

# Specifications for revisions to the Elective Surgery Information System (ESIS) for 1 July 2007

March 2007

**FINAL DRAFT**

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Melbourne, Victoria

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# Executive Summary

This document details the revisions to the Elective Surgery Information System (ESIS) for 1 July 2007. These revisions are summarised below:

1. Replace ASCCSS Country codeset with SACC Country codeset for Country of Residence reported in the Locality field to standardise across collections.
2. Reason for Scheduled Admission Date Change - revised codeset to capture more specific information on the reasons patients have their elective surgery postponed.
3. Multi-attribute Prioritisation Tool (MAPT) - a score derived by the MAPT tool (a tool to assess patients requiring joint replacement surgery on a 0-100 point scale by differentiating levels of severity). This score can be used to assist ranking, priority and state-wide resource allocation.
4. Planned Length of Stay - revised codeset will differentiate intended 23-hour stay episodes from other intended lengths of stay, to assist in the monitoring of the intention to facilitate "23-hour stay" episodes.

# Introduction

## The need for ESIS modifications

From 1 July 2007, changes to the Elective Surgery Information System (ESIS) are necessary to assist Victorian health program monitoring, planning and policy development by the Department of Human Services (DHS).

Comments from hospitals and software suppliers regarding the content of the document *Proposals for Revisions to ESIS, December 2006* have been taken into account and where possible, suggestions have been accommodated. Items presented in the *Proposals for revisions to ESIS* may be altered from their initial presentation in that document.

## Distribution and components of this document

This document will be distributed to all Victorian hospitals, software suppliers known to have Victorian clients, and to a range of industry bodies and DHS staff. It provides the following information:

- Amended, deleted and new concept definitions, data items and business rules.
- Reference files to be updated for 1 July 2007.
- End of financial year considerations.

Victorian hospitals are required to arrange for their software to be modified in accordance with the revised specifications.

The current *ESIS Manual, 9<sup>th</sup> Edition, July 2006* may be accessed on the Internet at <http://www.health.vic.gov.au/hdss/esis/2006-07/manual/index.htm>

Any questions related to this document may be directed to the HDSS Help Desk on 9096 8141, or [HDSS.Help-Desk@dhs.vic.gov.au](mailto:HDSS.Help-Desk@dhs.vic.gov.au).

## Orientation to this document

- New values and definitions relating to existing items appear in boxes
- ~~Redundant values and definitions relating to existing items are struck through.~~
- *[Comments relating only to the proposal document appear in square brackets and italics.]*
- Page numbers representing cross-referencing to another section of the ESIS Manual are represented by a #.
- Further information such as the background to each specified change, is provided.

## Amended/New/Deleted Data Definitions

# Introduction of SACC Country Codeset

<b>Revision Summary</b>	Introduction of SACC codeset to meet Commonwealth Reporting requirements, and for consistency with other data collections. <b>In ESIS this change affects only the Locality field, and only for those records where the patient's country of residence is not Australia.</b>
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**Implementation Date** 1 July 2007

**Implementation Notes** The change will align ESIS with:

- the NHDD
- other DHS data collections, such as VINAH
- HealthSMART.

It will also facilitate Commonwealth reporting requirements.

Like the ASCCSS codeset, the SACC codeset uses a four-digit numeric code to represent countries. Many codes are duplicated between the two classifications but represent different countries. Therefore, HDSS will be undertaking a data quality analysis to identify services that appear not to have updated their codeset prior to sending July 2007 data.

It is not intended this change introduce extra work for data collection staff rather that it be managed in hospital systems' reference tables.

All patient-level extracts with a Postcode of 8888 and an extract end date greater than or equal to 1 July 2007 must be submitted using the SACC codeset.

A spreadsheet mapping SACC codes to the ASCCSS codes is available for download from:  
<http://www.health.vic.gov.au/hdss/reffiles/index.htm>

# Reason for Scheduled Admission Date Change - revised codeset

<b>Revision Summary</b>	Introduction of an extended codeset to explain with more specificity, the reasons patients have their elective surgery postponed.
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**Implementation Date** 1 July 2007

**Implementation Notes** At present health services use a variety of different lists of reasons for Scheduled Admission Date (SAD) change. The classifications are inconsistent and ambiguous. To promote consistency of reporting, the Health Services and the Department have developed a common list of reasons for Scheduled Admission Date Change to be implemented across the sector by 1 July 2007.

At present there are only seven values in the Reason for Scheduled Admission Date Change codeset. These are very broad and do not give adequate insight into the reasons a patient's surgery is postponed. These will be replaced by seventeen new values to reflect the values agreed to by the sector.

All "Reason SAD Changed" intra episode event records with an Event Date that is greater or equal to 1 July 2007 must report codes from the revised codeset. All "Reason SAD Changed" intra episode event records with an Event Date less than 1 July 2007 must report codes from the previous codeset.

Appendix A provides a table for mapping between the new codeset and the previous one.

Specifications for any changes to KPI calculations relating to Reason For Scheduled Admission Date Change data are not within the scope this document. Please contact the Department for further details.

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# Reason For Scheduled Admission Date Change (Amended)

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## Specification

<b>Definition</b>	The reason this episode's Scheduled Admission Date has been revised or cancelled.		
<b>Label</b>	Event_Value		
<b>Field size</b>	N/A	<b>Valid values</b>	Code from Reason Scheduled Admission Date Change code set
<b>Reported in</b>	Intra Episode Table		
<b>Reported for</b>	All waiting list episodes where the Scheduled Admission Date has been revised or cancelled.		
<b>Reported when</b>	The decision is made not to admit the patient on the Scheduled Admission Date. The Event Date reported with this field MUST represent the date on which the cancellation decision was made, NOT the date of data entry (which may be some time after the event).		

**Code set**

**Reason For Scheduled Admission Date Change**

<i>Code</i>	<i>Descriptor</i>	<i>Code Valid With Event Dates</i>	
		<i>From</i>	<i>To</i>

**Hospital Initiated Postponement**

H	Hospital	01071980	30062007
D	Surgeon	01071980	30062007
100	Surgeon unavailable	01072007	Null
101	Surgical unit initiated	01072007	Null
102	Hospital staff unavailable	01072007	Null
103	Ward bed unavailable	01072007	Null
104	Critical care bed unavailable	01072007	Null
105	Equipment unavailable	01072007	Null
106	Theatre overbooked	01072007	Null
107	Theatre over-run	01072007	Null
108	Emergency priority	01072007	Null
109	Elective priority	01072007	Null

110	Hospital/surgeon has not prepared patient	01072007	Null
111	Clerical/Booking error	01072007	Null

### Other Postponement

A	Administrative change before patient notification	01071980	30062007
X	Admission postponed, surgery date unchanged	01071980	30062007
C	Clinical	01071980	30062007
P	Patient	01071980	30062007
120	Patient is unprepared	01072007	Null
121	Patient deemed unfit	01072007	Null
122	Patient has postponed	01072007	Null
123	Patient has failed to attend	01072007	Null
124	Admission postponed, surgery date unchanged	01072007	Null

### Scheduled Admission Date Brought Forward

F	Booking brought forward	01071980	30062007
130	Booking brought forward	01072007	Null

### Reporting guide

Report the most appropriate reason the patient's Scheduled Admission Date has been changed or cancelled.

Reason For Scheduled Admission Date Change must be reported with Event Type *Reason SAD Changed*, Event Date and SAD Identifier.

Where multiple reasons for Scheduled Admission Date change exist, select the most appropriate code.

The decision not to admit a patient as scheduled, will be made between the date the scheduling takes place and the date for which the admission is scheduled. While an admission cannot be cancelled after it has occurred, it is possible that the awaited procedure may be cancelled after the planned admission has commenced. In these instances the "Reason SAD Changed" event should reflect the reason the procedure was cancelled, and the Event Date can be later than the date of the admission. This will trigger an S287 Notifiable ("Scheduled Admission Date Exceeded").

If a booking (the setting of a Scheduled Admission Date) is entered onto the system **but not communicated to the patient**, and a decision is made not to proceed with that booking, the booking should be DELETED rather than reported as a booking and cancellation.

***The following alpha codes are only valid for event dates prior to 1 July 2007. For a more detailed explanation of their use refer to previous versions of the ESIS manual.***

<b>H</b>	<b>Hospital</b>
<b>D</b>	<b>Surgeon</b>
<b>A</b>	<b>Administrative change before patient notification</b>
<b>C</b>	<b>Clinical</b>
<b>P</b>	<b>Patient</b>
<b>X</b>	<b>Admission postponed, surgery date unchanged</b>
<b>F</b>	<b>Booking brought forward</b>

**H *Hospital***

~~Admission (where the patient *has* been given a Scheduled Admission Date) has been postponed because the operating room, hospital bed, staff or other hospital resource is unavailable, for example, because of the need to treat other patients in the hospital. Hospital resource includes prostheses for implantation, etc, but not blood (see code *C Clinical*).~~

~~*Excludes:* A Scheduled Admission Date postponed because of unavailability of a hospital resource and the patient has *not* been given a Scheduled Admission Date, (assign code *A Administrative change before patient notification*).~~

**D *Surgeon***

~~Admission (where the patient *has* been given a Scheduled Admission Date) has been postponed because the surgeon booked to perform this procedure has cancelled their scheduled theatre time.~~

~~*Excludes:* A Scheduled Admission Date postponed because the surgeon has cancelled their theatre time and the patient has *not* been given a Scheduled Admission Date, (assign code *A Administrative change before patient notification*).~~

**A *Administrative change before patient notification***

~~A tentative Scheduled Admission Date allocated to a patient (where the patient has not been notified) has now changed. This code must not be used if the patient has been advised of the Scheduled Admission Date.~~

**C *Clinical***

~~The surgeon has assessed the patient as being temporarily not Ready for Care due to a change in their clinical condition. This code is also used if the Scheduled Admission Date change is caused by shortage of blood for transfusion.~~

**P *Patient***

~~Booking is postponed at the request of the patient for personal, social or other non-clinical reasons.~~

**100** ***Surgeon unavailable***

The surgeon booked to perform the procedure has cancelled some or all of their scheduled theatre time due to leave, illness, lateness or being called away.

Where the postponement is due to leave, the surgeon has not informed the hospital within a timeframe that prevents the patient from being booked and informed of their date for surgery.

**101** ***Surgical unit initiated***

Surgery postponed due to surgeon/registrar preference to perform surgery on another patient.

Do not use this code where surgery is postponed because of the need to perform surgery on a patient of higher clinical urgency (use *Emergency priority* or *Elective priority*).

Use this code when the surgeon/registrar initiates the postponement and it is not due to leave, illness, lateness or being called away, or higher priority patient.

**102** ***Hospital staff unavailable***

Insufficient hospital staff (nurses, anaesthetists, non-clinical staff).

Report this code for Industrial action.

**103** ***Ward bed unavailable***

A bed (other than a critical care bed) is not available in the hospital.

**104** ***Critical care bed unavailable***

A critical care bed (intensive care, coronary care or high dependency) is not available in the hospital.

**105** ***Equipment unavailable***

Equipment (including power or water) is unavailable or has failed, or prosthesis for implantation is unavailable.

**106** ***Theatre overbooked***

Too many cases scheduled in the planning of the list. If the postponement is due to an unintentional list overrun because cases took longer than anticipated, report *Theatre over-run*.

**107** ***Theatre over-run***

Unintentional list over-run due to cases taking longer than anticipated.

**108** ***Emergency priority***

Rescheduled due to a higher priority emergency patient requiring surgery.

Includes:

- Emergency patients currently admitted
- Patients presenting via the emergency department
- Obstetric emergencies.

**109** ***Elective priority***

Rescheduled due to a higher priority elective patient requiring surgery. Includes elective patients seen in outpatients or private rooms.

**110** ***Hospital/Surgeon has not prepared patient***

Further preoperative workup is required.

This code is only to be reported when the patient has been insufficiently prepared for surgery by the hospital/surgeon. Where the patient has not prepared sufficiently report *Patient unprepared*.

**111** ***Clerical/Booking Error***

The patient has been incorrectly advised of date of surgery. A clerical/booking error occurred, for example incorrect patient, date or time.

**120** ***Patient is unprepared***

The patient has not adhered to the required preparations for surgery, for example has eaten or not done bowel preparation.

**121** ***Patient deemed unfit***

The patient has been assessed as unwell by a general practitioner, surgeon, anaesthetist or other clinical staff.

Includes:

- Surgeon's assessment that patient is temporarily not ready for care due to a change in their clinical condition
- Shortage of blood for transfusion
- Anaesthetic complications.

Excludes:

- Patient declaring themselves unwell.

**122** ***Patient has postponed***

Surgery postponed at the request of the patient for personal reasons, or because **they have declared themselves unwell**.

**123** ***Patient has failed to attend***

Surgery postponed because the patient has failed to attend.

**\* 124** ***Admission postponed, surgery date unchanged***

**124**

Patient was admitted after the Scheduled Admission Date, but the procedure was performed on the day originally planned

**F 130** ***Booking brought forward***

**130**

Patient's Scheduled Admission Date has been brought forward for any reason.

<b>Edits</b>	S297	Reason For Scheduled Admission Date Change Invalid
	S287	Scheduled Admission Date Exceeded
	S391	Intra Episode Event Value For Reason SAD Changed Invalid
	S417	Scheduled Admission Date Changed Without Reason For Change
	S418	Reason For SAD Change Reported But No Admission Currently Scheduled
	S429	SAD Identifier/Event Type Mismatch
<b>Related items</b>	Section 2: <i>Hospital Initiated Postponement, Hospital Initiated Postponement Ratio and Postponement.</i>	
	Section 3: <i>Event Type, Event Date and SAD Identifier.</i>	
	Section 4: <i>Scheduling.</i>	
	Section 5: <i>Structure.</i>	

## Administration

<b>Purpose</b>	Used to monitor waiting list management.		
<b>Principal data users</b>	Access and Metropolitan Performance Branch, DHS (Vic).		
<b>Collection start</b>	July 1997	<b>Version</b>	1 (Effective 1 July 1997)
			2 (Effective 1 July 2005)
			3 (Effective 1 July 2007)
<b>Definition source</b>	Access and Metropolitan Performance Branch, DHS (Vic).	<b>Code set source</b>	DHS

# Multi-attribute Prioritisation Tool (MAPT) Score

<b>Revision Summary</b>	Utilising a score generated from an 11-item questionnaire to rank patients who are listed to have hip and knee replacement surgery on a 0-100 point scale by differing levels of severity.
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**Implementation Date** 1 July 2007

**Implementation Notes** The MAPT score is generated by an algorithm based on responses to an 11-item questionnaire. It is not necessary for vendors to implement the MAPT scoring algorithm. The requirement is that the scores generated by it can be reported to ESIS.

Patients can have multiple MAPT assessments during a given waiting episode, and it is useful to be able to know the scores for all of them, and when they occurred. Therefore the reporting of MAPT Scores will be treated as Intra Episode Events. They must be reported as an Event Value in the Intra Episode Events extract and therefore must be accompanied by:

- An Episode Identifier,
- An Event Type ("MAPT"),
- An Event Date (the date on which the assessment was done NOT the date of data entry)

The SAD Identifier field should be blank (Null).

Note that the edit S384 (Invalid Event Date) will remain unchanged. The Event Dates relating to the MAPT Event Type must still be reported as being between the Clinical Registration Date and the Removal Date. It is possible for the patient to receive MAPT assessments that fall outside this range. If a MAPT assessment was done before the Clinical Registration Date and it is relevant to this waiting episode, report the Clinical Registration Date as the event date. If a MAPT assessment is done after the patient has been removed, do not report it.

Hospitals may validly report MAPT scores that existed prior to 1 July 2007 provided the Event Dates pass Edit S384.

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# Multi-attribute Prioritisation Tool (MAPT) Score (New)

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## Specification

<b>Definition</b>	A score used to assist in prioritising, monitoring and service planning for patients who may require joint replacement surgery. It is a value between 0 and 100 and is derived from patient responses to an 11-item questionnaire using an underlying algorithm.										
<b>Label</b>	MAPT										
<b>Field size</b>	7	<b>Layout</b>	<i>NNN.NNN</i>  Leading and trailing zero filled, numeric characters and decimal point only								
<b>Reported in</b>	Intra Episode Table as an Event Value.										
<b>Reported for</b>	Waiting list episodes where the patient undergoes one or more MAPT assessments.										
<b>Reported when</b>	Report a new MAPT Intra Episode Event each time a MAPT assessment is conducted. The event date reported must represent the date of the MAPT assessment UNLESS the MAPT score being reported occurred prior to the Clinical Registration Date (see reporting guide).										
<b>Reporting guide</b>	<p>Report the number that the MAPT tool generates zero filled as appropriate. For example, report a score of 2.3 as 002.300</p> <p>If a MAPT score exists at the Clinical Registration Date, report that value with the Clinical Registration Date as the Event Date. For example, if a patient had a MAPT assessment of 033.933 on 2 November 2007 and was clinically registered on 16 December 2007 and the MAPT was still current on this date, report the following Intra Episode event:</p> <table border="1"><thead><tr><th>Episode ID</th><th>Event Date</th><th>Event Type</th><th>Event Value</th></tr></thead><tbody><tr><td>000123456</td><td>16122007</td><td>MAPT</td><td>033.933</td></tr></tbody></table> <p>Although MAPT assessments may continue after removal, do not report where the date of the MAPT assessment is greater than the Removal Date.</p>			Episode ID	Event Date	Event Type	Event Value	000123456	16122007	MAPT	033.933
Episode ID	Event Date	Event Type	Event Value								
000123456	16122007	MAPT	033.933								
<b>Edits</b>	S383 Multiple Events Of Same Type For Same Episode On One Day S384 Invalid Event Date S385 Invalid Event Type <u>S431 Intra Episode Event Value For MAPT Invalid</u>										
<b>Related items</b>	Section 3: <i>Clinical Registration Date, Event Date, Event Value and Removal Date.</i>  Section 5: <i>Structure.</i>										

## Administration

<b>Purpose</b>	To support the evidence based allocation of resources for patients awaiting hip or knee joint surgery.		
<b>Principal data users</b>	DHS		
<b>Collection start</b>		<b>Version</b>	1
<b>Definition source</b>	DHS	<b>Code set source</b>	DHS

## Event Type

### Specification

**Definition** The types of Intra Episode Events that may occur multiple times within a waiting episode.

**Label** Event\_Type

**Field size** N/A **Valid values** Code from Event Type code set

**Reported in** Intra Episode Table

**Reported for** All events reported in Intra Episode Table.

**Reported when** An Intra Episode event occurs and is reported in the Intra Episode Table with an Event Date, Event Value and Episode Identifier.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	Urgency	Clinical Urgency (set or reset)
	Readiness	Readiness For Care (set or reset)
	Set SAD	Scheduled Admission Date (set or reset)
	Reason SAD Changed	Reason For Scheduled Admission Date Change
	MAPT	Multi-attribute Prioritisation Tool Score

**Reporting guide** Intra Episode Events may occur multiple times within a waiting episode, but there can only be one event per episode per day for Readiness, Clinical Urgency or MAPT. For example, only one change in Clinical Urgency can be reported per episode per day.

Scheduling events (Set SAD and Reason SAD Changed) can be reported as having occurred more than once per day provided the SAD Identifier is unique for each pair of bookings and cancellations within an episode.

Note that when an episode is first registered (clinically), it will have an

initial Clinical Urgency category and a Readiness For Care value. The Event Dates for these should be the same as the Clinical Registration Date.

Each Intra Episode Event will have an Event Value that is relevant to the Event Type. For example, valid values when setting Clinical Urgency (the Event Type) are 1 *Urgent*, 2 *Semi-Urgent* and 3 *Non-Urgent*.

### **Edits**

- S287 Scheduled Admission Date Exceeded
- S295 Date Of Admission Not Equal To Scheduled Admission Date
- S296 Reason For Removal Implies Procedure Performed, But Not Ready For Care
- S315 Clinical Urgency Cat 1, Wait More Than 30 Days
- S375 Clinical Urgency Category For ESAS Reason For Removal Invalid
- S383 Multiple Events Of Same Type For Same Episode On One Day
- S385 Invalid Event Type
- S389 Intra Episode Event Value For Clinical Urgency Change Invalid
- S390 Intra Episode Event Value For Readiness Change Invalid
- S391 Intra Episode Event Value For Reason SAD Changed Invalid
- S392 Intra Episode Event Value For Set SAD Event Invalid
- S412 Episode Registered Without A Clinical Urgency
- S413 Episode Registered Without A Readiness For Care Value
- S417 Scheduled Admission Date Changed Without Reason For Change
- S418 Reason For SAD Change Reported But No Admission Currently Scheduled
- S427 SAD Identifier Previously Reported For This Episode
- S429 SAD Identifier/Event Type Mismatch
- S431 Intra Episode Event Value For MAPT Invalid

### **Related items**

Section 3: *Clinical Registration Date, Event Date, Event Value, Clinical Urgency, Readiness For Care, Scheduled Admission Date, Reason For Scheduled Admission Date Change* and *SAD Identifier*.

Section 5: *Structure*.

## **Administration**

### **Purpose**

To identify the type of events relevant to ESIS that happened to Waiting List patients for a given episode.

### **Principal data users**

DHS

### **Collection start**

July 2005

### **Version**

1 (Effective 1 July 2005)

### **Definition source**

DHS

### **Code set source**

DHS

# Planned Length of Stay Codeset Revision

<b>Revision Summary</b>	To capture episodes that have a proposed 23-hour stay. Expand the existing codeset to capture a planned 23 hour stay and multi-day stay as separate items.
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**Implementation Date** 1 July 2007

**Implementation Notes** Sites will be able to continue to validly report Code 2 (*Planned Overnight*) only where the episode has a Clinical Registration Date that falls before 1 July 2007. All other codes can validly be reported for any episode regardless of Clinical Registration Date.

## Planned Length Of Stay (Amended)

### Specification

**Definition** The intention of the responsible clinician at the time the patient is placed on the waiting list, to separate (discharge) the patient either on the day of admission or a subsequent date.

**Label** Planned\_Length\_Of\_Stay

**Field size** N/A **Layout** N

**Reported in** Episode Table

**Reported for** All waiting list episodes.

**Reported when** The waiting list episode is first registered and updated when the planned length of stay is revised during the waiting episode.

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	<b>Clinical Registration Date between:</b>	
			<b>Start date</b>	<b>End date</b>
	1	Planned same day	01071980	Null
	2	Planned overnight	01071980	30062007
	3	Planned 23 hour stay	01071980	Null
	4	Planned multiday stay	01071980	Null

**Reporting guide** May be altered at any time during the waiting episode, for example, after a clinical review of the patient or because a procedure that had been considered multi-day is now being performed on a same-day basis.

The field represents planning during the waiting period, not intention, as decided on day of admission therefore the field must not be altered at, or after, admission regardless of any change in planned length of stay apparent at that time. In such an event, the ESIS Planned Length of Stay and the VAED Intended Duration of Stay will differ.

**Edits** S167 Planned Length Of Stay Invalid  
S404 Removal Date Is After Admission Date, But Planned Same Day

**Related items**

## Administration

**Purpose** Used in calculation of DOSA rates: the denominator is 'Total number of elective surgery admissions that were planned overnight'.

**Principal data users** DHS, AIHW and the Commonwealth Department of Health and Aged Care.

<b>Collection start</b>	July 1997	<b>Version</b>	1 (Effective 1 July 1997)
			2 (Effective 1 July 1999)
			2 (Effective 1 July 2002)

<b>Definition source</b>	National Health Data Committee	<b>Code set source</b>	NHDD
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## Appendix A

### Reason for Scheduled Admission Date Change - Mapping Table

<i>Code set</i>	<b>Reason For Scheduled Admission Date Change</b>		
	<i>Code</i>	<i>Descriptor</i>	<i>Codes for Event Dates Prior to 1 July 2007.</i>
<b>Hospital Initiated Postponement</b>			
	100	Surgeon unavailable	D
	101	Surgical unit initiated	D
	102	Hospital staff unavailable	H
	103	Ward bed unavailable	H
	104	Critical care bed unavailable	H
	105	Equipment unavailable	H
	106	Theatre overbooked	H
	107	Theatre over-run	C
	108	Emergency priority	H
	109	Elective priority	H
	110	Hospital/surgeon has not prepared patient	D
	111	Clerical/Booking error	H
<b>Other Postponement</b>			
	120	Patient is unprepared	P
	121	Patient deemed unfit	C
	122	Patient has postponed	P
	123	Patient has failed to attend	P
	124	Admission postponed, surgery date unchanged	X
<b>Scheduled Admission Date Brought Forward</b>			
	130	Booking brought forward	F

Note that where code "A" was used previously, for events with event dates greater than 30 June 2007, an intra-episode event delete should be used.