3006yyyy or 3009yyyy or 3112yyyy  
AND Admission Time (data item 67) ≠ 2359  
THEN PRINT error message #2710 EOQ ADMISSION TIME INCORRECT – MUST BE 2359

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### 2715 EOQ ADMISSION DATE INCORRECT

**Effect** Critical

**Details** End of Quarter Admission Date is incorrect.

**Logic** IF Source of Referral (data item 16) = E-End of Quarter  
AND Episode of Care (data item 51) = 2-Maintenance Care  
AND Admission Date (data item 21) ≠ 3103yyyy or 3006yyyy or 3009yyyy or 3112yyyy  
THEN PRINT error message #2715 EOQ ADMISSION DATE INCORRECT

---

### 2720 REFERRAL FOR FURTHER CARE H@H MUST HAVE NATURE OF SEP 'A'

**Effect** Critical

**Details** Referral for Further Care in Hospital at Home must have an “Administrative” Nature of Separation.

**Logic** IF Referral For Further Care (data item 72) = 07-Hospital at Home  
AND Nature of Separation ≠ A-Administrative  
THEN PRINT error message #2720 REFERRAL FOR FURTHER CARE H@H MUST HAVE NATURE OF SEP 'A'

---

### 2730 INCORRECT REFERRAL – PATIENT ALREADY H@H

**Effect** Critical

**Details** Patient has a Referral for Further Care for Hospital at Home; however they are already admitted as Hospital at Home.

**Logic** IF Episode of Care (data item 51) = 7-Hospital at Home  
AND Referral for Further Care (data item 72) = 07-Hospital at Home  
THEN PRINT error message #2730 INCORRECT REFERRAL – PATIENT ALREADY H@H

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## ISAAC Data Quality Edits (continued)

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### 2740 INCORRECT SOURCE OF REFERRAL FOR H@H/R@H EPISODE OF CARE

**Effect** Critical

**Details** The Source of Referral is incorrect for the Hospital at Home/Rehab at Home episode of care.

**Logic** IF Episode of Care (data item 51) = 7-Hospital at Home  
AND NOT Source of Referral (data item 16) = A-Administrative Admission or 1-Other Priv Medical Practice (excl psychiatrist) or 3-Comm Health Service or 4-Inter Hospital Transfer or 5-Outpatient Department or 6-Casualty/Emergency or P-Private psychiatric practice or R-Residential Mental Health Service  
THEN PRINT error message #2740 INCORRECT SOURCE OF REFERRAL FOR H@H/R@H EPISODE OF CARE

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### 2745 INCORRECT NATURE OF SEPARATION FOR EPISODE OF CARE TYPE

**Effect** Critical

**Details** Episode for Posthumous Organ Procurement must have a Nature of Separation of Died. Check and/or correct Episode of Care Type or Nature of Separation

**Logic** IF Episode of Care Type (data item 51) = P Posthumous Organ Procurement  
AND Nature of Separation (data item 42) ≠ 5 – Died no Autopsy or 6 – Died Autopsy  
THEN ACCEPT submitted values  
AND TRIGGER error message #2745 INCORRECT NATURE OF SEPARATION FOR EPISODE OF CARE TYPE

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### 2750 INCORRECT NATURE OF SEP & REFERRAL FOR FURTHER CARE FOR EPISODE OF CARE TYPE

**Effect** Critical

**Details** The Episode of Care, Nature of Separation and Referral for Further Care are not compatible.

**Logic** IF Episode of Care (data item 51) = 5-Unqualified Newborn or 6-Qualified Newborn or 7-Hospital at Home or 8-Psychogeriatric Care or L-Mental Health Psychogeriatric  
AND Referral for Further Care (data item 72) = 07-Hospital at Home  
AND Nature of Separation = A-Administrative  
THEN PRINT error message #2750 INCORRECT NATURE OF SEP & REFERRAL FOR FURTHER CARE FOR EPISODE OF CARE TYPE

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### 2751 RUG ADL CODE REQUIRED FOR MAINTENANCE CARE EPISODE

**Effect** Critical

**Details** Maintenance Episode of Care requires a RUG ADL

**Logic** IF Episode of Care = 2 Maintenance  
AND Source of Referral (data item 16) ≠ 'E'  
AND RUG-ADL (data item 104) is Null  
THEN print error message: #2751 - RUG ADL CODE REQUIRED FOR MAINTENANCE CARE EPISODES

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## ISAAC Data Quality Edits (continued)

<b>2753</b>	<b>SAMEDAY SCOPE – REPORTED AS INPATIENT, NOT FUNDED</b> (applicable ≥ 01/072013)
<b>Effect</b>	Critical
<b>Details</b>	Selected sameday scope procedures where no GA is administered and the admission category is not emergency are not considered valid inpatient episodes for funding purposes for metropolitan hospitals, nor are public patients treated in country public hospitals. These scopes are to be reported to MMSS for reporting and funding as an outpatient encounter..
<b>Logic</b>	<p>IF Hospital Code (data item 1) = 0049 to 0249 AND Admission Election (data item 19) ≠ "2 – private" OR Hospital Code (data item 1) = 0003, 0005, 0008, 0014, 0015, 0018, 0019, 0027, 0028, 0030, 0033, 0035, 0036, 0042, 0296, 0300  AND Admission Category (data item 15) ≠ "2-Emergency"  AND Admission Date (data item 21) = Separation Date (data item 43)  AND Principal Procedure (data item 49a) = 1182000 [1005], 3037522 [873], 3045102 [960], 3045103 [960], 3047300 [1005], 3047301 [1008], 3047302 [1005], 3047303 [850], 3047304 [861], 3047305 [1005], 3047306 [1008], 3047307 [1005], 3047308 [1005], 3047500 [882], 3047501 [882], 3047600 [851], 3047601 [851], 3047602 [856], 3047603 [874], 3047800 [1006], 3047801 [1007], 3047802 [1007], 3047803 [1007], 3047804 [1008], 3047805 [892], 3047806 [851], 3047807 [870], 3047809 [851], 3047810 [852], 3047811 [856], 3047812 [856], 3047813 [861], 3047814 [1006], 3047815 [1007], 3047816 [1007], 3047817 [1007], 3047818 [1008], 3047819 [856], 3047820 [1007], 3047821 [1007], 3047900 [856], 3047901 [931], 3047902 [908], 3048100 [870], 3048200 [870], 3048400 [957], 3048401 [957], 3048402 [974], 3048500 [963], 3048501 [963], 3049000 [853], 3049001 [853], 3049002 [853], 3049100 [958], 3049102 [975], 3049103 [975], 3049104 [975], 3049400 [971], 3207500 [904], 3207501 [910], 3207800 [910], 3208100 [910], 3208400 [905], 3208401 [911], 3208402 [905], 3208700 [911], 3209000 [905], 3209001 [911], 3209002 [905], 3209300 [911], 3209400 [917], 3209500 [891], 3842100 [554], 3843601 [549], 4176400 [370], 4176403 [520], 4177300 [421], 4181600 [850], 4181900 [862], 4182200 [861], 4182500 [852], 4183100 [862], 9029500 [906], 9029501 [906], 9029502 [906], 4183200 [862], 4184900 [520], 4185200 [523], 4185500 [520], 4186100 [523], 4186400 [523], 4186700 [523], 4186800 [522], 5203500 [419], 9016900 [551], 9017100 [556], 9029503 [929], 9029504 [929], 9029505 [929], 9030800 [908], 9031500 [933], 9034900 [975], 9046301 [1330], 9048800 [1330], 9206800 [892], 9206801 [892], 920680 [892]</p> <p>AND Additional Procedure (data items 49b to 49y) ≠ 9251410, 9251419, 9251420, 9251429, 9251430, 9251439, 9251440, 9251449, 9251450, 9251459, 9251469, 9251490, 9251499  THEN ACCEPT submitted values  AND PRINT error message #2753 SAMEDAY SCOPE – VERIFY INPATIENT STATUS</p>

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## ISAAC Data Quality Edits (continued)

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<b>2754</b>	<b>SAMEDAY CHEMO – REPORTED AS INPATIENT, NOT FUNDED</b> (applicable ≥ 01/07/2013)
<b>Effect</b>	Critical
<b>Details</b>	Sameday chemotherapy where no GA is administered and the admission category is not emergency are not considered valid inpatient episodes for funding for metropolitan hospitals or for public patients treated in country public hospitals. These scopes are to be reported to MMSS for reporting and funding as an outpatient encounter
<b>Logic</b>	IF Hospital Code (data item 1) = 0049 to 0249 AND Admission Election (data item 19) ≠ “2- private” OR Hospital Code (data item 1) = 0003, 0005, 0008, 0014, 0015, 0018, 0019, 0027, 0028, 0030, 0033, 0035, 0036, 0042, 0296, 0300 AND Admission Category (data item) ≠ “2-Emergency” AND Admission Date (data item 21) = Separation Date (data item 43) AND Principal Diagnosis (data item 45) = Z51.1 AND Additional Diagnosis (data item 46a-o) ≠ B20 or B21 or B22 or B23.0 or B23.8 or B24 AND Additional Procedure (data items 49b to 49y) ≠ 9251410, 9251419, 9251420, 9251429, 9251430, 9251439, 9251440, 9251449, 9251450, 9251459, 9251469, 9251490, 9251499 THEN ACCEPT submitted values AND PRINT error message #2754 SAMEDAY CHEMO – VERIFY INPATIENT STATUS

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## ISAAC Data Quality Edits (continued)

<b>2755</b>	<b>SAMEDAY SCOPE – REPORTED AS INPATIENT, NOT FUNDED (≥ 01/07/2007 AND ≤ 30/06/2008)</b>
<b>Effect</b>	Critical
<b>Details</b>	Selected sameday scope procedures where no GA is administered are not considered valid inpatient episodes for funding purposes and are to be reported to MMSS for reporting and funding as an outpatient encounter.
<b>Logic</b>	<p>IF Hospital Code (data item 1) = 0003 to 0300  AND Admission Date (data item 21) = Separation Date (data item 43)  AND Principal Procedure (data item 49a) = 1182000 [1005], 3037522 [873], 3045102 [960], 3045103 [960], 3047300 [1005], 3047301 [1008], 3047302 [1005], 3047303 [850], 3047304 [861], 3047305 [1005], 3047306 [1008], 3047307 [1005], 3047308 [1005], 3047500 [882], 3047501 [882], 3047600 [851], 3047601 [851], 3047602 [856], 3047603 [874], 3047800 [1006], 3047801 [1007], 3047802 [1007], 3047803 [1007], 3047804 [1008], 3047805 [892], 3047806 [851], 3047807 [870], 3047809 [851], 3047810 [852], 3047811 [856], 3047812 [856], 3047813 [861], 3047814 [1006], 3047815 [1007], 3047816 [1007], 3047817 [1007], 3047818 [1008], 3047819 [856], 3047820 [1007], 3047821 [1007], 3047900 [856], 3047901 [931], 3047902 [908], 3048100 [870], 3048200 [870], 3048400 [957], 3048401 [957], 3048402 [974], 3048500 [963], 3048501 [963], 3049000 [853], 3049001 [853], 3049002 [853], 3049100 [958], 3049102 [975], 3049103 [975], 3049104 [975], 3049400 [971], 3207500 [904], 3207501 [910], 3207800 [910], 3208100 [910], 3208400 [905], 3208401 [911], 3208402 [905], 3208700 [911], 3209000 [905], 3209001 [911], 3209002 [905], 3209300 [911], 3209400 [917], 3209500 [891], 3842100 [554], 3843601 [549], 4176400 [370], 4176403 [520], 4177300 [421], 4181600 [850], 4181900 [862], 4182200 [861], 4182500 [852], 4183100 [862], 9029503 [929], 9029504 [929], 9029505 [929], 5203500 [419], 4184900 [520], 4185500 [520], 4186800 [522], 4185200 [523], 4186100 [523], 4186400 [523], 4186700 [523], 9016900 [551], 9017100 [556], 4183200 [862], 9206800 [862], 9206801 [896], 9206802 [892], 9030800 [908], 9031500 [933], 9034900 [975], 9046301 [1330], 9048800 [1330].  AND Additional Procedure (data items 49b to 49y) ≠ 9251410, 9251419, 9251420, 9251429, 9251430, 9251439, 9251440, 9251449, 9251450, 9251459, 9251469, 9251490, 9251499  THEN ACCEPT submitted values  AND PRINT error message #2755 SAMEDAY SCOPE – VERIFY INPATIENT STATUS</p>
<b>2756</b>	<b>SAMEDAY CHEMO – REPORTED AS INPATIENT, NOT FUNDED (≥ 01/07/2007 AND ≤ 30/06/2008)</b>
<b>Effect</b>	Critical
<b>Details</b>	Sameday chemotherapy where no GA is administered and the admission category is not emergency are not considered valid inpatient episodes for funding purposes and are to be reported to MMSS for reporting and funding as an outpatient encounter.
<b>Logic</b>	<p>IF Hospital Code (data item 1) = 0003 to 0300  AND Admission Date (data item 21) = Separation Date (data item 43)  AND Principal Diagnosis (data item 45) = Z51.1  AND Additional Diagnosis (data item 46a-o) ≠ B20 or B21 or B22 or B23.0 or B23.8 or B24  AND Additional Procedure (data items 49b to 49y) ≠ 9251410, 9251419, 9251420, 9251429, 9251430, 9251439, 9251440, 9251449, 9251450, 9251459, 9251469, 9251490, 9251499  THEN ACCEPT submitted values  AND PRINT error message #2756 SAMEDAY CHEMO – VERIFY INPATIENT STATUS</p>

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## ISAAC Data Quality Edits (continued)

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### **2757      SAMEDAY BRONCHOSCOPY – REPORTED AS INPATIENT, NOT FUNDED (applicable ≥ 01/07/2013)**

**Effect**      Critical

**Details**      Sameday bronchoscopy where no GA is administered and the admission category is not emergency are not considered valid inpatient episodes for funding purposes for metropolitan hospitals or for public patients treated in country public hospitals. These scopes are to be reported to MMSS for reporting and funding as an outpatient encounter.

**Logic**      IF Hospital Code (data item 1) = 0049 to 0249 AND Admission Election (data item 19 ≠ “2 – private” OR Hospital Code (data item 1) = 0003, 0005, 0008, 0014, 0015, 0018, 0019, 0027, 0028, 0030, 0033, 0035, 0036, 0042, 0296, 0300  
AND Admission Category (data item 15) ≠ “2-Emergency”  
AND Admission Date (data item 21) = Separation Date (data item 43)  
AND Principal Procedure (data item 49a) = 4188900, 4188901, 4189200, 4189201, 4189500, 4189800, 4189801, 4190100, 4190400, 9016300  
AND Additional Procedure (data items 49b to 49y) ≠ 9251410, 9251419, 9251420, 9251429, 9251430, 9251439, 9251440, 9251449, 9251450, 9251459, 9251469, 9251490, 9251499  
THEN ACCEPT submitted values  
AND PRINT error message #2757 SAMEDAY BRONCHOSCOPY – VERIFY INPATIENT STATUS

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### **2760      TOTTDL INVALID**

**Effect**      Critical

**Details**      Is the time of which the patient was transferred to the Discharge/Transit Lounge during their hospital admission.

**Logic**      IF Time of Transfer To Discharge Lounge (data item 53) <0000 or >2400  
PRINT error message #2760 TOTTDL INVALID

---

### **2761      DOTTDL MUST BE ACCOMPANIED BY TOTTDL**

**Effect**      Critical

**Details**      Date and Time of when the patient was transferred to the Discharge/Transit Lounge during their hospital admission.

**Logic**      IF Date of Transfer To Discharge Lounge (data item 52) = valid date AND Time of Transfer To Discharge (data item 53) is null  
PRINT error message #2761 DOTTDL MUST BE ACCOMPANIED BY TOTTDL

---

### **2762      TOTTDL MUST BE ACCOMPANIED BY DOTTDL**

**Effect**      Critical

**Details**      Time and Date of when the patient was transferred to the Discharge/Transit Lounge during their hospital admission.

**Logic**      IF Date of Transfer To Discharge Lounge (data item 52) is null AND Time of Transfer To Discharge (data item 53) = valid Time and Date of when the patient was transferred to the Discharge/Transit Lounge during their hospital admission  
PRINT error message #2762 TOTTDL MUST BE ACCOMPANIED BY DOTTDL

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## ISAAC Data Quality Edits (continued)

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### 2763 TRANSFER TO DC LOUNGE DATE BEFORE ADMISSION DATE

**Effect** Critical

**Details** The Date of when the patient was transferred to the Discharge/Transit Lounge is before Admission Date.

**Logic** IF Date of Transfer To Discharge Lounge (data item 52) is before the Admission Date (data item 21)  
PRINT error message # 2763 TRANSFER TO DC LOUNGE DATE BEFORE ADM DATE

---

### 2764 TRANSFER TO DC LOUNGE DATE AFTER SEPARATION DATE

**Effect** Critical

**Details** The Date of when the patient was transferred to the Discharge/Transit Lounge is after Separation Date.

**Logic** IF Date of Transfer To Discharge/Transit Lounge (data item 52) is after the Separation Date (data item 43)  
PRINT error message #2764 TRANSFER TO DC LOUNGE DATE AFTER SEP DATE

---

### 2765 TRANSFER TO DC LOUNGE TIME BEFORE ADMISSION TIME

**Effect** Critical

**Details** The Time of when the patient was transferred to the Discharge/Transit Lounge is before Admission Time.

**Logic** IF Date of Transfer To Discharge Lounge (data item 52) = Admission Date (data item 21)  
AND Time of Transfer To Discharge Lounge (data item 53) is before the Admission Time (data item 67)  
PRINT error message #2765 TRANSFER TO DC LOUNGE TIME BEFORE ADM TIME

---

### 2766 TRANSFER TO DC LOUNGE TIME AFTER SEPARATION TIME

**Effect** Critical

**Details** The Time of when the patient was transferred to the Discharge/Transit Lounge is after Separation Time.

**Logic** IF Date of Transfer To Discharge Lounge (data item 52) = Separation Date (data item 43)  
AND Time of Transfer To Discharge Lounge (data item 53) is after the Separation Time (data item 70) PRINT error message #2766 TRANSFER TO DC LOUNGE TIME AFTER SEP TIME

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## ISAAC Data Quality Edits (continued)

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### Warning Edits

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#### **4000 INAPPROPRIATE SAMEDAY ADMISSION**

**Effect** Warning

**Details** The patient has been admitted for a Type C procedure. Ensure appropriate documentation has been recorded. Refer to Technical Bulletin 05:29 & 04:28.

**Logic** IF Hospital (data item 1) is between 0001 and 0500  
AND Admission Date (data item 21) = Separation Date (data item 43)  
AND Length of Stay is less than or equal to ( $\leq$ ) 240 minutes (4 hours)  
AND Nature of Separation (data item 42)  $\neq$  to "5-Died, no autopsy" or "6-Died, autopsy"  
AND Principal Procedure (data item 49a) = codes on the Inappropriate Sameday Admission Procedure list  
AND Additional Procedure (data item 49b) is null  
THEN ACCEPT the submitted record  
AND PRINT error message #4000-INAPPROPRIATE SAMEDAY ADMISSION: see TB 05:29 & 04:28

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#### **4001 WRONG ADMISS CATEG FOR STATISTICAL ADMISSION**

**Effect** Warning

**Details** Wrong admission category for statistical admission.

**Logic** IF Source of Referral (data item 16) = A-Administrative Admission or E-End of Quarter  
AND Admission Category (data item 15)  $\neq$  4-Not applicable  
THEN DEFAULT Admission Category (data item 15) to 4-Not applicable  
AND PRINT error message #4001 WRONG ADMISS CATEG FOR STATISTICAL ADMISSION

---

#### **4002 WRONG ADMISS CATEG FOR DIALYSIS PATIENT**

**Effect** Warning

**Details** Wrong admission category for dialysis patient.

**Logic** IF Source of Referral (data item 16)  $\neq$  A-Administrative Admission or E-End of Quarter  
AND Principal Diagnosis (data item 45) = Z49.1  
AND Admission Category (data item 15)  $\neq$  4-Not applicable  
THEN DEFAULT Admission Category (data item 15) to 4-Not applicable  
AND PRINT error message #4002-WRONG ADMISS CATEG FOR DIALYSIS PATIENT

---

#### **4003 WRONG ADMISS CATEG FOR CHEMO PATIENT**

**Effect** Warning

**Details** Wrong admission category for chemotherapy patient.

**Logic** IF Source of Referral (data item 16)  $\neq$  A-Administrative Admission or E-End of Quarter  
AND Principal Diagnosis (data item 45)  $\neq$  Z491  
AND Principal Diagnosis (data item 45) = Z511  
AND Admission Category (data item 15)  $\neq$  4-Not Applicable  
THEN DEFAULT Admission Category (data item 15) to 4-Not Applicable  
AND PRINT error message 4003 WRONG ADMISS CATEG FOR CHEMO PATIENT

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## ISAAC Data Quality Edits (continued)

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### **4004      WRONG ADMISS CATEG FOR RADIOTHERAPY PATIENT**

**Effect**      Warning

**Details**      Wrong admission category for radiotherapy patient.

**Logic**      IF Source of Referral (data item 16) ≠ A-Administrative Admission or E-End of Quarter  
AND Principal Diagnosis (data item 45) ≠ Z491  
AND Principal Diagnosis (data item 45) ≠ Z511  
AND Principal Diagnosis (data item 45) = Z510  
AND Admission Category (data item 15) ≠ 4-Not Applicable  
THEN DEFAULT Admission Category (data item 15) to 4-Not Applicable  
AND PRINT error message #4004 WRONG ADMISS CATEG FOR RADIOTHERAPY  
PATIENT

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### **4006      WRONG ADMISS CATEG FOR NORMAL DELIVERY**

**Effect**      Warning

**Details**      Wrong Admission Category for Normal Delivery.

**Logic**      IF Source of Referral (data item 16) ≠ A-Administrative or E-End of Quarter  
AND Principal Diagnosis (data item 45) ≠ Z49.1  
AND Principal Diagnosis (data item 45) ≠ Z51.1  
AND Principal Diagnosis (data item 45) ≠ Z51.0  
AND Principal Diagnosis (data item 45) = O80 or O84.0  
AND Admission Category (data item 15) ≠ 4-Not Applicable  
THEN DEFAULT Admission Category (data item 15) to 4-Not Applicable  
AND PRINT error message #4006 WRONG ADMISS CATEG FOR NORMAL  
DELIVERY

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### **4007      WRONG ADMISS CATEG FOR UNQUAL NEWBORN**

**Effect**      Warning

**Details**      Wrong Admission Category for Unqualified Newborn.

**Logic**      IF Source of Referral (data item 16) ≠ A-Administrative Admission or E-End of Quarter  
AND Principal Diagnosis (data item 45) ≠ Z49.1  
AND Principal Diagnosis (data item 45) ≠ Z51.1  
AND Principal Diagnosis (data item 45) ≠ Z51.0  
AND Principal Diagnosis (data item 45) ≠ O80 or O84.0  
AND Episode of Care (data item 51) = 5-Unqualified Newborn  
AND Admission Category (data item 15) ≠ "4-Not applicable"  
THEN DEFAULT Admission Category (data item 15) to "4-Not applicable"  
AND PRINT error message #4007-WRONG ADMISS CATEG FOR UNQUAL  
NEWBORN

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## ISAAC Data Quality Edits (continued)

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### 4008 WRONG ADMISS CATEG FOR BIRTH EPISODE

<b>Effect</b>	Warning
<b>Details</b>	Wrong Admission Category for birth episode.
<b>Logic</b>	IF data item 16, Source of Referral ≠ A-Administrative Admission or E-End of Quarter AND Principal Diagnosis (data item 45) ≠ Z49.1 AND Principal Diagnosis (data item 45) ≠ Z51.1 AND Principal Diagnosis (data item 45) ≠ Z51.0 AND Principal Diagnosis (data item 45) ≠ O80 or 84.0 AND Episode of Care (data item 51) ≠ 5-Unqualified Newborn AND Source of Referral (data item 16) ≠ 4-Interhospital Transfer or X-Retrieval AND Admission Date (data item 21) = Date of Birth (data item 9) AND Admission Category (data item 15) ≠ '4-Not applicable' THEN DEFAULT Admission Category (data item 15) to 4-Not applicable AND PRINT error message #4008-WRONG ADMISS CATEG FOR BIRTH EPISODE

---

### 4010 POSTCODE INVALID

<b>Effect</b>	Warning
<b>Details</b>	Post code entered is not recognised in the system reference table and has been defaulted to 0999.
<b>Logic</b>	IF Postcode (data item 6), is not valid then default to 0999 AND PRINT error message #4010 POSTCODE INVALID

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### 4020 COUNTRY OF BIRTH CODE INVALID

<b>Effect</b>	Warning
<b>Details</b>	Country of birth code entered is not in the Reference Table.
<b>Logic</b>	IF Country of Birth (data item 10) = null or invalid THEN DEFAULT Country of Birth (data item 10) to 0003 or UNKNOWN AND PRINT error message #4020 COUNTRY OF BIRTH CODE INVALID

---

### 4021 PATIENT IS MEDICARE INELIGIBLE BUT COB = AUSTRALIA

<b>Effect</b>	Warning
<b>Details</b>	The patient was born in Australia yet the principle source of funds indicates that the patient is not eligible for Medicare. In a small number of cases this may be correct. Check the patient's country of birth and verify the elected funding source.
<b>Logic</b>	IF Country of Birth (data item 10) = "1100-Australia (includes External Territories) (nfd)" or "1101-Australia" or "1102-Norfolk Island" or "1199-Australian External Territories" AND Funding Source (data item 95) = "7-Overseas RCHA" or "8-Non-medicare" THEN ACCEPT submitted record AND PRINT error message #4021 PATIENT IS MEDICARE INELIGIBLE BUT COB = AUSTRALIA

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## ISAAC Data Quality Edits (continued)

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### 4022 COB HAS CHANGED SINCE LAST EPISODE OF CARE

<b>Effect</b>	Warning
<b>Details</b>	The Country of Birth has changed since last episode of care. Check format and characters & correct invalid/incorrect Country of Birth for applicable episodes of care.
<b>Logic</b>	IF COB (data item 10) on previous episode of care = 0001 or 1000 – 9299 AND Country of Birth on current episode = 0000 or 0002 or 0003 OR IF Country of Birth on current episode = 0001 or 1000 – 9299 AND Country of Birth on previous episode = 0000 or 0002 or 0003 THEN ACCEPT submitted values AND TRIGGER error message 4022 COB HAS CHANGED SINCE LAST EPISODE OF CARE

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### 4030 SOURCE OF REFERRAL INVALID

<b>Effect</b>	Warning
<b>Details</b>	Source of Referral can only be 0 – 9, A, E X, L, P or R
<b>Logic</b>	IF Source of Referral (data item 16) = null OR ≠ 0-9, A, E, X, L, P or R THEN DEFAULT Source of Referral (data item 16) to 9-Unknown AND PRINT error message #4030 SOURCE OF REFERRAL INVALID

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### 4057 DUPLICATE RUG ADL CODE - DUPLICATE DELETED

<b>Effect</b>	Warning
<b>Details</b>	If there is more than 1 RUG-ADL code remove extra code.
<b>Logic</b>	IF the same RUG ADL code is recorded twice in either Principal Diagnosis (data Item 45) AND OR Additional Diagnosis (data Item 46) AND OR External Cause (data item 47) AND OR Place of Occurrence (data Item 94) AND OR Activity (data Item 93) THEN delete the second occurrence of the code and print error message: #4057 - DUPLICATE RUG-ADL CODE - DUPLICATE DELETED

---

### 4058 RUG ADL INVALID

<b>Effect</b>	Warning
<b>Details</b>	No valid RUG ADL is present
<b>Logic</b>	IF Additional Diagnosis (data Item 46) is in alphanumeric format NNNNR and ≠ valid diagnosis code or valid RUG-ADL as listed in reference file THEN PRINT error message: #4058 – RUG-ADL INVALID

---

### 4160 LOS > 92 DAYS

<b>Effect</b>	Warning
<b>Details</b>	The Length of stay is greater than 92 days.
<b>Logic</b>	IF Length of Stay > 92 days THEN ACCEPT submitted record AND PRINT error message #4160 LOS > 92 DAYS

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## ISAAC Data Quality Edits (continued)

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### 4170 LOS > 1 DAY IN A DAY HOSPITAL

**Effect** Warning

**Details** The patient is admitted to a “Day Hospital” and the length of stay is greater than 1 day.

**Logic** IF Length of Stay > 1 day  
AND submitting hospital is a day surgery hospital  
THEN ACCEPT submitted record  
AND DEFAULT Length of Stay = 001  
AND PRINT error message #4170 LOS > 1 DAY IN A DAY HOSPITAL

---

### 4175 LOS >9999, SET TO 9999

**Effect** Warning

**Details** The Length of Stay is greater than 9999 days, set to 9999.

**Logic** IF Length of Stay > 9999 days  
SET to 9999 days  
AND PRINT error message #4175 LOS >9999, SET TO 9999

---

### 4180 AGE > 100 YEARS

**Effect** Warning

**Details** Patient aged over 100 years. This may be correct, however this edit requires the Date of Birth to be checked.

**Logic** IF Patient's Age > 100 years  
AND DOB Accuracy flag (data item 91) = 1  
THEN ACCEPT submitted record  
AND PRINT error message #4180 AGE > 100 YEARS

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### 4190 MARITAL STATUS INVALID, AGE >= 16 YEARS

Warning

**Details** Marital Status must be entered as a valid code as listed in the ISAAC Reference Manual.

**Logic** IF Marital Status (data item 12) ≠ 1 or 2 or 3 or 4 or 5 or 9  
AND Age ≥ 16 years  
THEN DEFAULT to 9-Unknown  
AND PRINT error message #4190 MARITAL STATUS INVALID, AGE >= 16 YEARS

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### 4190a MARITAL STATUS INVALID, AGE < 16 YEARS

**Effect** Warning

**Details** Marital Status must be entered as a valid code as listed in the ISAAC Reference Manual.

IF Marital Status (data item 12) ≠ 1 or 2 or 3 or 4 or 5 or 9  
AND Age < 16 years  
THEN DEFAULT to 1-Never Married  
AND PRINT error message #4190a MARITAL STATUS INVALID, AGE < 16 YEARS

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## ISAAC Data Quality Edits (continued)

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### 4205 ABORIGINAL OR TSI PATIENT – CHECK COUNTRY OF BIRTH

**Effect** Warning

**Details** The patient is recorded as Aboriginal or Torres Strait Islander, however the Country of Birth is not Australia. This maybe correct, however, this edit requires the Country of Birth to be checked.

**Logic** IF Indigenous Status (data item 13) = 1 or 2 or 3  
AND Country of Birth (data item 10) = 1100 – 1199 or 1302  
THEN PRINT error message #4205 ABORIGINAL OR TSI PATIENT – CHECK COUNTRY OF BIRTH

---

### 4206 INDIGENOUS STATUS HAS CHANGED SINCE LAST EPISODE OF CARE

**Effect** Warning

**Details** The Indigenous Status has changed since last episode of care. Check format and characters and correct invalid/incorrect Indigenous Status for the relevant episode of care if appropriate.

**Logic** IF Indigenous Status (data item 13) on current episode of care = 1 – Aboriginal but not TSI origin  
AND Indigenous Status (data item 13) on last episode of care = 2 – TSI but not Aboriginal origin OR 3 – Both Aboriginal & TSI origin OR 4 – Neither Aboriginal nor TSI origin  
OR  
IF Indigenous Status (data item 13) on current episode of care = 2 – TSI but not Aboriginal origin  
AND Indigenous Status (data item 13) on last episode of care = 1 – Aboriginal but not TSI but not Aboriginal origin OR 3 – Both Aboriginal & TSI origin OR 4 – Neither Aboriginal nor TSI origin  
OR  
IF Indigenous Status (data item 13) on current episode of care = 3 – Both Aboriginal & TSI origin  
AND Indigenous Status (data item 13) on last episode of care = 1 – Aboriginal but not TSI origin OR 2 – TSI but not Aboriginal origin OR 4 – Neither Aboriginal nor TSI origin  
OR  
IF Indigenous Status (data item 13) on current episode of care = 4 – Neither Aboriginal nor TSI origin  
AND Indigenous Status (data item 13) on last episode of care = 1 – Aboriginal but not TSI origin OR 2 – TSI but not Aboriginal origin OR 3 – Both Aboriginal & TSI origin  
THEN ACCEPT submitted values  
AND TRIGGER error message #4206 INDIGENOUS STATUS HAS CHANGED SINCE LAST EPISODE OF CARE

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## ISAAC Data Quality Edits (continued)

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### 4210 INSURANCE INVALID

**Effect** Warning

**Details** The Hospital Insurance code must be entered as a valid code as listed in the ISAAC Reference Manual.

**Logic** IF Hospital Insurance (data item 17) ≠ 1-Hospital Cover or 2-NotInsured  
THEN DEFAULT to 9-Unknown  
AND PRINT error message #4210 INSURANCE INVALID

---

### 4215 SLA & POSTCODE DO NOT MATCH

**Effect** Warning

**Details** The Statistical Local Area (SLA) and the Postcode that has been submitted does not match the combination of SLA and Postcode to not match.

**Logic** IF the combination of Postcode (data item 6) and SLA (data item 7) do not match the postcode and SLA listed in the ISAAC Reference Table  
ACCEPT Postcode (data item 6)  
AND ASSIGN correct SLA  
AND PRINT error message #4215 SLA & POSTCODE DO NOT MATCH

---

### 4220 LEGAL STATUS INVALID

**Effect** Warning

**Details** The Legal Status code must be entered as a valid code as listed in the ISAAC Reference Manual.

**Logic** IF Legal Status (data item 71) ≠ 1-Involuntary or 2-Forensic or 3-Voluntary  
THEN DEFAULT Legal Status (data item 71) to 3-Voluntary  
AND PRINT error message #4220 LEGAL STATUS INVALID

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### 4230 REFERRAL FOR FURTHER HEALTH CARE INVALID

**Effect** Warning

**Details** The Referral for Further Care code must be entered as a valid code as listed in the ISAAC Reference Manual.

**Logic:** IF Referral for Further Health Care (data item 72) ≠ 01 – 08, 10 - 18 or 99  
THEN DEFAULT Referral for Further Health Care (data item 72) to 99-Other/Unknown  
AND PRINT error message #4230 REFERRAL FOR FURTHER HEALTH CARE INVALID

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## ISAAC Data Quality Edits (continued)

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### 4240 REFERRAL FOR FURTHER CARE SHOULD BE NOTREFERRED

**Effect** Warning

**Details** If the Nature of Separation is '2-Other Hospital – Up Transfer', '5-Died – No Autopsy' or '6-Died – Autopsy', '7- Other Hospital – Down Transfer' or 'E-End of Quarter Reporting' then the Referral for Further Care must be '1-Not Referred'.

**Logic** IF Nature of Separation (data item 42) = 2-Other Hosp – Up Trans or 5-Died – No Autopsy or 6-Died – Autopsy or 7-Other Hosp – Down Trans or E-End of Quarter Reporting  
AND Referral for Further Health Care (data item 72) ≠ 01-Not Referred  
SET Referral for Further Health Care (data item 72) 01-Not Referred  
THEN PRINT error Message #4240 – REFERRAL FOR FURTHER CARE SHOULD BE NOT REFERRED

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### 4250 HOSPITAL TRANSFERRED TO CODE INVALID

**Effect** Warning

**Details** The hospital code entered in the Hospital Transferred To field must be a valid code from the reference file.

**Logic** IF Hospital Transferred To (data item 44) is not a valid hospital code in the reference file  
THEN DEFAULT Hospital Transferred To (data item 44) to 9999  
AND PRINT error message #4250 HOSPITAL TRANSFERRED TO CODE INVALID

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### 4260 HOSPITAL TRANSFERRED TO NOT REQUIRED

**Effect** Warning

**Details** If the Nature of Separation is not '2-Other Hospital – Up Transfer' or '7-Other Hospital – down transfer' then a hospital code is not required in the Hospital Transferred To field.

**Logic** If Nature of Separation (data item 42) ≠ 2-Other Hospital-Up Transfer or 7-Other Hospital-Down Transfer or X - Retrieval  
AND Hospital Transferred To (data item 44) is a valid hospital code  
THEN DEFAULT to blank  
AND PRINT error message #4260 HOSPITAL TRANSFERRED TO NOT REQUIRED

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### 4270 HOSPITAL TRANSFERRED TO REQUIRED

**Effect** Warning

**Details** If the Nature of Separation is 2 or 7 then the Hospital the patient was transferred to is required.

**Logic** IF Nature of Separation (data item 42) = 2-Other Hospital Up Transfer or 7-Other Hospital Down Transfer or X-Retrieval  
AND Hospital Transferred To (data item 44) = null  
THEN PRINT error message #4270 HOSPITAL TRANSFERRED TO REQUIRED

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## ISAAC Data Quality Edits (continued)

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### 4280 HOSPITAL TRANSFERRED TO SAME AS ADMISSION HOSPITAL

**Effect** Warning

**Details** The hospital the patient was transferred to cannot be the same as the admitting hospital.

**Logic** IF Hospital Transferred To (data item 44) = Hospital Code (data item 1)  
THEN DEFAULT to 9999  
AND PRINT error message #4280 HOSPITAL TRANSFERRED TO SAME AS ADMISSION HOSPITAL

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### 4290 HOSPITAL TRANSFERRED FROM CODE INVALID

**Effect** Warning

**Details** The hospital code entered in the Hospital Transferred From field must be a valid code from the reference file.

**Logic** IF Hospital Transferred From (data item 18) is not a valid hospital code in the reference file  
THEN DEFAULT Hospital Transferred From (data item 18) to 9999  
AND PRINT error message #4290 HOSPITAL TRANSFERRED FROM CODE INVALID

---

### 4300 HOSPITAL TRANSFERRED FROM NOT REQUIRED

**Effect** Warning

**Details** The source of referral does not state that the patient was transferred from another hospital however, valid hospital code has been entered into the Hospital Transferred From.

**Logic** IF Source of Referral (data item 16) ≠ 4-Interhospital Transfer or X- Retrieval  
AND Hospital Transferred From (data item 18) is a valid hospital code  
THEN DEFAULT to the Hospital Transferred From (data item 18) to 0000  
AND PRINT error message #4300 HOSPITAL TRANSFERRED FROM NOT REQUIRED

---

### 4310 HOSPITAL TRANSFERRED FROM REQUIRED

**Effect** Warning

**Details** If the source of referral indicates that the patient was transferred then the hospital code for the hospital the patient was transferred from is required.

**Logic** IF Source of Referral (data item 16) = 4-Interhospital  
AND Hospital Transferred From (data item 18) = null or invalid  
THEN DEFAULT Hospital Transferred From (data item 18) to 9999  
AND PRINT error message #4310 HOSPITAL TRANSFERRED FROM REQUIRED

---

### 4320 HOSPITAL TRANSFERRED FROM SAME AS ADMISSION HOSPITAL

**Effect** Warning

**Details** The hospital the patient was transferred from cannot be the same as the admitting hospital.

**Logic** IF Hospital Transferred From (data item 18) = Hospital Code (data item 1)  
THEN DEFAULT to Hospital Transferred From to 9999  
AND PRINT error message #4320 HOSPITAL TRANSFERRED FROM SAME AS ADMISSION HOSPITAL

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## ISAAC Data Quality Edits (continued)

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### 4340 ADMISSION WEIGHT SET TO BLANK – PATIENT NOT BABY

**Effect** Warning

**Details** The patient's age is greater than 365 days and the admission weight has been completed. The admission weight only needs to be provided for babies aged less than 365 days whose weight is less than 2,500 grams.

**Logic** IF Age > 365 days  
AND Admission Weight (data item 11) ≠ blank or 0000  
THEN DEFAULT Admission Weight (data item 11) to blank  
AND PRINT error message #4340 ADMISSION WEIGHT SET TO BLANK – PATIENT NOT BABY

---

### 4350 BABY WEIGHT < 400 GRAMS

**Effect** Warning

**Details** Admission weight of baby is recorded as less than 400 grams. Check and verify that the admission weight is correct.

**Logic** IF Admission Weight (data item 11) is < 400 grams  
THEN ACCEPT submitted record  
AND PRINT error message #4350 BABY WEIGHT < 400 GRAMS

---

### 4360 BABY WEIGHT > 6000 GRAMS

**Effect** Warning

**Details** Admission weight of baby is recorded greater than 6000 grams. Check and verify that the admission weight is correct.

**Logic** IF Admission Weight (data item 11) is > 6000 grams  
THEN ACCEPT submitted record  
AND PRINT error message #4360 BABY WEIGHT > 6000 GRAMS

---

### 4370 CLINIC CODE INVALID

**Effect** Warning

**Details** The Clinic Code or Number entered is invalid or does not exist in the Clinic Code Reference Table.

**Logic** IF Clinic Number (data item 2) is invalid  
THEN DEFAULT Clinic Number to 00  
AND PRINT error message #4370 CLINIC CODE INVALID

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## ISAAC Data Quality Edits (continued)

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### 4380 MEDICARE NUMBER INVALID

**Effect** Warning

**Details** If invalid characters are entered in the Medicare Number field, ISAAC will default Medicare Number to "0000000000" and generate an error message.

**Logic** IF Medicare Number (data item 4) is invalid  
DEFAULT to Medicare Number (data item 4) to 0000000000  
AND PRINT error message #4380 MEDICARE NUMBER INVALID

---

### 4382 MEDICARE NUMBER IRN INVALID FOR MEDICARE NUMBER

**Effect** Warning

**Details** If invalid characters are entered in the Medicare Number IRN field, ISAAC will default Medicare Number IRN to blank and generate an error message *Introduced 1 July 2013*

**Logic** IF Medicare Number is not NULL or ≠ 0000000000 or 0000000009  
AND Medicare Number IRN (data item 100) ≠ 1, 2, 3, 4, 5, 6, 7, 8 or 9  
DEFAULT to Medicare Number IRN (data item 100) to blank  
  
AND PRINT error message #4382 MEDICARE NUMBER IRN INVALID FOR MEDICARE NUMBER

---

### 4382a MEDICARE NUMBER IRN INVALID FOR SUPPLEMENTARY MEDICARE NUMBER

**Effect** Warning

**Details** If invalid characters are entered in the Medicare Number IRN field for supplementary Medicare numbers, ISAAC will default Medicare Number IRN to '0' and generate an error message *Introduced 1 July 2013*

**Logic** IF Medicare Number = 0000000000 or 0000000009  
AND Medicare Number IRN (data item 100) ≠ 0  
DEFAULT to Medicare Number IRN (data item 100) to '0'  
  
AND PRINT error message #4382a MEDICARE NUMBER IRN INVALID FOR SUPPLEMENTARY MEDICARE NUMBER

---

### 4390 PATIENT CATEGORY INVALID, OVERNIGHT STAY

**Effect** Warning

**Details** Patient category must be 1, 2 or 4.

**Logic** IF Patient Category (data item 14) = null or invalid (not 1, 2, or 4)  
AND Admission Date (data item 21) ≠ Separation Date (data item 43)  
THEN DEFAULT Patient Category (data item 14) to 1-Overnight Stay  
AND PRINT error message #4390 PATIENT CATEGORY INVALID. OVERNIGHT STAY

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## ISAAC Data Quality Edits (continued)

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### 4390a PATIENT CATEGORY INVALID, DAY ONLY - OTHER

Effect	Warning
Details	Patient category must be 1, 2 or 4. Set to 4 if admission date = separation date
Logic	IF Patient Category (data item 14) = null or invalid (not 1, 2, or 4) AND Admission Date (data item 21) = Separation Date (data item 43) THEN DEFAULT Patient Category (data item 14) to 4-Day only-other AND PRINT error message #4390a PATIENT CATEGORY INVALID, DAY ONLY - OTHER

---

### 4395 INDIGENOUS STATUS INVALID

Effect	Warning
Details	If Indigenous Status is not equal to 1 – 4 then default to “9-Unknown”.
Logic	IF Indigenous Status (data item 13) ≠ 1 or 2 or 3 or 4 or 9 THEN DEFAULT Indigenous Status (data item 13) to 9 AND PRINT error message #4395 INDIGENOUS STATUS INVALID

---

### 4396 PATIENT IS MEDICARE INELIGIBLE BUT INDIGENOUS STATUS FLAGGED

Effect	Warning
Details	Indigenous status has been recorded however their principle source of funds indicates that the patient is not eligible for Medicare. This may be correct. Check the patient's indigenous status and elected funding source to ensure they are correct.
Logic	IF Indigenous Status (data item 13) = “1-Aboriginal but not Torres Strait Islander origin” or “2-Torres Strait Islander but not Aboriginal origin” or “3-Both Aboriginal and Torres Strait Islander origin” AND Funding Source (data item 95) = “7-Overseas RCHA” or “8-Non-medicare” THEN ACCEPT submitted record AND PRINT error message #4396 PATIENT IS MEDICARE INELIGIBLE BUT INDIGENOUS STATUS FLAGGED

---

### 4400 ADMISSION CATEGORY INVALID

Effect	Warning
Details	If Admission Category is not equal to 1 – 4 then default to “1-Elective”.
Logic	IF Admission Category (data item 15) ≠ 1 or 2 or 3 or 4 THEN DEFAULT Admission Category (data item 15) to 1-Elective AND PRINT error message #4400 ADMISSION CATEGORY INVALID

---

### 4410 ADMISSION ELECTION INVALID FOR PRIVATE HOSPITAL

Effect	Warning
Details	If Admission Election is not equal to “2-Private” then default to “2-Private” if the episode is in a private hospital.
Logic	IF Admission Election (data item 19) = null or invalid (not 2-Private) AND patient is in a private hospital THEN DEFAULT Admission Election (data item 19) to 2-Private AND PRINT error message #4410 ADMISSION ELECTION INVALID FOR PRIVATE

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## ISAAC Data Quality Edits (continued)

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### 4410a ADMISSION ELECTION INVALID FOR PUBLIC HOSPITAL

**Effect** Warning

**Details** If Admission Election is not equal to “1-Hospital” then default to “1-Hospital” if the episode is in a public hospital.

**Logic** IF Admission Election (data item 19) = null or invalid (not 1-Hospital)  
AND patient is in a public hospital  
THEN DEFAULT Admission Election (data item 19) to 1-Hospital  
AND PRINT error message #4410a ADMISSION ELECTION INVALID FOR PUBLIC HOSPITAL

---

### 4420 ADMISSION TYPE INVALID

**Effect** Warning

**Details** If the Admission Type is blank or invalid characters are entered in the field, then ISAAC will default Admission Type to “1-Ordinary” and generate an error message.

**Logic** IF Admission Type (data item 20) = blank or invalid (not 1-Ordinary or 2-Long Stay – Acute or 3 – Long Stay –Maintenance Care Type  
THEN DEFAULT Admission Type (data item 20) to 1-Ordinary  
AND PRINT error message #4420 ADMISSION TYPE INVALID

---

### 4450 STATUS CHANGE ELECTION INVALID

**Effect** Warning

**Details** An invalid character (s) (not “1-Hospital” or “2-Private”) has been entered in the Status Change Election field(s).

**Logic** IF Status Change Election (data item 22, 25 and 28) is invalid  
THEN DEFAULT Status Change Election (data item 22, 25 and 28) to 0  
AND PRINT error message #4450 STATUS CHANGE ELECTION INVALID

---

### 4460 STATUS CHANGE TYPE INVALID

**Effect** Warning

**Details** An invalid character(s) (not “1-Ordinary” or “2-Long Stay Acute” or “3- Long Stay Maintenance Care Type”) has been entered in the Status Change Type field(s).

**Logic** IF Status Change Type (data item 23, 26 and 29) is invalid  
THEN DEFAULT Status Change Type (data item 23, 26 and 29) to 0  
AND PRINT error message #4460 STATUS CHANGE TYPE INVALID

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## ISAAC Data Quality Edits (continued)

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### 4470 STATUS CHANGE DATE INVALID

**Effect** Warning

**Details** An invalid date(s) has been entered in the Status Change Date field(s).

**Logic** IF Status Change Date (data item 24, 27 and 30) is invalid  
THEN DEFAULT Status Change Type (data item 24, 27 and 30) to 00000000  
AND PRINT error message #4470 STATUS CHANGE DATE INVALID

---

### 4474 STATUS CHANGE DETAILS NOT REQUIRED

**Effect** Warning

**Details** The Status Change details are not required.

**Logic** IF Status Change Election (data item 22 or 25 or 28) = Admission Election (data item 19)  
AND Status Change Type (data item 23 or 26 or 29) = Admission Type (data item 20)  
THEN error  
AND REMOVE Status Change details from ISAAC record  
AND PRINT error message #4474 – STATUS CHANGE DETAILS NOT REQUIRED

---

### 4480 STATUS CHANGE ELECTION MISSING

**Effect** Warning

**Details** There must be a Status Change Election if Status Change Type is submitted.

**Logic** IF Status Change Type (data item 23 or 26 or 29) is valid  
AND Status Change Date (data item 24 or 27 or 30) is valid  
AND Status Change Election (data item 22 or 25 or 28) is blank  
THEN DEFAULT to Status Change Election (data item 22 or 25 or 28) to 0  
AND PRINT error message #4480 STATUS CHANGE ELECTION MISSING

---

### 4490 STATUS CHANGE TYPE MISSING

**Effect** Warning

**Details** There must be a Status Change Type if Status Change Election is submitted.

**Logic** IF Status Change Election (data item 22 or 25 or 28) is valid  
AND Status Change Date (data item 24 or 27 or 30) is valid  
AND Status Change Type (data item 23 or 26 or 29) is blank  
THEN DEFAULT to Status Change Type (data item 23 or 26 or 29) to 0  
AND PRINT error message #4490 STATUS CHANGE TYPE MISSING

---

### 4500 STATUS CHANGE DATE MISSING

**Effect** Warning

**Details** There must be a Status Change Date if Status Change Election and Status Change Type is submitted.

**Logic** IF Status Change Election (data item 22 or 25 or 28) is valid  
AND Status Change Type (data item 23 or 26 or 29) is valid  
AND Status Change Date (data item 24 or 27 or 30) is blank  
THEN DEFAULT to Status Change Date (data item 24 or 27 or 30) to 00000000  
AND PRINT error message #4500 STATUS CHANGE DATE MISSING

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## ISAAC Data Quality Edits (continued)

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### 4505 INDETERMINATE SEX INVALID FOR AGE 90 DAYS +, PLS CHECK

**Effect** Warning

**Details** If the patient has an Indeterminate Sex for greater than 90 days follow up to confirm if a definitive gender has been assigned.

**Logic** IF Sex (data item 8) = 3-Indeterminate  
AND Age (days) >90  
THEN PRINT error message #4505 INDETERMINATE SEX INVALID FOR AGE 90 DAYS+, PLS CHECK

---

### 4506 SEX HAS CHANGED SINCE LAST EPISODE OF CARE

**Effect** Warning

**Details** The Sex has changed since last episode of care. Check format and characters and correct invalid/incorrect Sex for the applicable episodes of care.

**Logic** FROM 1 July 2011  
IF Sex (data item 8) on current episode of care differs to Sex on last episode of care  
THEN ACCEPT submitted values  
AND TRIGGER error message: #4506 SEX HAS CHANGED SINCE LAST EPISODE OF CARE

---

### 4510 ADMISSION NUMBER REQUIRED

**Effect** Warning

**Details** Admission number is required.

**Logic** IF Admission Number (data item 68) = blank or non-numeric  
THEN DEFAULT Admission Number (data item 68) to 00000000  
AND PRINT error message #4510 ADMISSION NUMBER REQUIRED

---

### 4521 DVA STATUS HAS CHANGED SINCE LAST EPISODE OF CARE

**Effect** Warning

**Details** The DVA funding source has changed since last episode of care. Check format and characters and correct invalid/incorrect DVA status for relevant episodes of care if appropriate.

**Logic** IF Funding Source (data item 95) on current episode of care = 4 – DVA  
AND Funding Source (data item 95) on last episode of care ≠ 4 – DVA  
OR Funding Source (data item 95) on current episode of care ≠ 4 – DVA  
AND Funding Source (data item 95) on last episode of care = 4 – DVA  
THEN ACCEPT submitted values  
AND TRIGGER error message: #4521 DVA STATUS HAS CHANGED SINCE LAST EPISODE OF CARE

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## ISAAC Data Quality Edits (continued)

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### 4530 VETERAN CARD TYPE REQUIRED

**Effect** Warning

**Details** The Veteran Card Type is required.

**Logic** IF Veteran Card Number (data item 69) is valid  
AND Veteran Card Type (data item 31) = blank  
THEN DEFAULT Veteran Card Type (data item 31) to N-Not available  
AND PRINT error message #4530 VETERAN CARD TYPE REQUIRED

---

### 4540 VETERAN CARD TYPE INVALID

**Effect** Warning

**Details** The Veteran Card Type is invalid.

**Logic** IF Veteran Card Number (data item 69) is valid  
AND Veteran Card Type (data item 31) is invalid (not G-Treatment Entitlement Card – All Conditions or W-Treatment Entitlement Card – specific or N-Not available)  
THEN DEFAULT Veteran Card Type (data item 31) to N-Not Available  
AND PRINT error message #4540 VETERAN CARD TYPE INVALID

---

### 4560 CONTRACT HOSPITAL INVALID OR SAME AS SENT HOSPITAL

**Effect** Warning

**Details** Contract hospital cannot be the same as the admitting hospital

**Logic** IF Contracted Service Hospital (data item 65) = Hospital Code (data item 1)  
OR Contracted Service Hospital (data item 65) is an invalid Hospital Code  
THEN DEFAULT Contracted Service Hospital (data item 65) to 9999  
AND PRINT error message #4560 CONTRACT HOSPITAL INVALID OR SAME AS SENT HOSPITAL

---

### 4561 CONTRACTED SERVICE – DETAILS NOT COMPLETE

**Effect** Warning

**Details** If Source of Referral is Contract Service, must have contracted Service Details

**Logic** If Source of Referral (Data Item 16) <> 7 and any of Contracted Service - Hospital (Data Item 65), Contracted Service - Patient Unit Number (Data Item 63), Contracted Service - Admission Date (Data Item 64) has/have valid values (excluding zero filled)

AND any of Contracted Service - Hospital (Data Item 65), Contracted Service - Patient Unit Number (Data Item 63), Contracted Service - Admission Date (Data Item 64) has/have invalid values,

THEN RETAIN VALUE(S) and trigger ERROR MESSAGE: #4561 CONTRACTED SERVICE - DETAILS NOT COMPLETE.

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## ISAAC Data Quality Edits (continued)

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### 4562 CONTRACTED SERVICE - HOSPITAL CODE REQUIRED

**Effect** Warning

**Details** Contract Service - Valid hospital code required from both Hospitals. i.e The hospital contracting/requesting the service (originating site) and hospital providing the contracted service (destination site) .

**Logic** If Source of Referral (Data Item 16) = 7 and Contracted Service - Hospital (Data Item 65) has an invalid value (including zero filled);

THEN RETAIN VALUE(S) and trigger ERROR MESSAGE: #4562 Contracted Service – hospital code required.

---

### 4570 CONTRACT PATIENT UR INVALID OR SAME AS SENT HOSPITAL

**Effect** Warning

**Details** The contract patient has the Same UR as the sent hospital.

**Logic** IF Contracted Service Patient Unit Number (data item 63) = Patient Unit Number (data item 3)  
OR Contracted Service Patient Unit Number (data item 63) is invalid  
THEN DEFAULT Contract Patient Unit Number (data item 63) to 0000000000  
AND PRINT error message #4570 CONTRACT PATIENT UR INVALID OR SAME AS SENT HOSPITAL

---

### 4580 CONTRACT ADMISSION DATE INVALID

**Effect** Warning

**Details** The Contract Admission Date (data item 64) must be greater than or equal to Admission Date and less than or equal to Separation Date.

**Logic** IF Contract Admission Date (data item 64) = invalid date  
OR Contract Admission Date (data item 64) < Admission Date (data item 21)  
OR Contract Admission Date (data item 64) > Separation date (data item 43)  
THEN DEFAULT Contract Admission Date (data item 64) to 00000000  
AND PRINT error message #4580 CONTRACT ADMISSION DATE INVALID

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## ISAAC Data Quality Edits (continued)

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### 4610 PERIODS OF LEAVE – FROM TIME REQUIRED

**Effect** Warning

**Details** Period leave from time must be entered if there is a valid period of leave from date.

**Logic** IF Leave From Time (data items 73, 75, 77, 79) = invalid or blank  
AND Leave From Date (data item 32, 34, 36, 38) = valid date  
THEN DEFAULT Leave From Time (data items 73, 75, 77, 79) to 0000  
AND PRINT error message #4610 PERIODS OF LEAVE – FROM TIME REQUIRED

---

### 4620 PERIODS OF LEAVE – TO TIME REQUIRED

**Effect** Warning

**Details** Period leave to time must be entered if there is a valid leave to date.

**Logic** IF Leave To Time (data items 74, 76, 78, 80) = invalid or blank  
AND Leave To Date (data item 33, 35, 37, 39) = valid date  
THEN DEFAULT Leave To Time (data items 74, 76, 78, 80) to 2359  
AND PRINT error message #4620 PERIODS OF LEAVE – TO TIME REQUIRED

---

### 4625 LEAVE > 7 CONSECUTIVE DAYS

**Effect** Warning

**Details** Leave cannot be greater than 6 consecutive days in duration.

**Logic** IF Length of Leave (Days) > 7 consecutive days  
THEN ACCEPT submitted value  
AND PRINT error message #4625 LEAVE > 7 CONSECUTIVE DAYS

---

### 4630 UNPLANNED READMISSION INVALID (deactivated July 2015)

**Effect** Warning

**Details** Unplanned Readmission values can only be 1 – 3.

**Logic** IF Unplanned Readmission (data item 82) = invalid (not 1, 2 or 3)  
THEN DEFAULT Unplanned Readmission (data item 82) = 3-Not Applicable  
AND PRINT error message #4630 UNPLANNED READMISSION INVALID

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### 4640 MENTAL HEALTH LINKING NUMBER INVALID

**Effect** Warning

**Details** The number entered as the Mental Health Linking Number is invalid or is the same as the Patient's Unit Record Number.

**Logic** IF Hospital Code (data item 1) ≠ 0300-Glenside  
AND Mental Health Linking Number (data item 83) is invalid  
OR Mental Health Linking Number (data item 83) = Patient Unit Number (data item 3)  
THEN ACCEPT submitted values  
AND PRINT error message #4640 MENTAL HEALTH LINKING NUMBER INVALID

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## ISAAC Data Quality Edits (continued)

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### 4670 ADULT/CHILD FLAG INVALID

**Effect** Warning

**Details** If the Hospital is WCH and an invalid character is entered in the Adult/Child Flag field then ISAAC will default the field to "O-Other" and generate an error message.

**Logic** IF Hospital Code (data item 1) = 0003-WCH  
AND the Adult/Child Flag (data item 86) is invalid  
THEN DEFAULT Adult/Child Flag (data item 86) to O-Other  
IF Hospital Code (data item 1) = 0003-WCH  
THEN DEFAULT Adult/Child Flag (data item 86) to O-Other  
AND PRINT error message #4670 ADULT/CHILD FLAG INVALID

---

### 4680 ADULT/CHILD FLAG REQUIRED

**Effect** Warning

**Details** If the Hospital is WCH and the Adult/Child Flag field is blank then ISAAC will default the field "O-Other" and generate an error message.

**Logic** IF Hospital Code (data item 1) = 0003-WCH  
AND the Adult/Child Flag (data item 86) = blank  
THEN DEFAULT Adult/Child Flag (data item 86) to O-Other  
AND PRINT error message #4680 ADULT/CHILD FLAG REQUIRED

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### 4690 DAY AND MONTH OF BIRTH MISSING

**Effect** Warning

**Details** The day and month of birth is entered in the Date of Birth field.

**Logic** IF Date of Birth (data item 9) = blank day and month  
THEN DEFAULT day to 01  
AND DEFAULT month to 07  
AND PRINT error message #4690 DAY AND MONTH OF BIRTH MISSING

---

### 4691 DOB HAS CHANGED SINCE LAST EPISODE OF CARE

**Effect** Warning

**Details** The Date of Birth has changed since last episode of care. Check format and characters and correct invalid Date of Birth for the applicable episodes of care.

**Logic** IF Date of Birth (data item 9) on current episode of care differs to Date of Birth on last episode of care  
THEN ACCEPT submitted values  
AND TRIGGER error message: #4691 DOB HAS CHANGED SINCE LAST EPISODE OF CARE

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## ISAAC Data Quality Edits (continued)

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<b>4700</b>	<b>2400 RESET 0000 NEXT DAY – NO ACTION (inactivated 1 July 2014)</b>
<b>Effect</b>	Warning
<b>Details</b>	Time changed from 2400 to 0000 and date increase by 1 day.
<b>Logic</b>	IF Admission Time (data item 67) = 2400 THEN DEFAULT to 0000 AND INCREASE Admission Date (date item 21) by 1 day AND PRINT error message #4700 2400 RESET TO 0000 & DATE INCREASED BY 1 DAY.
<b>4710</b>	<b>SEPARATION DATE &gt; 1 YEAR OLD</b>
<b>Effect</b>	Warning
<b>Details</b>	The Separation Date is greater than 1 year from the Admission Date.
<b>Logic</b>	IF Separation Date (data item 43) is > 365 days ago THEN ACCEPT submitted record AND PRINT error message #4710 SEPARATION DATE > 1 YEAR OLD
<b>4730</b>	<b>ADULT/CHILD FLAG NOT REQUIRED</b>
<b>Effect</b>	Warning
<b>Details</b>	Adult/Child Flag is only required for WCH patient's.
<b>Logic</b>	IF Hospital Code (data item 1) ≠ 0003-WCH or 0296-WCH Helen Mayo AND Adult/Child Flag (data item 86) ≠ blank THEN DEFAULT Adult/Child Flag (data item 86) to blank AND PRINT error message #4730 ADULT/CHILD FLAG NOT REQUIRED
<b>4740</b>	<b>E INVALID FOR PRIVATE HOSPITALS – SET TO 9</b>
<b>Effect</b>	Warning
<b>Details</b>	E is not an acceptable source of referral or nature of separation for a private hospital.
<b>Logic</b>	IF Source of Referral (data item 16) = End of Quarter OR Nature of Separation (data item 42) = E-End of Quarter AND Hospital Code (data item 1) is between 4000 and 4999 (private) THEN DEFAULT Nature of Separation (data item 42) to 9-Unknown and/or Source of Referral (data item 16) to 9-Unknown AND PRINT error message #4740 E INVALID FOR PRIVATE HOSPITALS – SET TO 9

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## ISAAC Data Quality Edits (continued)

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<b>4750</b>	<b>FIRST PSYCH ADMISSION INVALID ((disabled from 01/07/2014))</b>
<b>Effect</b>	Warning
<b>Details</b>	First psych admission must be 0, 1 or 2.
<b>Logic</b>	IF First Psych Admission (data item 87) is invalid (not 0-Not Applicable, 1-No or 2-Yes) THEN DEFAULT First Psych Admission (data item 87) to 0-Not Applicable AND PRINT error message #4750 FIRST PSYCH ADMISSION INVALID
<b>4755</b>	<b>PREVIOUS SPECIALISED TREATMENT INVALID</b>
<b>Effect</b>	Warning
<b>Details</b>	Previous specialised treatment (palliative/mental health care) must be 1,2,3,4 or 5 <i>Introduced 1 July 2013</i> IF Previous Specialised Treatment is not NULL AND Previous Specialised Treatment is ≠ 0, 1, 2, 3, 4 or 5
<b>Logic</b>	THEN DEFAULT Previous Specialised Treatment (data item 101) to 'Z' AND PRINT error message #4755 PREVIOUS SPECIALISED TREATMENT INVALID
<b>4760</b>	<b>EMPLOYMENT STATUS INVALID</b>
<b>Effect</b>	Warning
<b>Details</b>	If an invalid character is entered into the Employment Status field then ISAAC will default the Employment Status must "9-Unknown".
<b>Logic</b>	IF Employment Status (data item 88) is invalid (not 0-Not Applicable or 6-Other or 9-Unknown) THEN DEFAULT Employment Status (data item 88) to 0-Not Applicable AND PRINT error message #4760 EMPLOYMENT STATUS INVALID
<b>4770</b>	<b>PENSION STATUS INVALID</b>
<b>Effect</b>	Warning
<b>Details</b>	If an invalid character is entered into the Pension Status field then ISAAC will default the Pension Status to "0-Not Applicable".
<b>Logic</b>	IF Employment Status (data item 88) is invalid (not 0-Not Applicable or 5-Sickness Benefit or 9-Other/Unknown) THEN DEFAULT Employment Status (data item 88) to 0-Not Applicable AND PRINT error message #4770 PENSION STATUS INVALID

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## ISAAC Data Quality Edits (continued)

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### 4780 USUAL ACCOMMODATION INVALID

**Effect** Warning

**Details** The Type of Usual Accommodation field should have a valid value

**Logic** If Hospital Code (data item 1) = 0003 -0019,0027 -0033, 0042, 0058, 0163, 0249 -0300  
And Type of Usual Accommodation (data item 90) is invalid OR ≠ 1 or 2 or 4 or 5 or 6  
or 7 or 8 or A or B or C or D or H or M or O or P or S  
THEN DEFAULT to 9- Unknown  
AND PRINT error message #4780 USUAL ACCOMMODATION INVALID

---

### 4789 DOB ACCURACY FLAG MUST BE 2 IF DOB IS 01/07/1890

**Effect** Warning

**Details** DOB accuracy flag = 2 must be used with default DOB *Introduced 1 July 2014*

**Logic** IF Date of Birth (data item 9) = 01/07/1890  
AND DOB Accuracy flag (data item 91) ≠ 2  
THEN DEFAULT DOB Accuracy flag (data item 91) = 2  
AND PRINT error message #4789 Check DOB Accuracy flag. Default DOB has been submitted

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### 4790 DOB ACCURACY FLAG INVALID

**Effect** Warning

**Details** Date of birth accuracy flag must be 1 or 2.

**Logic** IF Date of Birth Accuracy Flag (data item 91) is invalid  
THEN DEFAULT Date of Birth Accuracy Flag to 1-Accurate  
AND PRINT error message #4790 DOB ACCURACY FLAG INVALID

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### 4910 PROCEDURE INDICATOR REQUIRED

**Effect** Warning

**Details** The Procedure Indicator must be a 1 or 2(contractured service)

IF Principal Procedure or Additional Procedure = Not Null  
AND Proc Loc = null or invalid value  
**Logic** THEN DEFAULT to 1 AND PRINT error message #4910 PROC INDICATOR  
REQUIRED

---

### 4920 PROCEDURE INDICATOR NOT REQUIRED – No additional procedure

**Effect** Warning

**Details** Procedure indicator not required as there was no additional procedure

**Logic** IF data item 49b-y, Additional procedure is blank and data item 85b-y, Procedure  
indicator is valid  
THEN DEFAULT data item 85b-y, Procedure indicator to BLANK  
AND PRINT error message #4920 procedure indicator NOT REQUIRED - no additional  
procedure

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## ISAAC Data Quality Edits (continued)

<b>4920a</b>	<b>PROCEDURE INDICATOR NOT REQUIRED – No principal procedure</b>
<b>Effect</b>	Warning
<b>Details</b>	Procedure indicator not required as there was no principal procedure <i>Introduced 1 July 2014</i>
<b>Logic</b>	IF data item 49a Principal procedure is blank and data item 85a, Procedure indicator is valid THEN DEFAULT data item 85a, Procedure indicator to BLANK AND PRINT error message #4920a procedure indicator NOT REQUIRED - no principal procedure
<b>4930</b>	<b>CONTRACTED PATIENT, NO CONTRACT PROCIND</b>
<b>Effect</b>	Warning
<b>Details</b>	Procedure indicator of 2 not included for procedure performed on contracted patient at another hospital
<b>Logic</b>	If any of contracted service fields (Items 63, 64 or 65) are not null AND there is no procedure indicator of 2 (procedure performed at another hospital) THEN PRINT error message #4930 CONTRACTED PATIENT, NO CONTRACTED PROCEDURE INDICATOR
<b>4975</b>	<b>QUALIFIED NEWBORN AGE &gt; 1 YEAR, VERIFY EP OF CARE</b>
<b>Effect</b>	Warning
<b>Details</b>	The patient's age is greater than 1 year old and has a qualified episode of care. This may be correct in a small number of cases. Check the patient's age and episode of care type.
<b>Logic</b>	IF the Patient's Age > 1 year AND Episode of Care (data item 51) = "6-Qualified Newborn" THEN ACCEPT submitted record AND PRINT error message #4975 QUALIFIED NEWBORN AGE > 1 YEAR, VERIFY EP OF CARE
<b>4980</b>	<b>NEWBORN PATIENT – MUST BE QUALIFIED OR UNQUALIFIED</b>
<b>Effect</b>	Warning
<b>Details</b>	Newborn must be qualified or unqualified.
<b>Logic</b>	IF Episode of Care (data item 51) ≠ 5-Unqualified Newborn or 6-Qualified Newborn AND Patient Age is < 10 days THEN PRINT error message #4980 NEWBORN PATIENT-MUST BE QUALIFIED OR UNQUALIFIED
<b>4985</b>	<b>UNQUALIFIED NEWBORN WITH NOS = DEATH</b>
<b>Effect</b>	Warning
<b>Details</b>	Patient's episode of care type is unqualified newborn, however their nature of separation indicates that the patient died. Check episode of care type and nature of separation.
<b>Logic</b>	IF Episode of Care (data item 51) = "5-Unqualified Newborn" AND Nature of Separation (data item 42) = "5-Died no autopsy" or "6-Died autopsy" THEN ACCEPT submitted record AND PRINT error message #4985 UNQUALIFIED NEWBORN WITH NOS = DEATH

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<b>4990</b>	<b>AGE &gt;9 DAYS, INCORRECT EPISODE OF CARE</b>
<b>Effect</b>	Warning
<b>Details</b>	The baby's age is greater than 9 days, however the Episode of Care is incorrect.
<b>Logic</b>	IF Hospital Code (data item 1) ≥ 0003 or ≤ 0300 AND Episode of Care (data item 51) ≠ "1 – Acute" or "6 – Qualified" AND Patient's Age > 9 days or < 29 days THEN PRINT error message #4990 AGE > 9 DAYS, INCORRECT EPISODE OF CARE

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<b>4995</b>	<b>NATURE OF SEPARATION INVALID WITHOUT REPORTED LEAVE</b>
<b>Effect</b>	Warning
<b>Details</b>	The nature of separation indicates that the patient was on leave at the time of discharge, however no leave periods have been captured.
<b>Logic</b>	IF Nature of Separation (data item 42) = "0-Discharge on Leave" AND Leave From Date (data item 32) is null OR Leave From Date (data item 34) is null OR Leave From Date (data item 36) is null OR Leave From Date (data item 38) is null THEN ACCEPT submitted record AND PRINT error message #4995 NATURE OF SEPARATION INVALID WITHOUT REPORTED LEAVE

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<b>4998</b>	<b>RUG ADL CODE REQUIRED</b>	<b>Warning</b>
	IF Episode of Care (Item 51)= 2 Maintenance Care OR J Mental Health Maintenance Care AND IF Additional Diagnosis (data Item 46) ≠ a valid RUG-ADL as listed in reference file OR is blank THEN error message: #4998 – RUG-ADL CODE REQUIRED	



## SECTION 7: Appendices

Appendix number	Appendix name
1	ISAAC File Submission Format – 746 (effective from 1 July 2013)
2	ISAAC Correction File Submission Format - 746 (effective from 1 July 2013)
3	Contract Service and Component of Care – General Information
4	Example Scenarios Episode of Care
5	Supplementary Data Items EPAS Site Visit ID – EPAS sites only Mental Health Accommodation Prior – EPAS sites Only RUG-ADL Score– Non-acute Care only
6	ISAAC Control Log Instructions

## Appendix 1: File Submission Format – 746 (effective from 1 July 2013, applies 2016-17)

CHAR POSITION	FIELD NAME	LENGTH	TYPE	JUST	FILL
1	Record type	1	N	n/a	"2"
2-5	Hospital code	4	N	R	zero
6-15	Patient Unit number	10	N	R	zero
16	Sex	1	N	n/a	zero
17	Marital status	1	N	n/a	zero
18-20	Clinic code	3	N	R	zero
21-28	Admission Number	8	N	R	zero
29-38	Medicare number	10	N	R	blank
39	Medicare number Individual Reference Number	1	N	R	blank
40-43	SLA	4	N	R	zero
44-63	Suburb/locality	20	A	L	blank
64-67	Postcode	4	N	R	zero
68-71	Country of birth	4	N	R	zero
72	Indigenous Status	1	N	n/a	zero
73-80	Date of birth	8	N	R	zero
81	Patient category	1	N	n/a	zero
82	Source of referral	1	A/N	n/a	blank
83-90	Admission date	8	N	R	zero
91	Admission election	1	N	n/a	zero
92	Admission type	1	N	n/a	zero
93-100	Status Change 1 - Date effective from	8	N	R	zero
101	Status Change 1 - Admission election	1	N	n/a	zero

CHAR POSITION	FIELD NAME	LENGTH	TYPE	JUST	FILL
102	Status Change 1 - Admission type	1	N	n/a	zero
103-110	Status Change 2 - Date effective from	8	N	R	zero
111	Status Change 2 - Admission election	1	N	n/a	zero
112	Status Change 2 - Admission type	1	N	n/a	zero
113-120	Status Change 3 - Date effective from	8	N	R	zero
121	Status Change 3 - Admission election	1	N	n/a	zero
122	Status Change 3 - Admission type	1	N	n/a	zero
123	Veteran Card	1	A	n/a	blank
124-132	Veteran Identification number	9	A/N	L	blank
133	Insurance status	1	N	n/a	zero
134-141	Separation date	8	N	R	zero
142-143	Referral for further care	2	N	R	zero
144	Nature of separation	1	A/N	n/a	blank
145-148	Hospital transferred to	4	N	R	zero
149-153	Principal Diagnosis	5	A/N	L	blank
154	Principal Diagnosis - condition onset flag	1	N	n/a	blank
155-159	Additional Diagnosis A	5	A/N	L	blank
160	Additional Diagnosis - condition onset flag A	1	N	n/a	blank
161-165	Additional Diagnosis B	5	A/N	L	blank
166	Additional Diagnosis - condition onset flag B	1	N	n/a	blank
167-171	Additional Diagnosis C	5	A/N	L	blank
172	Additional Diagnosis - condition onset flag C	1	N	n/a	blank
173-177	Additional Diagnosis D	5	A/N	L	blank
178	Additional Diagnosis - condition onset flag D	1	N	n/a	blank

CHAR POSITION	FIELD NAME	LENGTH	TYPE	JUST	FILL
179-183	Additional Diagnosis E	5	A/N	L	blank
184	Additional Diagnosis - condition onset flag E	1	N	n/a	blank
185-189	Additional Diagnosis F	5	A/N	L	blank
190	Additional Diagnosis - condition onset flag F	1	N	n/a	blank
191-195	Additional Diagnosis G	5	A/N	L	blank
196	Additional Diagnosis - condition onset flag G	1	N	n/a	blank
197-201	Additional Diagnosis H	5	A/N	L	blank
202	Additional Diagnosis - condition onset flag H	1	N	n/a	blank
203-207	Additional Diagnosis I	5	A/N	L	blank
208	Additional Diagnosis - condition onset flag I	1	N	n/a	blank
209-213	Additional Diagnosis J	5	A/N	L	blank
214	Additional Diagnosis - condition onset flag J	1	N	n/a	blank
215-219	Additional Diagnosis K	5	A/N	L	blank
220	Additional Diagnosis - condition onset flag K	1	N	n/a	blank
221-225	Additional Diagnosis L	5	A/N	L	blank
226	Additional Diagnosis - condition onset flag L	1	N	n/a	blank
227-231	Additional Diagnosis M	5	A/N	L	blank
232	Additional Diagnosis - condition onset flag M	1	N	n/a	blank
233-237	Additional Diagnosis N	5	A/N	L	blank
238	Additional Diagnosis - condition onset flag N	1	N	n/a	blank
239-243	Additional Diagnosis O	5	A/N	L	blank
244	Additional Diagnosis - condition onset flag O	1	N	n/a	blank
245-249	Additional Diagnosis P	5	A/N	L	blank
250	Additional Diagnosis - condition onset flag P	1	N	n/a	blank

CHAR POSITION	FIELD NAME	LENGTH	TYPE	JUST	FILL
251-255	Additional Diagnosis Q	5	A/N	L	blank
256	Additional Diagnosis - condition onset flag Q	1	N	n/a	blank
257-261	Additional Diagnosis R	5	A/N	L	blank
262	Additional Diagnosis - condition onset flag R	1	N	n/a	blank
263-267	Additional Diagnosis S	5	A/N	L	blank
268	Additional Diagnosis - condition onset flag S	1	N	n/a	blank
269-273	Additional Diagnosis T	5	A/N	L	blank
274	Additional Diagnosis - condition onset flag T	1	N	n/a	blank
275-279	Additional Diagnosis U	5	A/N	L	blank
280	Additional Diagnosis - condition onset flag U	1	N	n/a	blank
281-285	Additional Diagnosis V	5	A/N	L	blank
286	Additional Diagnosis - condition onset flag V	1	N	n/a	blank
287-291	Additional Diagnosis W	5	A/N	L	blank
292	Additional Diagnosis - condition onset flag W	1	N	n/a	blank
293-297	Additional Diagnosis X	5	A/N	L	blank
298	Additional Diagnosis - condition onset flag X	1	N	n/a	blank
299-305	Principal Procedure - A	7	A/N	L	blank
306	Principal Procedure Location - A	1	A/N	n/a	blank
307-313	Procedure - B	7	A/N	L	blank
314	Procedure Location - B	1	A/N	n/a	blank
315-321	Procedure - C	7	A/N	L	blank
322	Procedure Location - C	1	A/N	n/a	blank
323-329	Procedure - D	7	A/N	L	blank
330	Procedure Location - D	1	A/N	n/a	blank

CHAR POSITION	FIELD NAME	LENGTH	TYPE	JUST	FILL
331-337	Procedure - E	7	A/N	L	blank
338	Procedure Location - E	1	A/N	n/a	blank
339-345	Procedure - F	7	A/N	L	blank
346	Procedure Location - F	1	A/N	n/a	blank
347-353	Procedure - G	7	A/N	L	blank
354	Procedure Location - G	1	A/N	n/a	blank
355-361	Procedure - H	7	A/N	L	blank
362	Procedure Location - H	1	A/N	n/a	blank
363-369	Procedure - I	7	A/N	L	blank
370	Procedure Location - I	1	A/N	n/a	blank
371-377	Procedure - J	7	A/N	L	blank
378	Procedure Location - J	1	A/N	n/a	blank
379-385	Procedure - K	7	A/N	L	blank
386	Procedure Location - K	1	A/N	n/a	blank
387-393	Procedure - L	7	A/N	L	blank
394	Procedure Location - L	1	A/N	n/a	blank
395-401	Procedure - M	7	A/N	L	blank
402	Procedure Location - M	1	A/N	n/a	blank
403-409	Procedure - N	7	A/N	L	blank
410	Procedure Location - N	1	A/N	n/a	blank
411-417	Procedure - O	7	A/N	L	blank
418	Procedure Location - O	1	A/N	n/a	blank
419-425	Procedure - P	7	A/N	L	blank
426	Procedure Location - P	1	A/N	n/a	blank

CHAR POSITION	FIELD NAME	LENGTH	TYPE	JUST	FILL
427-433	Procedure - Q	7	A/N	L	blank
434	Procedure Location - Q	1	A/N	n/a	blank
435-441	Procedure - R	7	A/N	L	blank
442	Procedure Location - R	1	A/N	n/a	blank
443-449	Procedure - S	7	A/N	L	blank
450	Procedure Location - S	1	A/N	n/a	blank
451-457	Procedure - T	7	A/N	L	blank
458	Procedure Location - T	1	A/N	n/a	blank
459-465	Procedure - U	7	A/N	L	blank
466	Procedure Location - U	1	A/N	n/a	blank
467-473	Procedure - V	7	A/N	L	blank
474	Procedure Location - V	1	A/N	n/a	blank
475-481	Procedure - W	7	A/N	L	blank
482	Procedure Location - W	1	A/N	n/a	blank
483-489	Procedure - X	7	A/N	L	blank
490	Procedure Location - X	1	A/N	n/a	blank
491-497	Procedure - Y	7	A/N	L	blank
498	Procedure Location - Y	1	A/N	n/a	blank
499-503	External cause	5	A/N	L	blank
504-508	Place of Occurrence	5	A/N	L	blank
509-513	Activity when Injured	5	A/N	L	blank
514	Episode of Care	1	N	n/a	zero
515-516	Funding Source	2	N	n/a	zero
517	Unplanned Readmission (Discontinued)	1	N	n/a	blank
518	Admission category	1	N	n/a	zero
519-528	Contract provider hospital patient unit number	10	N	R	zero

CHAR POSITION	FIELD NAME	LENGTH	TYPE	JUST	FILL
529-536	Date admitted to contract provider hospital	8	N	R	zero
537-540	Provider of contract services - hospital number	4	N	R	zero
541-548	Leave From Date - 1	8	N	R	zero
549-552	Leave From Time - 1	4	N	R	zero
553-560	Leave To Date - 1	8	N	R	zero
561-564	Leave To Time - 1	4	N	R	zero
565-572	Leave From Date - 2	8	N	R	zero
573-576	Leave From Time - 2	4	N	R	zero
577-584	Leave To Date - 2	8	N	R	zero
585-588	Leave To Time - 2	4	N	R	zero
589-596	Leave From Date - 3	8	N	R	zero
597-600	Leave From Time - 3	4	N	R	zero
601-608	Leave To Date - 3	8	N	R	zero
609-612	Leave To Time - 3	4	N	R	zero
613-620	Leave From Date - 4	8	N	R	zero
621-624	Leave From Time - 4	4	N	R	zero
625-632	Leave To Date - 4	8	N	R	zero
633-636	Leave To Time - 4	4	N	R	zero
637-640	Admission weight (grams)	4	N	R	zero
641-645	Hours in Intensive Care Unit	5	N	R	zero
646-649	Hours on mechanical ventilation	4	N	R	zero
650	Legal status	1	N	n/a	zero
651-654	Admission time	4	N	R	zero
655-658	Separation time	4	N	R	zero
659-662	Hospital transferred from	4	N	R	zero
663-672	Mental Health Linking Variable	10	N	R	zero



CHAR POSITION	FIELD NAME	LENGTH	TYPE	JUST	FILL
673-682	OACIS Linking Variable	10	N	R	zero
683	Adult/Child Flag	1	A	n/a	blank
684	First psychiatric admission (discontinued)	1	N	n/a	zero
685	Previous Specialised Treatment	1	N	R	blank
686	Employment Status	1	N	n/a	zero
687	Pension Status	1	N	n/a	zero
688	Type of usual accommodation	1	N	n/a	blank
689	Date of Birth Accuracy Flag	1	N	n/a	zero
690-697	Date of First OT Procedure Performed	8	N	n/a	zero
698-701	Time of First OT Procedure Performed	4	N	n/a	zero
702-711	Ward on Discharge	10	A/N	n/a	blank
712	External Cause - condition onset flag	1	N	n/a	blank
713	Place of Occurrence – condition onset flag	1	N	n/a	blank
714	Activity when Injured – condition onset flag	1	N	n/a	blank
715-722	Date Transfer To Discharge Lounge	8	N	n/a	zero
723-726	Time Transfer To Discharge Lounge	4	N	R	zero
727-736	Ward on Admission	10	A/N	n/a	blank
737-746	Research Items	10	A/N	L	
Note: An "end of record marker" should be placed after each record.					

**Note: The data items First psychiatric admission & Unplanned Readmission does not need to be collected in 2016-17**

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## Appendix 2: Correction File Format - 746 (effective from 1 July 2013)

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CHAR POSITION	FIELD NAME	LENGTH	TYPE	JUST	FILL
1	Record type	1	N	n/a	"5"
2-5	Hospital code	4	N	R	zero
6-15	Patient unit number	10	N	R	zero
16-23	Separation Date	8	N	R	zero
24-27	Separation Time	4	N	R	zero
28	Delete indicator	1	N	n/a	zero
29-31	Item number	3	A/N	L	blank
32-96	New Information	65	A/N	L	blank
97-746	Filler	650	A/N	L	blank

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## Appendix 3: Contract Service and Component of Care

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**Definition** With the specialisation of some hospitals and where specialised technology prohibits the service being widely available, hospitals are seeking to be able to provide a comprehensive service by making arrangements with those hospitals that have the particular equipment or offer a particular service.

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

**Component of Care** - Where a patient is an inpatient in a public hospital and is admitted to another public hospital for a period of less than 24 hours for a component of their overall episode of care, with the intention of coming back to the originating hospital (and frequently a bed is held for that patient) this should be considered a '**Component of Care**'. There may be more than one component of care instance during the overall episode of care but each time the intent is for the patient to return to the originating hospital within 24 hours and overall duty of care remains with the originating hospital

In these circumstances, the clinician at the originating hospital has overall responsibility for the patient's care for the entire episode.

**Data collection for these instances of 'Component of Care' should follow the same guidelines as for contract services and funding to LHNs for this activity will be on the same basis.**

Related Items:

- Contracted Admission Date
- Contracted Hospital Patient Unit Number
- Contracted Service Hospital

Examples of Component of Care are:

- A patient who is being treated at a public hospital for a mental health condition required Electroconvulsive Therapy (ECT) and receives this at another hospital (possibly multiple times).
- A patient with end stage kidney disease is admitted to a public hospital for another clinical condition and is required to travel to a second hospital to receive haemodialysis on one or more occasions.

**Please note, this does not include cases of other hospital up and down transfers where the entire care is moved to the Destination Hospital.**

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**Additional Information**

- A specific arrangement should apply whereby one hospital, either public or private, contracts with another (public or private) hospital, for the provision of specific services.
- This arrangement for the provision of specific services can include an agreement that the destination hospital (providing the contracted service) is remunerated by the originating hospital (requesting the service).
- An entire episode of care may be a contracted service, where the patient is admitted directly to the hospital providing the contracted service. For example, Hospital A may contract Hospital B to perform X number of cholecystectomies. In such a case, the patients are admitted directly to Hospital B with the Source of Referral recorded as (7) Contracted Service. However, Hospital A must ensure these patients are admitted on their computer system and the details forwarded to ISAAC, for funding purposes.
- Contracted service details are required to identify the incidence of contracted services and component of care by both the contracting hospital (originating hospital) and the destination hospital (hospital performing the contracted service).
- The Contract Service Hospital Identifier code (Data Item 65) is mandatory to report for both sites engaged in a contracted service or component of care arrangement. Hospital A records the Hospital Code of where the patient went for the contracted service (Hospital B) and also the other contracted service data items (63 & 64), Hospital B also records Data Item 65 but it is the Hospital Code of where the patient came from (Hosp A).
- Patients must not be placed on leave in Hospital A when they go to Hospital B. Placing a patient on leave affects the length of stay calculation
- For reporting purposes, the classification of a patient would be the same as if the procedure or service had been performed in the originating hospital. That is, the service, although it occurred off-site, is to be regarded as part of the episode at the originating hospital for AR-DRG grouping purposes.
- For patients admitted to a public hospital (originating hospital), and receiving a component of their overall care at another public hospital (destination hospital) this should be considered Component of Care. Examples of this are inpatients attending other public hospitals for dialysis or ECT procedures.

**Component of Care**

- The originating hospital will receive funding for this episode based on an AR-DRG that has been assigned with the treatment at the second hospital taken into account.
- The destination hospital should also provide a morbidity record to the Department for each encounter but should assign
  - Contracted Service code (7) in the Source of Referral field,
  - Other Hospital or Public Authority code (12) in the Funding Source field,
  - Include the details of the originating hospital in the contracted care data items.
- There will be no funding provided in these cases to the Destination Hospital. A recharge arrangement can be considered in these circumstances.
- For components of care where, due to unforeseen circumstances, the overall care is transferred to the destination hospital (i.e. the care lasts > 24 hours), the episode at the destination hospital should be changed to reflect a Source of Referral of (4) Inter-hospital transfer with the Funding Source and other Contract Fields altered accordingly. The episode at the originating hospital should also be adjusted to reflect a Separation Date and Time of 1 minute before the Admission Date and Time of the episode at the destination hospital with an appropriate Nature of Separation of either (2) Other Hospital – up transfer or (7) Other Hospital – down transfer, the other Contract Fields for the originating episode should also be altered accordingly

<b>Originating Hospital</b>	<p>Record and report the contract admission or Component of Care as if it were a complete and routine admission to your hospital. This includes any admission where the entire episode is at the Contracted Hospital.</p> <ul style="list-style-type: none"> <li>• <i>These additional items must also be reported:</i></li> <li>• <i>ALL procedures performed at the originating AND destination hospitals</i></li> <li>• <i>Procedure location indicators to be recorded as below:-</i> <ul style="list-style-type: none"> <li>○ <i>procedures performed at the originating hospital - Procedure Indicator '1' procedures performed at the destination hospital - Procedure Indicator '2'</i></li> </ul> </li> <li>• <i>Refer to Section 4: Clinical Data Items – 'Procedure location indicator'.</i></li> <li>• <i>The destination hospital's ISAAC Code</i></li> <li>• <i>The destination hospital's Unit Record Number</i></li> <li>• <i>The date the patient was admitted to the destination hospital</i></li> </ul>
<b>Destination Hospital</b>	<p>Record and report the contract admission or Component of Care as you would for an admission at your hospital, with these exceptions:</p> <ul style="list-style-type: none"> <li>• <i>Source of Referral</i> should be 7-Contracted Service;</li> <li>• <i>Funding Source</i> should be 12 – Other Hospital or Public Authority</li> <li>• The Contracting (originating) Hospital ISAAC Code (Mandatory 1 July 2012)</li> <li>• <i>Admission Election</i> should be 1-Hospital (only if destination hospital is a private hospital and treating a public hospital patient);</li> <li>• <i>Nature of Separation</i> would be 1- Home and <i>Referral for Further Care</i> as applicable.</li> </ul>
<b>Excludes</b>	<ul style="list-style-type: none"> <li>• Patients transferred to another hospital for on-going care, without a specific contract. For example, a patient who is admitted to a country hospital with multi-trauma and is transferred to a metropolitan hospital for ongoing care and treatment.</li> <li>• Patients sent to a privately owned service provider for a pathology or imaging test.</li> <li>• Cases of other hospital up and down transfers where the entire care is moved to the Destination Hospital.</li> </ul>
<b>Additional Information Continued</b>	<p>The following data items <b><u>must be collected</u></b> by the <u>originating hospital</u> (i.e. the hospital requesting the contracted service or component of care) <u>and the destination hospital</u> (i.e. the hospital providing the contracted service or component of care).</p> <p>All destination Hospitals will be required to ensure that they can record the hospital code of the originating hospital for any service they are contracted to undertake.</p>

**Note: The below relates specifically to admitted patient care arranged between hospitals. It does not refer to non-admitted patient care arranged between hospitals. Please refer to MMSS guidelines for non-admitted arrangements.**

	Contract Service	Component of Care
<b>Definition</b>		
Formal agreement b/w two hospitals	Yes	No
Agreement with private hospital	Yes	No
Admitted services	Yes	Yes
<b>Length of stay</b>		
Intended LOS ≤ 24 hr episode	Yes	Yes
Intended LOS ≤ 24 hr episode, but actual LOS >24 hrs	Yes	No
Intended LOS > 24 hr episode	Yes	No
<b>Data collection – Originating Hospital</b> <i>Report the contract admission or Component of Care as if it were a complete and routine admission to your hospital. This includes any admission where the entire contracted episode is at the Contracted Hospital</i>	Contract Service	Component of Care
Contracted Hospital Patient Unit Number (data item 63)	Dest. Hosp UR No	Dest. Hosp UR No
Contract Admission Date (data item 64)	Date admitted to Destination Hospital	Date admitted to Destination Hospital
Contract Service Hospital (data item 65)	Destination Hosp #	Destination Hosp #
Source of Referral (data item 16)	As appropriate	As Appropriate
Funding Source (data item 95)	As appropriate	As appropriate
Procedures (data item 49)	ICD-10-AM code for procedure performed at Destination Hospital	ICD-10-AM code for procedure performed at Destination Hospital
Procedure Location Indicator (data item 85)	2	2
<b>Data collection – Destination Hospital</b> <i>Report the contract admission or Component of Care as if it were an admission at your hospital, with the following exceptions</i>	Contract Service	Component of Care
Contracted Hospital Patient Unit Number (data item 63)	optional (originating Hospital Number UR No if collected)	optional (originating Hospital Number UR No if collected)
Contract Admission Date (data item 64)	optional	optional
Contract Service Hospital (data item 65)	Originating Hospital Number	Originating Hospital Number
Source of Referral (data item 16)	7	7
Funding Source (data item 95)	12	12
Procedures (data item 49)	ICD-10-AM code	ICD-10AM code
Procedure Location Indicator (data item 85)	1	1

ISAAC Edits	Contract Service	Component of Care
2611-Funding source must be other hosp for contract service	Yes	Yes
4560-Contract hospital invalid or same as sent hospital	Yes	Yes
4561-Contracted service details not complete	Yes	Yes
4562-Contracted service-hospital code required	Yes	Yes
4570-Contract patient UR invalid or same as sent hospital	Yes	Yes
4580-Contract admission date invalid	Yes	Yes
4930-Contracted patient, no contract procedure indicator	Yes	Yes

**Coding  
Examples for  
Component of  
Care between  
Public  
Hospitals**

Coding for contracted care should align with Medical Records ACS Coding Standard 0029 'Coding of Contracted Procedures' and should also align with the State standard outlined in this manual.

- **ECT**

Patient with schizophrenia is admitted to Hospital A (originating hospital). During their hospitalisation, the patient is transferred to Hospital B (destination hospital) on 6 different occasions for ECT under GA.

**Hospital A (originating) codes a single episode:**

PDX	As applicable to episode E.g. Schizophrenia
Procedure	93341-06, ECT 6 treatments- Procedure Indicator "2"
	92514-99, GA- Procedure Indicator "2"
	92514-99, GA- Procedure Indicator "2"
	92514-99, GA- Procedure Indicator "2"
	92514-99, GA- Procedure Indicator "2"
	92514-99, GA- Procedure Indicator "2"
	92514-99, GA- Procedure Indicator "2"

**Hospital B (destination) codes 6 individual episodes with the following codes:**

PDX	As applicable to episode E.g. Schizophrenia
Procedure	93341-01, ECT 1 treatment- Procedure Indicator "1"
	92514-99, GA- Procedure Indicator "1"

**Coding  
Examples for  
Component of  
Care between  
Public  
Hospitals  
continued**

- **DIALYSIS – Multiple episodes of care for dialysis**

Patient admitted to Hospital A (originating hospital) with #NOF. Whilst in hospital, the patient requires dialysis, so is transferred multiple times to Hospital B (destination hospital) where dialysis is available. Patient returns to Hospital A after each dialysis encounter.

**Hospital A (originating) codes a single episode:**

PDX                      As applicable to episode E.g. #NOF

Procedure              Dialysis - Procedure Indicator "2"

**Hospital B (destination) codes each individual dialysis episode:**

PDX                      Z49, Dialysis

Procedure              Dialysis - Procedure Indicator "1"



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## Appendix 4: Example Scenarios Episode of Care

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The following example scenarios for episode of care are divided into sections by which episode of care type the scenario is most applicable to

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### Maintenance Care

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**End of Quarter example** shows the administrative discharge and readmit requirements for Maintenance care inpatients who are admitted inpatients at the time of any end of quarter.

#### Separation Record

Discharge Date 31/12/2007  
Discharge Time 2358  
Nature of Separation E  
Admission number same

#### New Admission Record

Admission Date 31/12/2007  
Admission Time 2359  
Source of Referral E  
Admission number same

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### Newborns – Qualified and Unqualified Care

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#### Scenario 1

Unqualified, discharged prior to day 10. Note that all ICD-10-AM codes ARE REQUIRED for this unqualified episode, as this is the ONLY episode of care.

Item No.	Data item description	Unqualified	Day 10
16	Source of Referral ***	as appropriate	
42	Nature of separation	as appropriate	
45	Principal diagnosis	ACS	
46	Secondary diagnosis	ACS	
49	Operations/Procedures	ACS	
51	Episode of Care type	5	
66	Plan to re-admit	as appropriate	
68	Admission number	new number	
72	Referral for further health care	as appropriate	
	ATTESTATION FORM	Not required	

\*\*\* For newborns born on this episode, the source of referral is '8- Other'

### Scenario 2

Unqualified -> Qualified discharged prior to day 10.

Item No.	Data item description	Unqualified	Qualified	Day 10
16	Source of Referral	as appropriate	A	
42	Nature of separation	A	as appropriate	
45	Principal diagnosis	filler code	ACS	
46	Secondary diagnosis	nil	ACS	
49	Operations/Procedures	nil	ACS	
51	Episode of Care type	5	6	
66	Plan to re-admit	N	as appropriate	
68	Admission number	new number	same number	
72	Referral for further healthcare	1	as appropriate	
	ATTESTATION FORM	Not required	Required	

### Scenario 3

Qualified -> Unqualified discharged prior to day 10

Item No.	Data item description	Qualified Day 10	Unqualified Day 10	Day 10
16	Source of Referral	as appropriate	A	
42	Nature of separation	A	as appropriate	
45	Principal diagnosis	filler code	ACS	
46	Secondary diagnosis	nil	ACS	
49	Operations/Procedures	nil	ACS	
51	Episode of Care type	6	5	
66	Plan to re-admit	N	as appropriate	
68	Admission number	new number	same number	
72	Referral for further health care	1	as appropriate	
	ATTESTATION FORM	Not required	Required	

#### Scenario 4

Qualified -> Unqualified -> Qualified -> Unqualified remaining in hospital on day 10 & receiving acute care -> Acute.

Item No.	Data item description	Qualified	Unqualified	Qualified	Unqualified	Day 10	Acute
16	Source of Referral	as appropriate	A	A	A		A
42	Nature of separation	A	A	A	A		as appropriate
45	Principal diagnosis	filler code	filler code	filler code	filler code		ACS
46	Secondary diagnosis	Nil	nil	nil	nil		ACS
49	Operations/Procedures	Nil	nil	nil	nil		ACS
51	Episode of Care type	6	5	6	5		1
66	Plan to re-admit	N	N	N	N		as appropriate
68	Admission number	new no.	same no.	same no.	same no.		same no.
72	Referral for further health care	1	1	1	1		as appropriate
	ATTESTATION FORM	Not required	Not required	Not required	Not required		Required

#### Scenario 5

Qualified -> Unqualified -> Qualified -> Unqualified remaining in hospital on day 10 & NOT receiving acute care -> Boarder.

(Boarders are NOT submitted to ISAAC)

Item No.	Data item description	Qualified	Unqualified	Qualified	Unqualified	Day 10	Boarder
16	Source of Referral	as appropriate	A	A	A		
42	Nature of separation**	A	A	A	1		
45	Principal diagnosis	filler code	filler code	filler code	ACS		
46	Secondary diagnosis	Nil	nil	nil	ACS		
49	Operations/Procedures	Nil	nil	nil	ACS		
51	Episode of Care type	6	5	6	5		
66	Plan to re-admit	N	N	N	N		
68	Admission number	new no.	same no.	same no.	same no.		
72	Referral for further health care	1	1	1	As appropriate		
	ATTESTATION FORM	Not required	Not required	Not required	Required		

\*\* Note when a newborn is discharged to a boarder, the nature of separation is Home.

### Scenario 6

Unqualified -> Qualified -> Unqualified -> Qualified remaining in hospital on day 10 (no change in episode required)

Item No	Data item description	Unqualified	Qualified	Unqualified	Qualified	Day 10	Remains Qualified
16	Source of Referral	as appropriate	A	A	A		
42	Nature of separation	A	A	A			as appropriate
45	Principal diagnosis	filler code	filler code	filler code			ACS
46	Secondary diagnosis	Nil	nil	nil			ACS
49	Operations/Procedures	Nil	nil	nil			ACS
51	Episode of Care Type	5	6	5	6		
66	Plan to re-admit	N	N	N			as appropriate
68	Admission number	new no.	same no.	same no.	same no.		
72	Referral for further health care	1	1	1			as appropriate
	ATTESTATION FORM	Not required	Not required	Not required			Required

## Hospital at Home Care

The following scenarios have been provided as a guide to indicate the required value for associated fields for both the In-patient and Hospital at Home (H@H) episodes depending on certain circumstances.

### Scenario 1

Patient admitted as inpatient for acute care, then discharged to H@H. The patient is then formally discharged from the hospital's care.

Hospital episode

Item No	Data item description	Required value
21	Admission Date	20/1/2011
16	Source of Referral	(any number 0 to 9, or 'A')
51	Episode of Care	1 = acute
43	Separation Date	24/1/2011
70	Separation Time	1425
42	Nature of Separation	A (Administrative Discharge)
72	Referral for Further Health Care	7 = Hospital at home
45	Principal Diagnosis	As per principal diagnosis definition

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H@H episode

Item No	Data item description	Required value
21	Admission Date	24/1/2011
67	Admission Time	1426
16	Source of Referral	A (Administrative Admission)
51	Episode of Care	7 = Hospital @ Home
43	Separation Date	30/1/2011
42	Nature of Separation	any number 1,5,6,8,9
45	Principal Diagnosis	'Filler' principal diagnosis

### **Scenario 2**

Patient enters emergency department for treatment and is admitted directly to H@H, the patient is then formally discharged.

*Emergency department*

Not collected on ISAAC

H@H

Item No	Data item description	Required value
21	Admission Date	24/1/2011
67	Admission Time	1426
16	Source of Referral	6 = Casualty/ Emergency)
51	Episode of Care	7 = Hospital @ Home
43	Separation Date	30/1/2011
42	Nature of Separation	any number 1,5,6,8,9
45	Principal Diagnosis	As per principal diagnosis definition

### **Scenario 3**

Patient attends an outpatient clinic for treatment and is admitted directly to H@H. The patient is then formally discharged.

*Outpatient clinic*

Not collected on ISAAC

H@H

Item No	Data item description	Required value
21	Admission Date	24/1/2011
67	Admission Time	1426
16	Source of Referral	5 = Outpatient
51	Episode of Care	7 = Hospital @ Home
43	Separation Date	30/1/2011
42	Nature of Separation	any number 1,5,6,8,9
45	Principal Diagnosis	As per principal diagnosis definition

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**Scenario 4**

Patient is admitted to H@H and then has a planned inpatient admission for any condition (and does not return to H@H).

Original In-patient episode

Item No	Data item description	Required value
21	Admission Date	20/1/2011
16	Source of Referral	(any number 0 to 9 or 'A')
51	Episode of Care	1 = acute
43	Separation Date	24/1/2011
70	Separation Time	1425
42	Nature of Separation	A (Administrative Discharge)
72	Referral for Further Health Care	7 = hospital at home
45	Principal Diagnosis	As per principal diagnosis definition

Hospital @ Home Episode

Item No	Data item description	Required value
21	Admission Date	24/1/2011
67	Admission Time	1426
16	Source of Referral	A (Administrative Admission)
51	Episode of Care	7 = Hospital @ Home
43	Separation Date	26/1/2011
42	Nature of Separation	1 = Home
45	Principal Diagnosis	'Filler' principal diagnosis

New in-patient episode

Item No	Data item description	Required value
21	Admission Date	26/1/2011
67	Admission Time	Time admitted
16	Source of Referral	8 = Other
51	Episode of Care	1 = Acute
43	Separation Date	30/1/2011
42	Nature of Separation	(any number 0 to 9)
45	Principal Diagnosis	As per principal diagnosis definition

**Scenario 5**

Patient is admitted to H@H from an outpatient clinic, develops a complication and needs to be admitted to hospital. The patient is formally discharged from H@H and admitted as a new inpatient episode.

Hospital @ Home Episode

Item No	Data item description	Required value
21	Admission Date	24/1/2011
67	Admission Time	1426
16	Source of Referral	5= Outpatient
51	Episode of Care	7 = Hospital @ Home
43	Separation Date	26/1/2011
42	Nature of Separation	1 = Home
45	Principal Diagnosis	As per principal diagnosis definition

---

In-patient episode

Item No	Data item description	Required value
21	Admission Date	26/1/2011
67	Admission Time	Time admitted
16	Source of Referral	8 = Other
51	Episode of Care	1 = Acute
43	Separation Date	30/1/2011
42	Nature of Separation	(any number 0 to 9)
45	Principal Diagnosis	As per principal diagnosis definition

### **Scenario 6**

Patient is admitted to H@H from an outpatient clinic, develops a complication and needs to be admitted to hospital. The patient is formally discharged from H@H and admitted as a new inpatient episode.

Hospital @ Home Episode

Item No	Data item description	Required value
21	Admission Date	24/1/2011
67	Admission Time	1426
16	Source of Referral	5= Outpatient
51	Episode of Care	7 = Hospital @ Home
43	Separation Date	26/1/2011
42	Nature of Separation	1 = Home
45	Principal Diagnosis	As per principal diagnosis definition

In-patient episode

Item No	Data item description	Required value
21	Admission Date	26/1/2011
67	Admission Time	Time admitted
16	Source of Referral	8 = Other
51	Episode of Care	1 = Acute
43	Separation Date	30/1/2011
42	Nature of Separation	(any number 0 to 9)
45	Principal Diagnosis	As per principal diagnosis definition

### **Scenario 7**

The patient is admitted as H@H and needs to return to hospital for same day chemotherapy or renal dialysis treatment.

- There is no need to discharge and readmit between H@H and such same day admissions.
- When a patient in H@H is required to return to hospital for a same day type service such as renal dialysis or chemotherapy, then record codes as part of the H@H episode.

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### **Home Births – Example Scenarios**

The rules for reporting home births to ISAAC are described below. Home births from 1 July 2013 can be reported to ISAAC.

#### **For the mother**

For a home birth, the mother is to be reported to ISAAC as a Hospital at Home episode of care. The following values are to be reported for key data items:

<b>Item No</b>	<b>Data item description</b>	<b>Required value</b>
51	Episode of care	7 = Hospital at Home
16	Source of referral	5 for Outpatient Department
21 + 67	Admission date/ time	Date/time that the midwife arrives at the home
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

If the mother requires inpatient care during or after the baby's birth, an Acute episode of care is to be reported to ISAAC for the mother in addition to the mother's Hospital at Home record. The values for the hospital at home record are the same if a mother needs further care in the hospital. The hospital may record the accompanying baby as a boarder if the baby does not require inpatient care.

<b>Item No</b>	<b>Data item description</b>	<b>Required value</b>
51	Episode of care	1 for Acute
16	Source of referral	8 for Other
21 + 67	Admission date/ time	As per current definition
43 + 70	Separation date/time	As per current definition
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	The applicable code
72	Referral for Further Care	The applicable code

#### **For the Baby**

For a home birth, the baby is to be reported to ISAAC as an Unqualified Newborn episode of care. The following values are to be reported for key data items:

<b>Item No</b>	<b>Data item description</b>	<b>Required value</b>
51	Episode of care	5 for Unqualified Newborn
16	Source of referral	8 for Other
21 + 67	Admission date/ time	Date/time of birth
11	Admission weight	Birth weight
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred



If the baby requires inpatient care during or after birth, a Qualified Newborn episode of care is to be reported to ISAAC for the baby, in addition to the baby's Unqualified Newborn episode of care record. A Qualified Newborn episode is also required for the second and each subsequent live born infant in a multiple birth. The following values are to be reported for key data items:

Item No	Data item description	Required value
51	Episode of care	6 for Qualified Newborn
16	Source of referral	8 for Other
21 + 67	Admission date/ time	As per current definition
11	Admission weight	Weight on admission
43 + 70	Separation date/time	As per current definition
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	The applicable code
72	Referral for Further Care	The applicable code

### **Scenario 1**

A woman begins a single birth process as a Hospital at Home episode, baby is born and no complications arise for the mother or the baby.

#### **Mother's record**

Item No	Data item description	Required value
51	Episode of care	7 for Hospital at Home
16	Source of referral	5 for Outpatient Department
21 + 67	Admission date/ time	Date/time that the midwife arrives at the home
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

#### **Baby's record**

Item No	Data item description	Required value
51	Episode of care	5 for Unqualified Newborn
16	Source of referral	8 for Other
21 + 67	Admission date/ time	Date/time of birth
11	Admission weight	Birth weight
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

### **Scenario 2**

A woman begins a single birth process as a Hospital at Home episode, baby is born, no complications arise for the baby but the mother requires inpatient care for a few days and is then discharged home.

#### **Mother's 1st record**

Item No	Data item description	Required value
51	Episode of care	7 for Hospital at Home
16	Source of referral	5 for Outpatient Department
21 + 67	Admission date/ time	Date/time that the midwife arrives at the home
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition

42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

#### **Mother's 2nd record**

Item No	Data item description	Required value
51	Episode of care	1 for Acute
16	Source of referral	8 for Other
21 + 67	Admission date/ time	As per current definition
43 + 70	Separation date/time	As per current definition
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

#### **Baby's record**

Item No	Data item description	Required value
51	Episode of care	5 for Unqualified Newborn
16	Source of referral	8 for Other
21 + 67	Admission date/ time	Date/time of birth
11	Admission weight	Birth weight
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

Baby may be recorded as boarder when accompanying the mother requiring care.

### **Scenario 3**

A woman begins a single birth process as a Hospital at Home episode, baby is born, no complications arise for the mother but the baby requires inpatient care for a few days and is then discharged home.

#### **Mother's record**

Item No	Data item description	Required value
51	Episode of care	7 for Hospital at Home
16	Source of referral	5 for Outpatient Department
21 + 67	Admission date/ time	Date/time that the midwife arrives at the home
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

Mother may be recorded as boarder when accompanying the baby requiring care.

#### **Baby's 1st record**

Item No	Data item description	Required value
51	Episode of care	5 for Unqualified Newborn
16	Source of referral	8 for Other
21 + 67	Admission date/ time	Date/time of birth
11	Admission weight	Birth weight
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition

42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

#### **Baby's 2nd record**

Item No	Data item description	Required value
51	Episode of care	6 for Qualified Newborn
16	Source of referral	8 for Other
21 + 67	Admission date/ time	As per current definition
11	Admission weight	Weight on admission
43 + 70	Separation date/time	As per current definition
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

Mother may be recorded as boarder if she stays in hospital with the baby.

#### **Scenario 4**

A woman begins a single birth process as a Hospital at Home episode, baby is born, complications arise for both the mother and the baby, and both require inpatient care for a few days. Baby's care ends first, followed by the mother and both are discharged home.

#### **Mother's 1st record**

Item No	Data item description	Required value
51	Episode of care	7 for Hospital at Home
16	Source of referral	5 for Outpatient Department
21 + 67	Admission date/ time	Date/time that the midwife arrives at the home
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

#### **Mother's 2nd record**

Item No	Data item description	Required value
51	Episode of care	1 for Acute
16	Source of referral	8 for Other
21 + 67	Admission date/ time	As per current definition
43 + 70	Separation date/time	As per current definition
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

#### **Baby's 1st record**

Item No	Data item description	Required value
51	Episode of care	5 for Unqualified Newborn
16	Source of referral	8 for Other
21 + 67	Admission date/ time	Date/time of birth
11	Admission weight	Birth weight
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

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**Baby's 2nd record**

Item No	Data item description	Required value
51	Episode of care	6 for Qualified Newborn
16	Source of referral	8 for Other
21 + 67	Admission date/ time	As per current definition
11	Admission weight	Weight on admission
43 + 70	Separation date/time	As per current definition
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

Baby recorded as unqualified newborn after the care provided to the baby has finished.

**Scenario 5**

A woman begins a multiple birth process as a Hospital at Home episode, 2 babies are born and no complications arise for the mother or the babies

**Mother's record**

Item No	Data item description	Required value
51	Episode of care	7 for Hospital at Home
16	Source of referral	5 for Outpatient Department
21 + 67	Admission date/ time	Date/time that the midwife arrives at the home
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

**Baby no.1's record**

Item No	Data item description	Required value
51	Episode of care	5 for Unqualified Newborn
16	Source of referral	8 for Other
21 + 67	Admission date/ time	Date/time of birth
11	Admission weight	Birth weight
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

**Baby no.2's record**

Item No	Data item description	Required value
51	Episode of care	6 for Qualified Newborn
16	Source of referral	8 for Other
21 + 67	Admission date/ time	Date/time of birth
11	Admission weight	Birth weight
43 + 70	Separation date/time	Date/time that the midwife leaves the home
45	Principal Diagnosis	As per principal diagnosis definition
42	Nature of separation	1 for Home
72	Referral for Further Care	1 for Not referred

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## Mental Health Care

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### **Scenario 1**

Patient is admitted for same day ECT, does not go to a designated Mental Health ward (episode 1)

Item No.	Data item description	Episode 1
51	Episode of Care Type	I – MH Acute
	All other values	as appropriate

### **Scenario 2**

A patient is admitted to hospital for treatment of medical complications due to the medication the patient is taking for a diagnosed mental disorder. The patient is located on a general ward under the care of a General Medicine physician. Whilst admitted the patient is seen by their normal Community Mental Health team as well as an Inpatient Mental Health team for assessment but the primary clinical purpose is management of the patient's acute physical condition, not the management of a diagnosed mental disorder (episode 1)

Item No.	Data item description	Episode 1
51	Episode of Care Type	1 – Acute
	All other values	as appropriate

### **Scenario 3**

A patient is admitted to a general hospital after an increase in schizophrenia symptoms such as paranoia and delusions, have led the patient to stop taking his regular cardiac medications. The Mental Health team review and assess the patient, documenting a Mental Health management plan which includes pharmacotherapy as well as psychiatric therapy to manage the schizophrenia and allow the patient to restart the cardiac medications (episode 1)

Item No.	Data item description	Episode 1
51	Episode of Care Type	I – MH Acute
	All other values	as appropriate

### **Scenario 4**

An older patient has been triaged by the Community Mental Health team as being acutely depressed and is referred to ED. Patient is seen in ED and the decision is made to admit the patient to the Older Person's Mental Health Ward OPMH. (episode 1)

Item No.	Data item description	Episode 1
16	Source of Referral	6 – ED
51	Episode of Care Type	I – MH Acute
42	Nature of separation	as appropriate
72	Referral for further health care	as appropriate

### **Scenario 5**

Patient is an ED visit at Hospital A who is admitted as an inpatient to a Mental Health Short Stay Unit located within the ED for management of an acute mental health disorder (episode 1). The patient is then transferred to a Mental Health ward at another site Hospital B for equivalent care (episode 2)

Item No.	Data item description	Episode 1	Episode 2
16	Source of Referral	6 – ED	4 – Inter-hospital Transfer
18	Hospital Transfer From	n/a	Hospital Code A Hosp Code
51	Episode of Care Type	I – MH Acute	I – MH Acute
42	Nature of separation	2 – Hosp Up	as appropriate
72	Referral for further health care	01 – Not ref	as appropriate
44	Hospital Transfer To	Hospital Code B Hosp Code	as appropriate

### **Scenario 6**

Patient presents to ED at Hospital A and is admitted to a Mental Health ward at Hospital B for management of an acute mental health disorder (episode 1) point is SOR from ED of other hospital is 8 Other not ED,

Item No.	Data item description	Episode 1
16	Source of Referral	8 – Other
51	Episode of Care Type	I – MH Acute
42	Nature of separation	as appropriate
72	Referral for further health care	as appropriate

### **Scenario 7**

Patient presents to ED for an overdose e.g. Paracetamol poisoning. Patient is admitted under the Medical team as the primary clinical purpose is to stabilise and treat the patient for the overdose e.g. manage the paracetamol poisoning (episode 1). Once medically stable the primary clinical purpose changes to management of the patient's acute mental health disorder under the Mental Health team (episode 2). A week later the patient deteriorates medically and is returned to the care of the Medical team after which they are discharged home and referred to the Community Mental Health Service (episode 3)

Item No.	Data item description	Episode 1	Episode 2	Episode 3
21 +67	Admission Date and Time	as appropriate	1 min after Episode 1 Separation Date Time	1 min after Episode 2 Separation Date Time
16	Source of Referral	6 – ED	A – Administrative	A – Administrative
51	Episode of Care Type	1 Acute	I – MH Acute	1 Acute
42	Nature of separation	A – Administrative	A – Administrative	1 - Home
72	Referral for further health care	01 – Not ref	01 – Not ref	05 Com MH
43 +70	Separation Date and Time	1 min before Episode 2 Admission Date Time	1 min before Episode 3 Admission Date Time	as appropriate

### **Scenario 8**

Patient is admitted at Hospital A for the treatment and management of schizoaffective disorder and challenging behaviour (episode 1). Once their condition stabilises and the patient no longer requires the intense treatment delivered at the acute service, the Mental Health team determine the patient is to be transferred to Hospital B to begin their non-acute phase of illness treatment and mental health rehabilitation (episode 2)

<b>Item No.</b>	<b>Data item description</b>	<b>Episode 1</b>	<b>Episode 2</b>
18	Hospital Transfer From	as appropriate	Hospital A Hosp Code
16	Source of Referral	as appropriate	4 – Inter-hospital Transfer
51	Episode of Care Type	I – MH Acute	K – MH Rehabilitation
42	Nature of separation	7 – Hosp Down	as appropriate
72	Referral for further health care	01 – Not ref	as appropriate
44	Hospital Transfer To	Hospital B Hosp Code	as appropriate

### **Scenario 9**

Patient is in an outlying medical ward awaiting a bed in a CHSA Integrated Mental Health Inpatient Unit (IMHIU) located at the same site, the primary clinical purpose is to manage the patient's acute mental health disorder and the admitting team is regularly informed by the Mental Health team on the management plan. Patient transfers to the IMHU ward once a bed becomes available. Once the patient is stable they are discharged home from the IMHU (episode 1)

<b>Item No.</b>	<b>Data item description</b>	<b>Episode 1</b>
54	Ward on Admission	Outlying Medical Ward
16	Source of Referral	as appropriate
51	Episode of Care Type	I – MH Acute
42	Nature of separation	1 – Home
66	Ward on Discharge	IMHU Ward
72	Referral for further health care	As applicable



### **Scenario 10**

Patient is in an outlying medical ward in Hospital A awaiting a bed in a CHSA Integrated Mental Health Inpatient Unit (IMHIU) located at another site Hospital B, the primary clinical purpose is to manage the patient's acute mental health disorder and the admitting team are regularly informed by the Mental Health team on the management plan (episode 1). Once a bed becomes available the patient is transferred to the IMHU ward at Hospital B for equivalent care (episode 2)

Item No.	Data item description	Episode 1	Episode 2
18	Hospital Transfer From	as appropriate	Hospital A Hosp Code
16	Source of Referral	as appropriate	4 – Inter-hospital Transfer
51	Episode of Care Type	I – MH Acute	I – MH Acute
42	Nature of separation	2 – Hosp Up	as appropriate
72	Referral for further health care	01 – Not ref	as appropriate
44	Hospital Transfer To	Hospital B Hosp Code	as appropriate

### **Scenario 11**

Patient is admitted at Hospital A (originating hospital) for the primary clinical purpose of managing the patient's acute mental health disorder (episode 1). As part of their inpatient treatment plan, the patient requires ECT at another site Hospital B (destination hospital). The overall care remains with Hospital A and the intention is for the patient to return to Hospital A after the same day ECT (episode 2). This may occur once (in this example) or many times within the duration of the overall stay at Hospital A (episode 1). Note this example should be recorded in line with 15/16 Admission process rules outlined in the ISAAC 2015 manual under 'Appendix 3: Contract Service and Component of Care

Item No.	Data item description	Episode 1 Originating Hospital A	Episode 2 Destination hospital B
64	Contract Admission Date	Hospital B Admission Date	as appropriate
63	Contract Hospital Patient Unit Number	Hospital B Patient Unit Number	Hospital A Patient Unit Number
65	Contracted Service Hospital	Hospital B Hosp Code	Hospital A Hosp Code
20	Funding Source	as appropriate	12-Other Hospital or Public Authority
16	Source of Referral	as appropriate	7 – Contracted Service
51	Episode of Care Type	I – MH Acute	I – MH Acute
42	Nature of separation	as appropriate	1 - Home
72	Referral for further health care	as appropriate	01 – Not ref
	Episode Coding & Election	Refer to Appendix 3	Refer to Appendix 3

### **Scenario 12**

A patient is admitted under a surgical team for surgical treatment of a condition e.g. Under an Orthopaedic team for a total hip replacement (THR). During their stay the patient undergoes Maintenance ECT as part of a Mental Health Plan determined prior to admission. The primary clinical purpose remains for surgical treatment of the condition e.g. THR, the patient is transferred to theatre for ECT and then returns to the surgical ward to continue treatment of their surgical condition (episode 1)

Item No.	Data item description	Episode 1
51	Episode of Care Type	1 – Acute
49A - Y	Procedure Code	Include procedure code for ECT in coding of record
	All other values	as appropriate

### **Scenario 13**

Patient is admitted to another unit e.g. GEM team, after several days it is determined the primary clinical purpose is not the improvement of medical conditions relating to aging but in fact to treat symptoms related to their mental health illness which were first thought to be conditions related to aging (episode 1), the patient is transferred to Mental Health team for management and treatment of mental health illness (episode 2)

Item No.	Data item description	Episode 1	Episode 2
21 +67	Admission Date and Time	as appropriate	1 min after Episode 1 Separation Date Time
16	Source of Referral	as appropriate	A – Administrative
51	Episode of Care Type	9 – GEM	I – MH Acute
42	Nature of separation	A – Administrative	as appropriate
72	Referral for further health care	01 – Not ref	as appropriate
43 + 70	Separation Date and Time	1 min before Episode 2 Admission Date Time	as appropriate

### **Scenario 14**

After ED triage, patient is admitted at a hospital that does not have a mental health or other emergency short stay unit; patient is admitted within ED by general ED staff. Following a Mental Health assessment; it is determined the patient does not require Mental Health treatment and the primary clinical purpose of treatment is managing behaviour caused by the result of a medical condition e.g. delirium from an infection /alzheimers as opposed to the management of the patients diagnosed Mental Health disorder. The entire admission may occur in ED (in this example) or patient may transfer to an inpatient ward for further care.

Item No.	Data item description	Episode 1
21 +67	Admission Date and Time	as appropriate
16	Source of Referral	6 – ED
51	Episode of Care Type	as appropriate – Not Mental Health Acute

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## **Posthumous Organ Procurement**

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### **Scenario 1**

Patient is an inpatient and is subsequently declared brain dead. Posthumous organ procurement then occurs after consent is obtained.

Item No.	Data item description	Episode 1	Episode 2
21 + 67	Admission Date and Time	As appropriate	1 min after Episode 1 Separation Date Time
16	Source of Referral	6 – ED	A – Administrative
51	Episode of Care Type	1 Acute	P - Posthumous Organ Procurement
41	Hours on mechanical ventilation	As appropriate	As appropriate
42	Nature of separation	A – Administrative	5 – Died, no autopsy
72	Referral for further health care	01 – Not ref	01 – Not ref
43 + 70	Separation Date and Time	Date and time patient is transferred to theatre for procurement to occur	Date and Time procurement is completed

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## Appendix 5: Supplementary Data Items

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### EPAS Site Visit ID – EPAS sites only

#### Identifying and definitional attributes

<i>Technical name:</i>	<b>EPAS Site Visit ID</b> , identifier N(20)
<i>Synonymous names:</i>	ISAAC Supplementary Data item 102
<i>SAHMR identifier:</i>	SA
<i>Registration status:</i>	SA Health, Standard 24/04/2013
<i>Definition:</i>	This is not a mandatory reporting data element. An EPAS Site Visit ID is used to identify inpatient episodes in conjunction with the patient's medical record number. Applicable to EPAS specific sites. The EPAS Site Visit ID is unique for each hospitalisation
Data Element Concept:	EPAS Site Visit ID

#### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Identifier
<i>Data type:</i>	Number
<i>Format:</i>	N(20)
<i>Maximum character length:</i>	20

#### Collection and usage attributes

*Guide for use:*

#### Data element attributes

---

#### Collection and usage attributes

*Guide for use:* The EPAS Site Visit ID is assigned automatically when a patient is admitted. Assigned ID will be included in EPAS Hospital data extractions

<i>Permissible values:</i>	Value	Meaning
	NNNNNNNNNNNNNNNNNNNN	A valid EPAS Site Visit ID
	00000000000000000000	Fill for an EPAS site
	Null	Fill for a non EPAS site

*Collection methods:* The new EPAS system uses an EPAS Site Visit ID to identify inpatient episodes. The field is 20 characters in length and exceeds the current ISAAC Admission Number field of 8 characters so is required to be able to cross match between the ISAAC system and EPAS and in order to capture the unique key used by EPAS, EPAS Site Visit ID will be included with EPAS sites hospital extract submissions

## Mental Health Accommodation Prior – EPAS sites Only

### Identifying and definitional attributes

<i>Technical name:</i>	Patient—Mental Health accommodation prior, code N
<i>Synonymous names:</i>	ISAAC Supplementary Data Item 103
<i>SAHMR identifier:</i>	SA - AIHW METeOR id 270079 (APMHC NMDS)
<i>Registration status:</i>	
<i>Definition:</i>	The type of physical accommodation the person lived in prior to admission..
Data Element Concept:	Patient—Accommodation prior

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	Number
<i>Format:</i>	N
<i>Maximum character length:</i>	2

#### Permissible values

Code	Description
01	Private Residence
02	Boarding-Rooming House
03	Domestic-Scale Supported Living Facility
04	Homeless – Homeless Persons Shelter
05	Homeless – Boarding-Rooming House
06	Homeless – No Usual Accommodation
07	Homeless – Public Place
08	Hospital – Psychiatric
09	Hospital – Other
10	Independent Unit as part of retirement village or similar
11	Other Supported Accommodation
12	Palliative Care Facility – Hospice
13	Prison-Remand Centre-Youth Training Centre
14	Hostel or Hostel Type accommodation
15	Residential Aged Care Facility – High
16	Residential Aged Care Facility – Low
17	Shelter-Refuge – Not including Homeless persons shelter
18	Specialised Alcohol/Other Drug Treatment Service
19	Specialised Mental Health Community Based Residential Support Service
20	Other Accommodation nec
21	Unable to Determine

#### Collection and usage attributes

<i>Guide for use:</i>	<p>‘The type of physical accommodation the person lived in prior to admission. The data item is to be submitted by EPAS sites only and only needs to be collected for patients separated from designated Mental Health Wards.</p> <ul style="list-style-type: none"><li>• Record the appropriate value as reported by the patient.</li><li>• Should be differentiated from Accommodation Type (Usual).</li><li>• Only required for admissions to designated Mental Health wards.</li></ul>
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Adopt the national definition’s guide for use which is:

- Admitted Patients Mental Health Care NMDS:  
<http://meteor.aihw.gov.au/content/index.phtml/itemId/504646>
- APMHC NMDS data item Accommodation Type (Prior to Admission):

## RUG-ADL Score– Non-acute Care only

### Identifying and definitional attributes

<i>Technical name:</i>	Resource Utilisation Group - Activities of Daily Living Score Code AN [NNNNN]
<i>Short Name</i>	RUG-ADL Score Code
<i>Synonymous names:</i>	ISAAC Supplementary Data Item 104
<i>SAHMR identifier:</i>	SA1588
<i>Registration status:</i>	SA Health, Candidate 01/07/2015
<i>Definition:</i>	The RUG-ADL Score for a patient reflects their functioning ability on admission for Bed Mobility, Toileting, Transfers and Eating. Functional independence is the ability to carry out activities of daily living safely and autonomously.
<i>Data Element Concept:</i>	Patient - Level of Functional Independence Score

### Value domain attributes

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#### Representational attributes

<i>Representation class:</i>	Code
<i>Data type:</i>	String (alpha-numeric)
<i>Format:</i>	NNNNR

### Data element attributes

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#### Collection and usage attributes

*Guide for use:* RUG-ADL Score is a mandatory data element for separations where the Episode of Care is 2 - Maintenance.

The RUG-ADL code for a patient is a combination of scores recorded at admission reflecting functional ability as measured by four activities - Bed Mobility, Toileting, Transfers and Eating.

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

- Bed mobility
- Toileting
- Transfers
- Eating
- R

A code list for all valid RUG-ADLscore codes is available on the ISAAC website [www.sahealth.sa.gov.au/isaac](http://www.sahealth.sa.gov.au/isaac), click on ' Integrated SA Activity Collection (ISAAC) Resources' tab: RUG ADL Listing. The code should be entered as follows:

2	1	3	1	R
---	---	---	---	---

Collection methods:

Without decimal points

Include end alpha characters

Left justify, blank fill

Submit with Condition Onset Flag (COF) = 9 if required

RUG ADL Score is to be captured each and every time a patient begins a Maintenance Care episode except for End of Quarter Administrative Discharges and Readmissions. One RUG-ADL score is required for each Maintenance Care episode.

RUG-ADL is required Nationally for Activity Based Funding of Maintenance (non-acute) Care episodes. Failure to submit the code will impact national funding.

A RUG-ADL Score form has been developed for use by the Medical Records Advisory Unit to assist sites to capture the score. The Medical Records Form code identifier for RUG-ADL Score is MR-RUG. Use of the form is optional at sites discretion.

Due to limitation on the ability for some sites to modify their legacy Patient Administration System ( PAS) the code will be submitted in the first free Additional Diagnosis field in the ISAAC extract from 1/7/2015. Further details are available in the ISAAC 1 July 2015 specification.

If required e.g. due to a site's PAS functionality or business requirements, a corresponding Condition Onset Flag (COF) of 9 may be submitted however this is optional and at the discretion of the hospital.

*Collection  
methods:*

**Related ISAAC Edits**

#4057 – Duplicate RUG ADL submitted - duplicate deleted

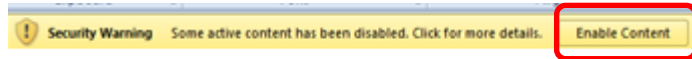
#4058 – RUG ADL Invalid

#2751 - RUG ADL code required for maintenance care episode

#2520 - Additional Diagnosis Code invalid

## Appendix 6: ISAAC Control Log Instructions

- Copy and or Rename the control log to reflect your hospital code and submission month (*right click on file, select rename*) e.g. for WCH July submission rename 000307.xls
- Open control log, click *Enable Content*



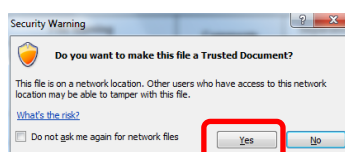
- Click *Enter Data* to prepare the control log
- Follow steps numbered below with step number referenced in screen shots

1. Enter your Name, Email, Phone Number, Fax Number - *only required first time using 15/16 log. Date will default to today's date but you can adjust this if required*
2. Click *Submission Details* tab

Hospital Code	Hospital Name	Records	Month	Year	File Type	Edited	Comments	Rec Len	ICD	Status
0003	WCH	100	Jun	2014	Correctic			746	8th	OK
0003	WCH	200	Jun	2014	New	Resubmi	June re-run	746	8th	OK
0003	WCH	300	Jul	2014	New			746	8th	OK
0003	WCH	400	Apr	2014	Correctic		EOY correction for April	746	8th	OK
0003	WCH	0	Mar	2014	Correctic			746	8th	do not submit this file
0003	WCH	500	Mar	2014	Correctic			746	8th	OK

3. Enter the details about extract submission files (ISAAC data files extracted from your system) you are submitting using the drop down boxes provided
4. Check details entered are correct, status is OK and fix if not – note Zero record files not to be submitted
5. Click OK – *this sorts and transfers details into the control log*
6. Close the form by clicking the X in the top right hand corner of the form

7. If Warning pops up click yes





000TEST7Aug14V2.xls [Compatibility Mode] - Microsoft Excel

File Home Insert Page Layout Formulas Data Review View Developer

C15 WCH

1 INTEGRATED SOUTH AUSTRALIAN ACTIVITY COLLECTION (ISAAC)

2 2013/2014 CONTROL LOG FOR DISPATCH/RECEIPT OF ELECTRONIC DATA SUBMISSION

3 \*\* Failure to submit this completed form with your electronic file will result in a rejected submission \*\*

4

5

6

7 CONTACT PERSON Anna Bent DATE (DD/MM/YY) 11 08 2014

8 No. of files submitted 5 EMAIL anna.bent@health.sa.gov.au PHONE 8226 7323 FAX 8226 8150

9

Order of files to be processed on ISAAC	Hospital Code	Hospital Name	File Naming		Comments	Separations for		Number of records	Record length - 744 or 746	ICD-10-AM Code Version
			Name	Extension		Month	Year			
Example	0003	WCH	000307NEExample	.dat		Jul	2013	2000	746	8th
1st	0003	WCH	000303C1	.txt		Mar	2014	500	746	8th
2nd	0003	WCH	000304C1	.txt	EDV correction for April	Apr	2014	400	746	8th
3rd	0003	WCH	000306C1	.txt		Jun	2014	100	746	8th
4th	0003	WCH	000306N1Resub	.txt	June re-run	Jun	2014	200	746	8th
5th	0003	WCH	000307N1	.txt		Jul	2014	300	746	8th
6th										

10

Record Length: RECORD FORMAT - 746 (for separations from July 2013)

Coding A file must contain only a SINGLE coding version, ie. ICD-10-AM 8th Ed

DATA OPERATIONS CENTRE USE ONLY:

Date Received

ENQUIRIES TO: Information Assembly (08) 8226 7322 isaac@health.sa.gov.au

8. Save the control log

9. Rename your extract submission files (ISAAC data files extracted from your system) as specified in File Naming columns ensuring file extension is changed to .txt

10. Click the Email button to attach this control log to an email

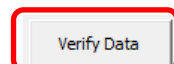
11. Close the control log spreadsheet (left click X on top right hand corner of control log)

12. Attach extract submission files to email (same process as 14/15)

13. Click send to send files to ISAAC Submissions

#### Notes

- If you have saved the control log and exited but wish to reopen the file without clearing the submission data click the Verify Data button when reopening



- More than 6 data submission files** (excluding the Control Log): There are only 6 rows on the control log for you to include your data submission files. If you require more rows (ie have more than 6 files to submit) you must complete a second Control Log or the files will not be recognised by the system.
- Save:** Don't forget to click 'Save' when you have entered your information on the control log.
- Blue email Button:** If your system allows use the 'Blue Button' (i.e. email button) to send your submission. A new email window will open and you will see the email address has been pre-populated and the Control Log automatically attached. Include any additional information and attach the data submission files to this email.

**Email:** If your system does not allow you to use the 'Blue Button', prepare your email and send as you would normally.