Policy Directive

NSW HEALTH

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Admitted Patient Reporting Requirements: Changes from 1 July 2003

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Summary Describes changes to admitted reporting requirements that apply for public sector sites.

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This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

NSW HEALTH
DEPARTMENT

CIRCULAR

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Admitted Patient Reporting Requirements: Changes from 1 July 2003

A. Purpose

A.1 This circular describes changes to admitted patient reporting requirements that apply from 1 July 2003 for public sector sites. This circular should be read in conjunction with Circular 2001/73.

B. Intended Audience

B.1 This document is indended for distribution to all staff involved in public sector patient administration systems, and public sector admitted patient reporting. This includes:

- Inpatient Statistics Collection Coordinators
- DOHRS Coordinators
- Patient Administration System Administrators
- Medical Records Staff, including Clinical Coders
- Health Information Exchange Coordinators
- Business Objects Coordinators
- Hospital & Rural Hospital and Health Service General Managers
- Area Chief Executive Officers

B.2 Recipients of this document within each Area Health Service are requested to ensure a copy of this document is received by all staff in scope of the intended audience listed above. In most cases it is assumed that the nominated ISC Coordinator will take responsibility for the distribution of this document throughout the Area Health Service.

Distributed in accordance with circular list(s):

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In accordance with the provisions incorporated in the Accounts and Audit Determination, the Board of Directors, Chief Executive Officers and their equivalents, within a public health organisation, shall be held responsible for ensuring the observance of Departmental policy (including circulars and procedure manuals) as issued by the Minister and the Director-General of the Department of Health.

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D. Executive Summary

D.1 The key changes from 1 July 2003 are as follows:

- **Urgency of Admission:** There are two new categories to cover admissions for maternity/newborn (without complications), and regular same day procedures (e.g. renal dialysis and chemotherapy).
- **Bed/Unit Type:** New Bed/Unit Type categories have been added to improve the quality of automated DOHRS counts in the HIE. There are two new admitted patient categories – a category for "Emergency Departments Levels 1 & 2"; and a category for "Bassinets" on hospital wards for the accommodation of newborns (usually unqualified newborns). Brain Injury Rehabilitation Units (BIRP) category has been split into Admitted Patient Units and Transitional Living Units, and there are additional categories for Community Residential and Commonwealth block funded Respite Aged Care. Bed/ward transfer transactions between non-admitted and admitted patient beds/wards are not permitted.
- **Service Category:** Service Category "6 – Other Care" will be used only for non-admitted patient care (including Community Residential and Commonwealth Block Funded Residential Aged Care). The "Service Category" of "0 – Boarder" may continue to be used for non-admitted activity if clinical coding is not required.

- **Collaborative Care (Contract) Services:** All admitted patient activity provided by a private facility to public hospital patients under a contractual arrangement must be recorded on the public facility's Patient Administration System and reported to the NSW Health Department.
- **Collaborative Care Facility:** The "Collaborative Care Facility" is a new data item that allows public sector sites to record the other facility that is providing the care in a collaborative care (or contract care) service delivery situation.
- **Clinical Coding (HOSPAS/WinPAS):** For sites reporting activity using HOSPAS or WinPAS the "Additional Diagnosis" fields will be used for External Cause, Activity when Injured and Place of Occurrence codes, and be coded the order specified in the national coding standards. To support this change there will be an increased number of fields for coding complex cases and adverse events. A new field "Diagnosis Onset Type" will be available for recording adverse events but this is for local use and is not a mandatory State data item.
- **Infant Weight:** The requirement to reporting "Infant weight" has been increased to all infants less than 365 days and less than 9000 grams.
- **Country**: There are changes to the names of selected countries in line with national standards.

D.2 The benefits of the changes to the collection are as follows:

- Ability to comply with the national standard for "Urgency of Admission" for interstate comparisons;
- Ability to monitor and assess "Hospital in the Home" activity;
- Ability to quantify, monitor and assess contracts with private facilities;
- Ability to identify non-admitted and community residential activity delivered at public hospital campuses and reported on Patient Administration Systems; and
- Improved accuracy of automated DOHRS activity counts for admitted patients.

E. New and Changed Data Items

E.1 The following data items have changed name, have new categories, changed category definitions, or changed business rules:

- Collaborative Care Status (previously "Contract Status")
- Infant Weight (previously "Admission Weight")
- Service Category
- Procedure Location
- Additional Diagnoses
- Bed/Unit Type (previously "Service Unit Type")
- Urgency of Admission (previously "Admission Status" or "Emergency Status")
- Country (for "Country of Birth" and "Country of Usual Residence")

E.2 The following reference tables have annual updates:

- Facility Code (for “Facility Transferred To” and “Facility Referred From”
- Locality / Postcode (for “Usual Address of Residence”)

E.3 The following data items are new from 1 July 2003:

- Collaborative Care Facility
- Diagnosis Onset Type (HOSPAS & WinPAS only – not mandatory)

F. Urgency of Admission

F.1 New categories for “Urgency of Admission” have been added and the category definitions of existing categories have been modified.

F.2 The purpose of this change is to ensure NSW data complies with national standards (thereby improving accuracy of inter-State comparisons), and standardise reporting for obstetric/newborns and regular same day planned procedures.

F.3 The new classification is as follows:

- 1 – Emergency
- 2 – Non-Emergency/Planned
- 3 – Other/Urgency Not Assigned
- 4 – Maternity/Newborn #
- 5 – Regular Same Day Planned Admission #

# indicates a new category.

F.4 The following category definitions have been changed:

- 1 – Emergency
  - Includes: all admissions that are required within 24 hours of initial diagnosis.
  - Includes: all admissions where the patient has a booking, but the condition has deteriorated and at time of re-assessment, required an admission within 24 hours.
  - Includes: obstetric/newborn admissions where there are obvious complications at the time of presentation (including pre-term admissions).
  - Excludes: obstetric/newborn admissions for normal delivery where the patient did not have a booking at the hospital.

    - Excludes: admissions that were not clinically required within 24 hours but were nevertheless admitted within 24 hours of the diagnosis because a bed was available immediately.

- 2 – Planned/Non-Emergency
    - Includes: all admissions that are not required within 24 hours of the diagnosis, other than obstetric/newborn and regular same day admissions (e.g. renal dialysis and chemotherapy).
    - Includes: admissions that were not clinically required within 24 hours but were nevertheless admitted within 24 hours of the diagnosis because a bed was available immediately.
    - Excludes: obstetric/newborn admissions for normal delivery regardless of whether or not the patient had a booking for the delivery at the hospital.

- 3 – Other/No Urgency Assigned
    - Includes: Only admitted patient transfers from another admitted patient facility.

- 4 – Maternity/Newborn
    - Includes: maternity/newborn admissions for normal delivery regardless of whether or not the patient had a booking for the delivery at the hospital.

- 5 – Regular Sameday Planned Admissions
    - Includes: regular same day planned admissions (e.g. renal dialysis and chemotherapy).

G. Collaborative Care Status

G.1 The data item “Contract Status” has been renamed “Collaborative Care Status”. “Collaborative Care Status” captures all admitted patient activity where:

- the service is provided by two or more public facilities, where one public facility provides a sameday service;
- the admitted patient service is provided by a private sector site under a contract arrangement with a public hospital or an Area Health Service (except for Hawkesbury Hospital and Port Macquarie Hospital); and
- the public sector site performs an admitted patient service on behalf of a private facility.

G.2 The purpose of this change is to ensure public patient activity is appropriately accounted for and reported, in line with national reporting standards. The change will provide information that will identify:

- the role each facility plays in a collaborative care arrangement (purchaser / requestor of the service, or provider of the service); and

- the type of the collaborative care arrangement (full care or part care, two public facilities, or one public and one private facility).

G.3 For HOSPAS and WinPAS sites the new classification (in the August 2003 release) is accompanied by functionality that allows patient to be admitted at two facilities simultaneously in a shared patient master index environment. This change supports the occupation of a community residential bed, and an admitted patient bed at the same time.

G.4 The new classification is as follows:

- 0 – Single Admitted Patient Facility Care
- 3 – Full Care Purchased from a Private Facility
- 4 – Part Care Purchased from a Private Facility
- 5 – Part Care Obtained from another Public Facility
- 7 – Part Care Provided for a Public Facility
- 8 – Part Care Provided for a Private Facility
- R – Community Residential

G.5 Both the purchaser/requestor of the service and the provider of a collaborative care admitted patient service must admit the patient and report the collaborative care activity, except where the service is provided under a contract with Hawkesbury or Port Macquarie Hospitals.

G.6 Where a patient is admitted to one public facility, transferred to another public facility for a same day service, and then returns to the original facility for a continuation of admitted patient care, the first facility should report the "Collaborative Care Status" as "5 – Part Care Obtained from another Public Facility" and the second facility should report the same day service with a "Collaborative Care Status" of "7 – Part Care Provided for a Public Facility".

G.7 A continuous admitted patient service provided by two public facilities where the patient stays overnight at the second facility, is not covered under the concept of "Collaborative Care". This event should continue to be reported as a formal discharge from the first public hospital, and a transfer/admission to the second hospital. Both sites report the "Collaborative Care Status" as "0 – Single Admitted Patient Facility Care".

H. Collaborative Care Facility

H.1 A new data item titled "Collaborative Care Facility" has been added to the collection. This data item captures the other facility involved in providing continuous admitted patient care under a collaborative care, or contract, arrangement.

H.2 The purpose of this new data item is to identify the facilities involved in collaborative care and contract care arrangements in NSW. This new data item will support improved monitoring and assessment of contracts with private sector sites, and support initiatives to improve the reporting of contracted care services by private sector sites.

H.3 The “Collaborative Care Facility” must be reported (in the standard 4 character facility code format) where the “Collaborative Care Status” is one of the following:

- 3 – Full Care Purchased from a Private Facility
- 4 – Part Care Purchased from a Private Facility
- 5 – Part Care Obtained from another Public Facility
- 7 – Part Care Provided for a Public Facility
- 8 – Part Care Provided for a Private Facility

I. Bed/Unit Type

I.1 New categories have been added to the “Bed/Unit Type” classification (previously “Service Unit Type”).

I.2 The purpose of this change is to improve the accuracy of automated DOHRS activity counts for admitted patients. Specifically the new categories will ensure that:

- non-admitted (including community residential) activity is separately identified from admitted patient activity,
- activity in Emergency Departments of all levels is assigned both the correct cost weight, and the correct Financial Program;
- bed days are counted for newborns accommodated on the ward

I.3 The new “Bed/Unit Type” categories are as follows:

- 51 – Respite – High: Commonwealth Block Funded
- 52 – Respite – Low: Commonwealth Block Funded
- 53 – Transitional Living Unit (BIRP)
- 54 – Mental Health Community Residential
- 55 – Other Community Residential
- 58 – Emergency Department – Level 1 and 2
- 60 – Bassinet

I.4 Categories that have been renamed and have a revised definition are:

- 17 – Emergency Department Level 3 and Above
- 08 – Brain Injury Rehabilitation Program – Inpatient
- 29 – Collaborative Care Provider – General
- 30 – Collaborative Care Provider – Drug & Alcohol
- 32 – Collaborative Care Provider – Mental Health

I.5 Some “Bed/Unit Type” categories are designated by the NSW Health Department and therefore are to be used by a limited number of facilities only. A listing of the facilities with designated beds/units is provided in the detailed instructions for Bed/Unit Type.

I.6 It is important that Bed and Ward mappings to the “Bed/Unit Type” classification are correct as “Bed/Unit Type” is used to derive “Financial Program” and “Institution Type” for DOHRS reporting, and for assigning correct cost weights to activity for episode funding.

J. Service Category

J.1 The definition of the Service Category “6 – Other Care” has been changed such that only non-admitted patient care (including Community Residential and Commonwealth Funded Residential Aged Care) is in scope of the category “6 – Other Care”.

J.2 It is not mandatory to report unit record level data for non-admitted (including community residential care) activity via a patient administration system. Sites that do elect to record this activity on their patient administration system typically do so because the services are co-located with admitted patient wards on the public hospital campus, and the site wishes to use the system for patient tracking, bed management, dietary services, billing, and monitoring of patient activity.

J.3 It is appropriate to use “Service Category” of “6 – Other Care” when the site requires clinical coding to be attached to the non-admitted patient activity, or where there is a requirement for DOHRS statistics reports (e.g. from HOSPAS or WinPAS). Where neither clinical coding or DOHRS statistics reports are required for local purposes, “0 – Boarder” may also be used for reporting the non-admitted (including community residential care) activity.

J.4 As a guide all activity in the following Bed/Unit Types must be reported with a “Service Category” of either “6 – Other Care” or “0 – Boarder” if recorded on a patient administration system:

- 14 – Commonwealth Block Funded Residential Aged Care – High
- 23 – Commonwealth Block Funded Residential Aged Care – Low
- 51 – Commonwealth Residential Aged Care Respite – High
- 52 – Commonwealth Residential Aged Care Respite – Low
- 53 – Transitional Living Unit (BIRP)
- 54 – Mental Health Community Residential
- 55 – Community Residential Other

J.5 From 1 July 2003, any admitted patient activity previously reported as “6 – Other Care” (such as drug and alcohol or respite care) must be reported under a more appropriate “Service Category” such as “3 – Rehabilitation” or “4 – Maintenance Care”.

J.6 The purpose of this change is to ensure non-admitted, community residential, and Commonwealth Block funded Residential Aged Care activity is easily identified, and excluded from admitted patient activity reporting. The change also allows sites who wish to use the DOHRS reports in HOSPAS and WinPAS for non-admitted, community residential and residential aged care activity reporting.

K. Legal Status

K.1 From 1 July 2003, the legal status of involuntary mental health patients should be recorded as involuntary even if the patient is admitted to a bed that is not a designated psychiatric bed.

K.2 Involuntary patients may be admitted to beds/units that are not designated as psychiatric beds/units if they require additional treatment and/or care that is unable to be delivered in the designated psychiatric bed/unit (for example, ECT).

K.3 Where an involuntary patient of a public psychiatric hospital is transferred to another hospital for treatment in a bed that is not a designated psychiatric bed, the patient must remain admitted to the designated psychiatric bed and be placed on leave until the patient returns from the treating hospital, or the involuntary legal status expires (which ever is earlier). The new "Collaborative Care Status" functionality will support a dual admissions to two facilities (see "Collaborative Care Status" field).

L. Infant Weight

L.1 For admissions dated from 1 July 2003, the data item "Admission Weight" has been renamed "Infant Weight" and the scope of the patients for whom this data item must be reported has been increased. These changes align the NSW collection with the National Health Data Dictionary standards and the reporting requirements of the National Minimum Data Set for Admission Patient Care.

L.2 "Infant Weight" is the first weight of the live-born baby obtained after birth, or the weight of the neonate or infant on the date of the commencement of the episode of care for infants whose episode of care did not commence with birth.

L.3 The infant weight at the time of commencement of each episode of care must be recorded for every infant that:

- Weighs less than, or equal to, 9000 grams at the time the episode of care commences; AND
- Is aged less than 365 days.

L.4 For live births, the birth weight should preferably be measured within the first hour of life before significant post-natal weight loss has occurred.

L.5 The infant's weight should be recorded to the same degree of accuracy as indicated by the instrument used to measure the weight.

M. Procedure Location

M.1 New categories have been added to "Procedure Location". This change supports the identification of procedures performed in the patient's home under a "Hospital in the

Home” program, and of procedures performed on behalf of another public or private facility (under a Collaborative Care arrangement).

M.2 The revised classification is as follows:

- 1 – This Facility as a Direct Service
- 2 – Other Facility as an Admitted Patient
- 3 – Other Facility as a Non-admitted Patient
- 4 – Patient’s Home as an Admitted Patient #
- 5 – This Facility on behalf of a Public Hospital #
- 6 – This Facility on behalf of a Private Facility #

# Indicates that the category is new from 1 July 2003.

M.3 All procedures performed on an admitted patient basis to patients in a “Hospital in the Home” program must have an associated “Procedure Location” of “4 – Patient’s Home as an Admitted Patient”.

M.4 Categories “5 – This Facility on behalf of a Public Hospital” and “6 – This Facility on behalf of a Private Facility” must but be used for procedures performed on behalf of another facility under a contract or collaborative care arrangement. These “Procedure Location” categories are only valid when the “Collaborative Care Status” is “7 – Part Care Provided for a Public Facility” or “8 – Part Care Provided for a Private Facility”.

N. Clinical Coding

N.1 For separations dated from 1 July 2003, in line with the national coding standards, “External Cause of Injury or Poisoning”, “Activity when Injured” and “Place of Occurrence” codes should be coded in the “Additional Diagnosis” fields following the Diagnosis to which they relate.

N.2 To support this change, there will be an increase in the number of Diagnosis and Procedure codes in HOSPAS and WinPAS. PIMS and Cerner have no limit in the number of Diagnosis and Procedure codes.

O. Diagnosis Onset Type

O.1 As part of the change to the Disease Index, HOSPAS and WinPAS will have a new indicator field (“Diagnosis Onset Type”) for each Diagnosis. This field is not mandatory for reporting, however it allows sites to set a qualifier for each coded diagnosis to indicate the onset and/or significance of the diagnosis to the episode of care.

O.2 The purpose of this additional field is to improve analysis of diagnostic information, especially in relation to patient safety and adverse event monitoring.

O.3 The classification is as follows:

- 1 – Primary Condition
- 2 – Post Admit Condition
- 9 – Unknown / Uncertain

O.4 The “Diagnosis Onset Type” for an injury or diagnosis code should be classified as “1 – Primary Condition” for:

- a condition present on admission such as the presenting problem, a comorbidity,chronic disease or disease status; or
- for neonates, a condition present at birth; or
- a previously existing condition not diagnosed until the current episode of care; or
- for delivered obstetric cases, all conditions which arise from the beginning of labour to the end of second stage.

O.5 The “Diagnosis Onset Type” for an injury or diagnosis code should be classified as “2 – Post Admit Condition” for any condition which arose during the episode of care being reported and would not have been present on admission. In some cases this may be the Principal Diagnosis.

O.6 The “Diagnosis Onset Type” for an injury or diagnosis code should be classified as “9 - Unknown / Uncertain” if the documentation for the condition does not support assignment of any other category.

O.7 For external cause, place of occurrence and activity codes, the Diagnosis Onset Type should match that of the corresponding injury or disease code. The “Diagnosis Onset Type” flag on morphology codes should match that on the corresponding neoplasm code.

P. Recording of Inter Hospital Transfer Deaths

P.1 Where a patient dies during transportation from one hospital to another during an inter hospital transfer where the patient had been admitted at the first hospital immediately prior to the transfer, and was not on leave at the first hospital at the time of death, the following reporting guidelines should be followed:

- If a hospital vehicle was used to transport the patient, or the patient was under the direct care of sending hospital staff in a private vehicle, and the patient dies en route:
  - the time of discharge/transfer at the sending hospital must be the time the patient died; and
  - the “Mode of Separation”, must be “Death without Autopsy” or “Death with Autopsy”.
- If an Ambulance Service vehicle was used to transport the patient, or the patient was transported in a private vehicle without the accompaniment of sending hospital staff, and the patient dies en route:

- the time of discharge/transfer at the sending hospital is the time patient leaves the sending hospital; AND
- The “Mode of Separation” must be "Transferred to other Hospital”

P.2 Patients who are dead on arrival to hospital must not be admitted to the hospital to which the patient was being transferred to, but any service provided (e.g. to confirm the patient is dead) may be reported as a non-admitted patient occasion of service.

P.3 Where a patient dies while on leave, the “Mode of Separation” must be set to either “Died with Autopsy” or “Died without Autopsy”.

Q. Cancer Notifications

Q.1 The “Pathology Laboratory Name” or “Pathology Laboratory Code” field must be completed for all Cancer Notifications.

Q.2 Where “Best Basis for Diagnosis” is “3 – Other”, and there are no pathology laboratory results, the Pathology Laboratory should be reported as “Z995 – Not Applicable”, not left blank.

Q.3 The morphology code “M8000/3” should be reported where coding needs to be completed but the pathology laboratory results have not been received. When the pathology laboratory results have been received, the record should be updated with a new “Morphology of Primary Site of Cancer” code.

Q.4 A Cancer Notification will remain incomplete and in error if it has a “Morphology of Primary Site of Cancer” code of “M8000/3”, the “Best Basis for Diagnosis” is not “3 – Other” and the “Pathology Laboratory” is not “Z995 – Not Applicable”.

R. Facility Reference Table

R.1 The reference table of facility codes used for the data items “Facility Referred From” and “Facility Transferred To” has been updated to include new facilities that have opened, merged or changed names in the past 12 months.

R.2 The purpose of this change is to ensure that facility codes and names are available for staff for the purpose of accurately reporting the facility from which patient was referred, or to which patient is being transferred. It also will support accurate reporting of the other facility providing the admitted patient service where care is provided under a “Collaborative Care” arrangement.

R.3 The facilities opened after 1 July 2002.

Code	Name of Facility (including open date)
A391	Sydney Eastern Eye Centre (13/1/2003)
B408	Perfect Vision Eye Surgery (18/12/2002)
C392	Sydney Retina Clinic & Day Surgery (13/12/2002)
D392	Healthwoods Specialist Centre (19/9/2002)

H391	Taree Community Dialysis Centre (4/11/2002)
L382	Orange Day Surgery Centre (18/11/2002)
Q389	Pendlebury Clinic (28/10/2002)

R.4 As part of a review of the reporting of Commonwealth block funded residential aged care, additional facility codes may need to be added to the facility reference table. A separate circular will announce those facility codes and the start date for establishing reporting under those codes. Following the commencement of reporting under the new codes, those additional facility codes must be added to the facility reference table in each patient administration system.

S. Country

S.1 In recent years there have been some changes to countries in the Standard Australian Classification of Countries (SACC). These changes affect the data items “Country of Birth” and “Country of Address”. The areas of change are outlined in this section. In addition, the codes for “not further defined” categories are provided.

S.2 HOSPAS does not use the SACC codes for data entry, however the codes used for HOSPAS are converted to SACC codes on upload to the Health Information Exchange. Changes to country categories in HOSPAS and WinPAS are made by the Department and will be issued with software enhancements. PIMS and Cerner system administrators should confirm that all listed countries in this section are available and have the correct label.

S.3 The country “Federal Republic of Yugoslavia” (SACC code “3213”) must now be referred to as “Serbia and Montenegro”. This change maintains compliance with the Standard Australian Classification of Countries, and should be applied to all displays of country on patient labels, records, and computer systems.

S.4 The table below shows the country names and codes for all countries in South Eastern Europe.

Code	Country
3201	Albania
3202	Bosnia and Herzegovina
3203	Bulgaria
3204	Croatia
3205	Cyprus
3206	Former Yugoslav Republic of Macedonia (FYROM)
3207	Greece
3208	Moldova
3211	Romania
3212	Slovenia
3213	Serbia and Montenegro

S.5 The table below shows the country names and codes for all countries in Maritime South-East Asia.

Code	Country
5201	Brunei Darussalam
5202	Indonesia
5203	Malaysia
5204	Philippines
5205	Singapore
5206	East Timor

S.6 The table below shows the country names and codes for all countries in Chinese Asia (includes Mongolia).

Code	Country
6101	China (excludes SARs and Taiwan Province)
6102	Hong Kong (SAR of China)
6103	Macau (SAR of China)
6104	Mongolia
6105	Taiwan

S.7 The following should also be noted about the countries in the table above:

- **Macau**: Macau reverted to China on 20 December 1999, and therefore has a label change.
- **Taiwan**: While Australia acknoweldges the position of the Chinese Government that Taiwan is a province of China, the Standard Australian Classification of Countries specifies that the nomenclature remains "Taiwan" for any activity reported as "6105", and the category "6105 – Taiwan" may still be included in display values for "Country". This is consistent with advice from the Department of Foreign Affairs and Trade.

S.8 The table below shows the country names and codes for supplementary country categories.

Code	Country
0000	Inadequately Described
0001	At Sea
0002	Not Elsewhere Classified
0003	Not Stated

S.9 For the country "1199 – Australian External Territories, nec" two additional display categories should be created as shown in the table below. For reporting "1199" should always be displayed with a label of "Australian External Territories, nec".

Code	Country
1199	Australian External Territories, nec
1199	Christmas Island
1199	Cocos (Keeling Islands)

S.10 The table below shows additional categories that should be added to display values of "Country" in systems where the "Country" reported by the client may be of inadequate detail to report in full.

Code	Country
1300	Melanesia, nfd
1400	Micronesia, nfd
1500	Polynesia (excludes Hawaii), nfd
1600	Antarctica, nfd
2100	United Kingdom, nfd
2300	Western Europe, nfd
2400	Northern Europe, nfd
3100	Southern Europe, nfd
3200	South Eastern Europe, nfd
3300	Eastern Europe, nfd
4100	North Africa, nfd
4200	Middle East, nfd
5100	Mainland South-East Asia, nfd
5200	Maritime South-East Asia, nfd
6000	North-East Asia, nfd
7100	Southern Asia, nfd
7200	Central Asia, nfd
8100	Northern America, nfd
8200	South America, nfd
8300	Central America, nfd
8400	Caribbean, nfd
9100	Central and West Africa, nfd
9200	Southern and East Africa, nfd

T. Management of Data Quality

T.1 The Health Information Exchange (HIE) is designed to maintain consistency between source system data, and data that is used for reporting by the AHS and Department. This design means that data errors can only be corrected in the source system by hospital staff, and that Department staff are unable to change the HIE data reported by Area Health Services.

T.2 In this environment, Area Health Services are responsible for the quality of the data they report to the NSW Health Department. There are two types of error that Area Health Service staff are responsible for:

- Operational Errors: Errors made by staff at the time of data entry
- Source System Setup Errors: Errors in the mapping of local classifications to State standard classifications, or errors in the design of local classifications, such as failure of the classification to have all inclusive, and mutually exclusive, categories.

T.3 While high priority errors need to be corrected by the due dates, Area Health Services should also introduce a data quality improvement program that has a goal of reducing and/or preventing operational errors over time. Addressing errors through a prevention program will reduce the cost of correcting data and result in earlier availability of reliable data for decision making and performance indicators.

T.4 The most effective data quality improcement programs consist of four elements:

- **Staff Awareness:** Advising the staff member, and/or unit, of the errors they have made.
- **Coaching & Support:** Advising the staff member who made the error of the correct reporting procedure.
- **Practice:** The staff member, and/or unit, responsible for the error should correct the records in error to reinforce the correct value or work process.
- **Work Process Review:** At a higher level, consider whether work process, work flow, or operational guidelines contributed to the error being made and make any adjustments that may prevent the future errors.

T.5 "System Setup Errors" may lead to gross data quality errors over extended periods of time. In all Patient Administration Systems the following data items have local classifications which the system administrator must map to State standard classifications:

- Doctors
- Beds and/or Wards
- Financial Class
- Indicator Procedure Codes

T.6 For Area Health Services using PIMS and Cerner Patient Administration Systems, all data items must be built and mapped in line with the agreed State standards. The lead sites (HAHS, WSAHS, SWSAHS and CSAHS) are required to comply with the standards agreed with the Data Mangement Section. All other Areas must comply with the specifications of a State standard build of each product. Such standards may apply to both the local display values, and also the mapping of those display values to the State master values.

T.7 It is the system administrator, not the staff who enter data, who is responsible for preventing, and correcting, "system setup errors". The classifications and mappings to State standards must be carefully checked and monitored regularly. Where a mapping error has occurred, it should be corrected, and data should then be re-extracted and re-loaded into the HIE.

U. Further Information

U.1 Detailed instructions for the data items described in this document are available on the NSW Health Deparmtent's Intranet "HealthNet". See the URL below:

- http://internal.health.nsw.gov.au/im/ims/isc/

U.2 For clarification of the changes to the order of clinical coding, contact:

- Joanne Chicco
  Senior Consultant, Clinical Data
  Phone: (02) 9391 9684
  E-mail: jchic@doh.health.nsw.gov.au.

U.3 For clarification of all other instructions, contact:

- Janet Kesby
  Project Officer, Patient Administration Systems
  Phone: (02) 9391 9081
  E-mail: jkesb@doh.health.nsw.gov.au.

Robyn Kruk
Director-General