Commissioning and Performance

KEY PERFORMANCE INDICATORS

Master Definition Document

2024 - 2025

Government of South Australia

SA Health

Contents

Version Control

Version No.	Changes Made	By Whom	Date
V1.0	First iteration	Lauren Bell	15/9/2020
V2.0	Updated KPIs where definitions or targets were previously unavailable.	Lauren Bell	21/12/2020
V3.0	Updated to reflect 2021/2022 KPIs	Lincy Varghese	30/09/2021
V4.0	Updated to reflect 2022/2023 KPIs	Chris Killington	01/09/2022
V5.0	Updated to reflect 2023/2024 KPIs	Chris Killington	27/06/2023
V6.0	Updated KPI IDs and additional KPIs for 2024/2025	Damian Robinson	01/07/2024

Timely Access to Care

Ambulance to Emergency Department

Hours Lost due to Transfer of Care Delays > 30 minutes

Identifying and definitional attributes

Short Name:	TOC Delay- Hours Lost
Tier:	Tier 1
KPI ID:	TAC-AED-T1-1
Description:	Total ambulance hours lost due to delays in the transfer of care of patients from ambulance paramedic to a major metropolitan hospital ED where the transfer of care exceeds 30 minutes.
Computation:	Count (#) of hours lost caused by Transfer of Care delays where Transfer of Care time exceeds 30 minutes

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- SALHN: FMC, NHS
- NALHN: LMH, MH
- WCHN: WCH

Benchmarks:

Hours lost due TOC delays > 30 minutes (SA Specific KPI)
Target <= 200% ramping target

CALHN <=800hrs / month

Target	≤800	>800 and <=880	>880
Performance Score	5	2.5	0

NALHN<=500hrs / month

Target	≤500	>500 and <=550	>550
Performance Score	5	2.5	0

SALHN <= 520hrs / month

Target	≤520	>520 and <=570	>570
Performance Score	5	2.5	0

WCHN <=30 hrs / month

Target	≤30	>30 and <=40	>40
Performance Score	5	2.5	0

Representation Class: Count (#)

Data Type:	Real
Unit of Measure:	Hours
Data Source:	SAAS CAD as per OIU database and supplied by SAAS
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Transfer of care is deemed complete only when clinical handover has occurred between hospital staff and paramedics, the patient has been offloaded from the ambulance stretcher and/or the care of the ambulance paramedics is no longer required. > Hours lost will be counted in minutes where Ambulance At Hospital Time > 30 minutes until a Transfer of Care time is recorded. > Includes patients arriving at ED where the ambulance incident priority is: • P1 • P2 • P3 • P4 • P5 > Excludes patients arriving at ED where the ambulance incident priority is: • P6 • P7 • P8 > Data with missing timestamps is excluded.
Related Information:	> Service Agreements 2024-25 SA Health

Patients with Delayed Transfer of Care ≥ 1 hour (%)

Identifying and definitional attributes

Short Name:	Transfer of Patient Care >1 Hours
Tier:	Tier 2
KPI ID:	TAC-AED-T2-1
Description:	Percentage (%) of patients arriving by ambulance whose care is transferred from ambulance paramedic to emergency department (ED) clinician is delayed by greater than 1 hour of ambulance arrival at a metropolitan public hospital.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients arriving by ambulance where the difference between patient time of arrival at a metropolitan public hospital and time of transfer of care from ambulance paramedic to ED clinician is greater than 1 hour (60 minutes).
Denominator:	Count (#) of patients who arrived at a metropolitan public hospital by ambulance.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- SALHN: FMC, NHS
- NALHN: LMH, MH
- WCHN: WCH

Benchmarks:

% / no. of patients with delayed transfer of care (TOC) => 1 hour
Target = (SA specific KPI)

Target	≤10%	>10 and ≤15%	>15%
Performance Score	2.5	1.25	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Services Type
Data Source:	SAAS CAD as per OIU database
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:

> Transfer of care is deemed complete only when clinical handover has occurred between hospital staff and paramedics, the patient has been offloaded from the ambulance stretcher and/or the care of the ambulance paramedics is no longer required.

> Includes patients arriving at ED where the ambulance incident priority is:

- P1
- P2
- P3

	• P4 • P5 > Excludes patients arriving at ED where the ambulance incident priority is: • P6 • P7 • P8 > Data with missing timestamps is excluded.
Related Information:	> Service Agreements 2024-25 SA Health

Transfer Of Patient Care ≤ 30 Minutes

Identifying and definitional attributes

Short Name:	ED Transfer of Patient Care ≤30MIN
Tier:	Tier 2
KPI ID:	TAC-AED-T2-2
Description:	Percentage (%) of patients arriving by ambulance whose care is transferred from ambulance paramedic to emergency department (ED) clinician within 30 minutes of ambulance arrival at a metropolitan public hospital.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients arriving by ambulance where the difference between patient time of arrival at a metropolitan public hospital and time of transfer of care from ambulance paramedic to ED clinician is less than or equal to 30 minutes.
Denominator:	Count (#) of patients who arrived at a metropolitan public hospital by ambulance.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- SALHN: FMC, NHS
- NALHN: LMH, MH
- WCHN: WCH

Benchmarks:

TOC <= 30 mins
Target 66% (NEAT KPI 90%)

Target	≥66%	55%	45%	30%	15%	<15%
Performance Score	2.5	2	1.5	1	0.5	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Services Type
Data Source:	SAAS CAD as per OIU database
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:

> Transfer of care is deemed complete only when clinical handover has occurred between hospital staff and paramedics, the patient has been offloaded from the ambulance stretcher and/or the care of the ambulance paramedics is no longer required.

> Includes patients arriving at ED where the ambulance incident priority is:

- P1
- P2
- P3
- P4
- P5

	> Excludes patients arriving at ED where the ambulance incident priority is: • P6 • P7 • P8 > Data with missing timestamps is excluded.
Related Information:	> Service Agreements 2024-25 SA Health

SAAS Transports who had a Transfer of Care (TOC) > 180 minutes

Identifying and definitional attributes

Short Name:	SAAS Transports TOC > 180 minutes
Tier:	Monitor
KPI ID:	TAC-AED-M-1
Description:	Total number (#) of SAAS Ambulance Transfers where the Transfer of Care (TOC) from Ambulance to Emergency Department exceeds (>) 180 minutes (3 Hours).
Computation:	Count (#) of SAAS Ambulance Transfers where the Transfer of Care (TOC) from Ambulance to Emergency Department exceeds (>) 180 minutes (3 Hours).

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH
Benchmarks:	
Representation Class:	Count (#)
Data Type:	Real
Unit of Measure:	Transports
Data Source:	SAAS CAD as per OIU database and supplied by SAAS
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Transfer of care is deemed complete only when clinical handover has occurred between hospital staff and paramedics, the patient has been offloaded from the ambulance stretcher and/or the care of the ambulance paramedics is no longer required. > Hours lost will be counted in minutes where Ambulance At Hospital Time > 30 minutes until a Transfer of Care time is recorded. > Includes patients arriving at ED where the ambulance incident priority is: • P1 • P2 • P3 • P4 • P5 > Excludes patients arriving at ED where the ambulance incident priority is: • P6 • P7 • P8 > Data with missing timestamps is excluded.
Related Information:	> Service Agreements 2024-25 SA Health

Emergency Department

Emergency Department Length of Stay ≤ 4 Hours - Non-Admitted

Identifying and definitional attributes

Short Name:	ED LOS ≤4HR Non-admitted
Tier:	Tier 1
KPI ID:	TAC-ED-T1-1
Description:	Percentage (%) of patient presentations to an emergency department (ED) where the time from presentation to the time of physical departure, i.e., the length of the ED stay, is less than or equal to four hours (240 Mins).
Computation:	(Numerator/Denominator)*100
Numerator:	ED LOS ≤4HR Non-admitted: Count (#) of ED presentations who were not subsequently admitted from an ED where the visit time is less than or equal to 4 hours (240 minutes).
Denominator:	ED LOS ≤4HR Non-admitted: Count (#) of ED presentations who were not subsequently admitted from an ED.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- NALHN: LMH, MH
- SALHN: FMC, NHS
- WCHN: WCH
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mt Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Regional Target	≥90%	85%	80%	75%	70%	<70%
Metro Target	≥80%	70%	60%	50%	40%	<40%
Performance Score	5	4	3	2	1	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)

Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Length of stay is calculated as the difference between the Presentation Date/Time and the Physical Departure Date/Time. > Patients who are transferred to Extended Emergency Care Unit (EECU), as an admitted patient or as Inpatient Overflow, are classified as leaving ED at the time of their EECU Arrival Date/Time. > ED LOS ≤ 4HR Non-admitted: Percentage of presentations who were not subsequently admitted from an ED where the time from presentation to the time of physical departure, i.e., the length of the ED stay, is less than or equal to four hours. > Non-admissions are calculated as the total number of presentations with Departure Status: • Advised of Alternate Treatment Options (AATO) • Did Not Wait to be seen (DNW) • Died within ED (includes DOA with resus) • Episode Complete-Home • Episode Complete-Nursing Home • Episode Complete-Other • Left at own risk after treatment started • Not Stated/Unknown • Transfer out of this hospital to another. > Standard Emergency Department Business Rules are applied (refer to Appendix A).
Related Information:	> National Healthcare Agreement: PI 21b–Waiting times for emergency hospital care: proportion of patients whose length of emergency department stay is less than or equal to four hours, 2022. https://meteor.aihw.gov.au/content/740838 > Australian Health Performance Framework: PI 2.5.7–Waiting times for emergency department care: percentage of patients whose length of emergency department stay is 4 hours or less, 2020 https://meteor.aihw.gov.au/content/728373 > Service Agreements 2024-25 SA Health

Emergency Department Presentations Seen Within Clinically Recommended Time - Overall

Identifying and definitional attributes

Short Name:	ED Seen on Time (Overall)
Tier:	Tier 2
KPI ID:	TAC-ED-T2-1
Description:	Percentage (%) of patients who are treated within national benchmarks for waiting times for each triage category in a public hospital emergency department (ED).
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients presenting at an ED who commenced treatment within the nationally specified benchmark.
Denominator:	Count (#) of patients presenting at an ED.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- SALHN: FMC, NHS
- NALHN: LMH, MH
- WCHN: WCH
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mt Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Metro Target	≥70%	65%	60%	55%	50%	<50%
Performance Score	2.5	2	1.5	1	0.5	0

Target	≥85%	<85% and >=80%	<80%
Performance Score	2.5	1.25	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Data excludes patients classified as: • Did not wait • Advised of Alternate Treatment Options and

	• Dead on arrival, no resuscitation. > Standard Emergency Department Business Rules are applied (refer to Appendix A). > Benchmarks have been informed by Health Round Table (HRT) peer group data and Report on Government Services (RoGS) data.
Related Information:	> Service Agreements 2024-25 SA Health

Emergency Department Length of Stay ≥ 24 Hours

Identifying and definitional attributes

Short Name:	ED LOS >24HR
Tier:	Tier 2
KPI ID:	TAC-ED-T2-2
Description:	Count (#) of breaches where Emergency Department Length of Stay was Greater Than 24 Hours.
Computation:	Count (#) of occurrences where Emergency Department Length of Stay was Greater Than 24 Hours during the assessment period.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH
Benchmarks:	Quarterly Target: ≤50 | 70 | 90 | 110 | 130 | >130 Performance Score: 2.5 | 2 | 1.5 | 1 | 0.5 | 0
Representation Class:	Count (#)
Data Type:	Integer
Unit of Measure:	Episode
Data Source:	Commissioning
Frequency of Reporting:	Annual (i.e., July to June data reported in July of the following year)
Notes:	> Length of stay is calculated as the difference between the Presentation Date/Time and the Physical Departure Date/Time. > Patients who are transferred to Extended Emergency Care Unit (EECU), as an admitted patient or as Inpatient Overflow, are classified as leaving ED at the time of their EECU Arrival Date/Time. > Standard Emergency Department Business Rules are applied
Related Information:	> Service Agreements 2024-25 SA Health

Emergency Department Presentations Seen Within Clinically Recommended Time Per Triage Category

Identifying and definitional attributes

Short Name:	ED Seen on Time: Triage Cat 1 ED Seen on Time: Triage Cat 2 ED Seen on Time: Triage Cat 3 ED Seen on Time: Triage Cat 4 ED Seen on Time: Triage Cat 5
Tier:	Triage Cat 1: Monitor Triage Cat 2: Monitor Triage Cat 3: Monitor Triage Cat 4: Monitor Triage Cat 5: Monitor
KPI ID:	TAC-ED-M-1 TAC-ED-M-2 TAC-ED-M-3 TAC-ED-M-4 TAC-ED-M-5
Description:	Percentage (%) of patients who are treated within national benchmarks for waiting times for each triage category in a public hospital emergency department (ED).
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients presenting at an ED who commenced treatment within the nationally specified benchmark for their clinically assigned triage category.
Denominator:	Count (#) of patients presenting at an emergency department within the same clinically assigned triage category.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- SALHN: FMC, NHS
- NALHN: LMH, MH
- WCHN: WCH
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mt Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Triage Category 1 Target	=100%
Triage Category 2 Target	≥80%
Triage Category 3 Target	≥75%
Triage Category 4 Target	≥70%
Triage Category 5 Target	≥70%

	Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> The maximum waiting times for each triage category are specified by the Australasian College for Emergency Medicine (ACEM) as: • Triage Cat 1: Resuscitation – seen within seconds, calculated as less than or equal to 2 minutes • Triage Cat 2: Emergency – seen within 10 minutes • Triage Cat 3: Urgent – seen within 30 minutes • Triage Cat 4: Semi-urgent – seen within 60 minutes • Triage Cat 5: Non-urgent – seen within 120 minutes. > Data excludes patients classified as: • Did not wait • Advised of Alternate Treatment Options • Dead on arrival, no resuscitation. > Standard Emergency Department Business Rules are applied (refer to Appendix A).
Related Information:	> National Healthcare Agreement: PI 21a–Waiting times for emergency hospital care: proportion seen on time, 2022 https://meteor.aihw.gov.au/content/740840 > Australian Health Performance Framework: PI 2.5.5–Waiting times for emergency department care: proportion seen on time, 2020 https://meteor.aihw.gov.au/content/728367 > Service Agreements 2024-25 SA Health

Emergency Department Length of Stay ≤ 6 Hours

Identifying and definitional attributes

Short Name:	ED LOS ≤ 6HR Overall ED LOS ≤ 6HR Admitted ED LOS ≤ 6HR Non-admitted
Tier:	Monitor Monitor Monitor
KPI ID:	TAC-ED-M-6 TAC-ED-M-7 TAC-ED-M-8
Description:	Percentage (%) of patient presentations to an emergency department (ED) where the time from presentation to the time of physical departure, i.e., the length of the ED stay, is less than or equal to six hours.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of ED presentations who were not subsequently admitted from an ED where the visit time is less than or equal to 6 hours (360 minutes).
Denominator:	Count (#) of ED presentations who were not subsequently admitted from ED.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH • BHFLHN: Gawler, South Coast, Mount Barker • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Northern Yorke (Wallaroo)
Benchmarks:	Metro Target ≥85% Regional Target ≥90% Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:	> Length of stay is calculated as the difference between the Presentation Date/Time and the Physical Departure Date/Time. > Patients who are transferred to Extended Emergency Care Unit (EECU), as an admitted patient or as Inpatient Overflow, are classified as leaving ED at the time of their EECU Arrival Date/Time. > Admissions are calculated as the total number of presentations with Departure Status: Admission to ward and Admission within ED. > Percentage of presentations who were not subsequently admitted from an ED where the time from presentation to the time of physical departure, i.e., the length of the ED stay, is less than or equal to six hours. > Non-admissions are calculated as the total number of presentations with Departure Status: • Advised of Alternate Treatment Options (AATO) • Did Not Wait to be seen (DNW) • Died within ED (includes DOA with resus) • Episode Complete-Home • Episode Complete-Nursing Home • Episode Complete-Other • Left at own risk after treatment started • Not Stated/Unknown • Transfer out of this hospital to another. > Standard Emergency Department Business Rules are applied
Related Information:	> Australian Health Performance Framework: PI 2.5.6–Waiting times for emergency department care: waiting times to commencement of clinical care, 2020 https://meteor.aihw.gov.au/content/728369 > Australian Health Performance Framework: PI 2.5.5–Waiting times for emergency department care: proportion seen on time, 2020 https://meteor.aihw.gov.au/content/728367 > Service Agreements 2024-25 SA Health

Emergency Department Average Visit Time (Hours)

Identifying and definitional attributes

Short Name:	ED Average Visit Time (Hours) - Overall ED Average Visit Time (Hours) - Admitted ED Average Visit Time (Hours) - Non-Admitted
Tier:	Monitor Monitor Monitor
KPI ID:	TAC-ED-M-9 TAC-ED-M-10 TAC-ED-M-11
Description:	Average Visit Time (Hours) of a patient presentation to an emergency department (ED).
Computation:	(Numerator/Denominator)
Numerator:	Sum (#) of Total ED Visit Time.
Denominator:	Count (#) of ED Presentations.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH • BHFLHN: Gawler, South Coast, Mount Barker • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Northern Yorke (Wallaroo)
Benchmarks:	N/A
Representation Class:	Mean (Average)
Data Type:	Real
Unit of Measure:	Hours
Data Source:	Emergency Department Data Collection (EDDC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Visit Time (Hours) is calculated as the difference between the Presentation Date/Time and the Departure Date/Time.

	> Patients who are transferred to Extended Emergency Care Unit (EECU), as an admitted patient or as Inpatient Overflow, are classified as leaving ED at the time of their EECU Arrival Date/Time. > Admissions are calculated as the total number of presentations with Departure Status: Admission to ward, Admission to EECU and Admission within ED. > Non-admissions are calculated as the total number of presentations with Departure Status: • Advised of Alternate Treatment Options (AATO) • Did Not Wait to be seen (DNW) • Died within ED (includes DOA with resus) • Episode Complete-Home • Episode Complete-Nursing Home • Episode Complete-Other • Left at own risk after treatment started • Not Stated/Unknown • Transfer out of this hospital to another. > Standard Emergency Department Business Rules are applied
Related Information:	> Service Agreements 2024-25 SA Health

Emergency Department Length of Stay ≤ 4 Hours - Overall

Identifying and definitional attributes

Short Name:	ED LOS ≤4HR Overall
Tier:	Monitor
KPI ID:	TAC-ED-M-12
Description:	Percentage (%) of patient presentations to an emergency department (ED) where the time from presentation to the time of physical departure, i.e., the length of the ED stay, is less than or equal to four hours (240 Mins).
Computation:	(Numerator/Denominator)*100
Numerator:	ED LOS ≤4HR Overall: Count (#) of ED presentations where the visit time is less than or equal to 4 hours (240 minutes).
Denominator:	ED LOS ≤4HR Overall: Count (#) of ED presentations.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • NALHN: LMH, MH • SALHN: FMC, NHS • WCHN: WCH • BHFLHN: Gawler, South Coast, Mount Barker • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Northern Yorke (Wallaroo)
Benchmarks:	

Regional Target	≥90%	85%	80%	75%	70%	<70%
Metro Target	≥80%	70%	60%	50%	40%	<40%
Performance Score	5	4	3	2	1	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:	> Length of stay is calculated as the difference between the Presentation Date/Time and the Physical Departure Date/Time. > Patients who are transferred to Extended Emergency Care Unit (EECU), as an admitted patient or as Inpatient Overflow, are classified as leaving ED at the time of their EECU Arrival Date/Time. > ED LOS ≤ 4HR Overall: Percentage of presentations where the time from presentation to the time of physical departure, i.e., the length of the ED stay, is less than or equal to four hours. > Standard Emergency Department Business Rules are applied (refer to Appendix A).
Related Information:	> National Healthcare Agreement: PI 21b–Waiting times for emergency hospital care: proportion of patients whose length of emergency department stay is less than or equal to four hours, 2022. https://meteor.aihw.gov.au/content/740838 > Australian Health Performance Framework: PI 2.5.7–Waiting times for emergency department care: percentage of patients whose length of emergency department stay is 4 hours or less, 2020 https://meteor.aihw.gov.au/content/728373 > Service Agreements 2024-25 SA Health

Inpatient

Emergency Department Length of Stay ≤ 4 Hours - Admitted

Identifying and definitional attributes

Short Name:	ED LOS ≤4HR Admitted
Tier:	Tier 1
KPI ID:	TAC-IP-T1-1
Description:	Percentage (%) of patient presentations to an emergency department (ED) where the time from presentation to the time of admission, i.e., the length of the ED stay, is less than or equal to four hours.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of ED presentations who were subsequently admitted from an ED where the visit time is less than or equal to six hours (240 minutes).
Denominator:	Count (#) of ED presentations who were subsequently admitted from an ED.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH • BHFLHN: Gawler, South Coast, Mount Barker • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Northern Yorke (Wallaroo)
Benchmarks:	

Metro Target	≥50%	40%	30%	25%	20%	<20%
Regional Target	≥85%	65%	45%	40%	30%	<30%
Performance Score	5	4	3	2	1	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:	> Length of stay is calculated as the difference between the Presentation Date/Time and the Physical Departure Date/Time. > Patients who are transferred to Extended Emergency Care Unit (EECU), as an admitted patient or as Inpatient Overflow, are classified as leaving ED at the time of their EECU Arrival Date/Time. > Admissions are calculated as the total number of presentations with Departure Status: Admission to ward and Admission within ED. > Percentage of presentations who were not subsequently admitted from an ED where the time from presentation to the time of physical departure, i.e., the length of the ED stay, is less than or equal to six hours. > Non-admissions are calculated as the total number of presentations with Departure Status: • Advised of Alternate Treatment Options (AATO) • Did Not Wait to be seen (DNW) • Died within ED (includes DOA with resus) • Episode Complete-Home • Episode Complete-Nursing Home • Episode Complete-Other • Left at own risk after treatment started • Not Stated/Unknown • Transfer out of this hospital to another. > Standard Emergency Department Business Rules are applied
Related Information:	> National Healthcare Agreement: PI 21a–Waiting times for emergency hospital care: proportion seen on time, 2022. https://meteor.aihw.gov.au/content/740840 > Australian Health Performance Framework: PI 2.5.6–Waiting times for emergency department care: waiting times to commencement of clinical care, 2020 https://meteor.aihw.gov.au/content/728369 > Service Agreements 2024-25 SA Health

General Bed Long Stay Beds Length of Stay ≥ 21 Days (%)

Identifying and definitional attributes

Short Name:	LOS ≥ 21 Days
Tier:	Tier 2
KPI ID:	TAC-IP-T2-1
Description:	The proportion of total bed days that are occupied by long stay consumers in relation to the total bed days for the referenced General Beds represented as a percentage (%).
Computation:	(Numerator/Denominator)*100
Numerator:	Sum of (General Bed) Bed Days with a length of stay greater than or equal to 21 Days within the reporting period (Long Stay Bed Days).
Denominator:	Sum of (General Bed) Bed Days within reporting period (Total Bed Days).

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- NALHN: LMH, MH
- SALHN: FMC, NHS
- BHFLHN: Gawler, Mount Barker, South Coast
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mt Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie & Northern Yorke (Wallaroo)

Benchmarks:

Metro Target	≤13%	15%	17%	19%	21%	>21%
Regional Target	≤8%	10%	12%	14%	16%	>16%
Performance Score	2.5	2	1.5	1	0.5	0

Representation Class:	Percentage
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:	**Inclusion Criteria** > Acute Episode of Care Type ONLY > Medical & Surgical DRGs > General Beds ONLY **Exclusion Criteria** > Specialist Beds (Burns, Coronary Care, Critical Care, Emergency (EECU), GEM, Intensive Care, Mental Health, Neonatal, Obstetrics, Paediatrics, Palliative Care & Rehabilitation) > Episodes including HITH & RITH. > Hours (Days) in ICU > U DRGS (Mental Health) > Error DRGs **Additional Data** > The count (#) of episodes with a length of stay greater than or equal to 21 days within the reporting period will also be provided within the Inpatient.xlsx workbook
Related Information:	> Service Agreements 2024-25 SA Health > Definition broadly based on the Health Round Table definition for long stay share of bed days. https://home.healthroundtable.org/

General Bed Long Stay Beds Length of Stay ≥ 100 Days (%)

Identifying and definitional attributes

Short Name:	LOS ≥ 100 Days
Tier:	Monitor
KPI ID:	TAC-IP-M-1
Description:	The proportion of total bed days that are occupied by long stay consumers in relation to the total bed days for the referenced General Beds represented as a percentage (%).
Computation:	(Numerator/Denominator)*100
Numerator:	Sum of (General Bed) Bed Days with a length of stay greater than or equal to 100 Days within the reporting period (Long Stay Bed Days).
Denominator:	Sum of (General Bed) Bed Days within reporting period (Total Bed Days).

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • NALHN: LMH, MH • SALHN: FMC, NHS • BHFLHN: Gawler, Mount Barker, South Coast • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie & Northern Yorke (Wallaroo)
Benchmarks:	N/A
Representation Class:	Percentage
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	**Inclusion Criteria** > Acute Episode of Care Type ONLY > Medical & Surgical DRGs > General Beds ONLY

	Exclusion Criteria > Specialist Beds (Burns, Coronary Care, Critical Care, Emergency (EECU), GEM, Intensive Care, Mental Health, Neonatal, Obstetrics, Paediatrics, Palliative Care & Rehabilitation) > Episodes including HITH & RITH. > Hours (Days) in ICU > U DRGS (Mental Health) > Error DRGs **Additional Data** > The count (#) of episodes with a length of stay greater than or equal to 21 days within the reporting period will also be provided within the Inpatient.xlsx workbook
Related Information:	> Definition broadly based on the Health Round Table definition for long stay share of bed days. https://home.healthroundtable.org/

General Bed Occupancy (%)

Identifying and definitional attributes

Short Name:	Occupancy Rate
Tier:	Monitor
KPI ID:	TAC-IP-M-2
Description:	Ratio of the number of occupied general beds to the number of available general/medical beds.
Computation:	(Numerator/Denominator)*100
Numerator:	Sum of occupied beds as at midnight each day for the reporting period.
Denominator:	Sum of available beds in each ward as at midnight each day for the reporting period.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • NALHN: LMH, MH • SALHN: FMC, NHS
Benchmarks:	Target: <=90% Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Operational Business Intelligence (OBI)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Occupied beds are calculated based on total occupancy as at **midnight** each day. > Available beds are calculated based on the number of available beds in each ward as at **midnight** each day. > Exclusions (Specialist Beds): • Burns • Coronary Care • Critical Care • Emergency Dept. • Emergency (EECU) • GEM • Intensive Care

	• Mental Health • Neonatal • Obstetrics • Paediatrics • Palliative Care • Rehabilitation • Specialised Dementia Unit • Hospital in the Home • Rehab in the Home
Related Information:	> Service Agreements 2024-25 SA Health

Inpatient Weekend Discharge Rate (%)

Identifying and definitional attributes

Short Name:	IP Weekend Discharge (%)
Tier:	Monitor
KPI ID:	TAC-IP-M-3
Description:	The percentage (%) of total Inpatient weekly separations that occur on a weekend (either Saturday or Sunday).
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of IP Separations that occur on the weekend (either Saturday or Sunday).
Denominator:	Count (#) of IP Separations.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH • BHFLHN: Gawler, South Coast, Mount Barker • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Northern Yorke (Wallaroo)
Benchmarks:	Target ≥ 25%
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	**Inclusion Criteria** > Overnight Separations ONLY. > Acute Care Types (Acute & Mental Health Acute). > In-Scope Weekend Discharges have a separation day of the week of Saturday or Sunday. > Standard ISAAC Public Sub Setting Rules are applied.
Related Information:	> Service Agreements 2024-25 SA Health

Elective Surgery

Elective Surgery - Percentage of Elective Surgery wait list patients overdue for procedure	
Identifying and definitional attributes	
Short Name:	% ES Overdue: Overall % ES Overdue: Cat 1 % ES Overdue: Cat 2 % ES Overdue: Cat 3
Tier:	Tier 1 Monitor Monitor Monitor
KPI ID:	TAC-ES-T1-1 TAC-ES-M-1 TAC-ES-M-2 TAC-ES-M-3
Description:	Percentage (%) of patients classified as ready for surgery on the elective surgery waiting list who, at the census date, are overdue for surgery according to the clinically recommended wait times for their assigned urgency category.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients classified as ready for surgery on the elective surgery waiting list who, at the census date, are overdue for surgery according to the clinically recommended wait times for their assigned urgency category.
Denominator:	Count (#) of patients classified as ready for surgery on the elective surgery waiting list for their assigned urgency category.
More Information	
Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH • BHFLHN: Gawler, South Coast, Mount Barker, Angaston, Kapunda, Kangaroo Island, Strathalbyn • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla, Quorn • LCLHN: Mt Gambier, Bordertown, Millicent, Naracoorte • RMCLHN: Riverland (Berri), Murray Bridge, Renmark, Loxton, Waikerie • YNLHN: Port Pirie, Balaklava, Clare, Crystal Brook, Jamestown, Wallaroo

Benchmarks:

Metro Target	≤0%	10%	15%	20%	25%	>25%
Performance Score	5	4	3	2	1	0

Regional Target	≤0%	1%	>1%
Performance Score	5.0	2.5	0

Representation Class: Count (#)

Data Type: Integer

Unit of Measure: Person

Data Source: Elective Surgery Waiting List (ESWL) was previsously known as the Elective Surgery Booking List (BLIS)

Frequency of Reporting: Monthly (i.e., July data reported in August)

Notes:

> Data can only be provided as a point in time measure.

> A patient is overdue when they are:
- assigned as Category 1 and waiting time >30 days; or
- assigned as Category 2 and waiting time >90 days; or
- assigned as Category 3 and waiting time >365 days.

> Waiting time is determined as the time elapsed (in days) from the date the patient was added to the waiting list for their procedure to the date they were removed from the waiting list.

> Days when the patient was deemed 'not ready for surgery' are subtracted from the total count of days waited and is calculated by subtracting the date(s) the patient was recorded as 'not ready for surgery' from the date(s) the patient was subsequently recorded as again being 'ready for surgery'.

> In cases where there has been only one category reassignment (i.e., to the more urgent category attached to the patient at removal) the count of days at the less urgent clinical urgency category should be calculated by subtracting the date the patient was added to the list from the date the patient's urgency category was reassigned. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one category reassignment date from the subsequent category reassignment date, and then adding the days together.

> When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore, at the removal date, the patient's waiting time includes the count of days waited on an elective surgery waiting list, before, during and after any cancelled surgery admission.

> Excludes people who are not ready for surgery (deferred). If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at removal, then the number of days waited at the less urgent clinical urgency should be subtracted from the total number of days waited.

> Metro Only - Formula used to determine Overall Overdue % incorporates the allowed overdue patients for Category 2 and 3 as follows:
Overall Overdue % = ((Overdue Cat 1 + (Cat 2 Numerator – 10% of Cat 2 Denominator) + (Cat 3 Numerator – 10% of Cat 3 Denominator)) / Total Patients)*100

Related Information:

> National Healthcare Agreement: PI 20b–Waiting times for elective surgery: proportion seen on time, 2022
https://meteor.aihw.gov.au/content/740843

> Australian Health Performance Framework: PI 2.5.3–Waiting times for elective surgery: proportion admitted within clinically recommended time, 2020
https://meteor.aihw.gov.au/content/728361

> Service Agreements 2024-25 SA Health

Elective Surgery Timely Admissions

Identifying and definitional attributes

Short Name:	ES Timely Admissions: Overall ES Timely Admissions: Cat 1 ES Timely Admissions: Cat 2 ES Timely Admissions: Cat 3
Tier:	Monitor Monitor Monitor Monitor
KPI ID:	TAC-ES-M-4 TAC-ES-M-5 TAC-ES-M-6 TAC-ES-M-7
Description:	Percentage (%) of elective surgery patients admitted within the clinically recommended time.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients who were admitted for elective surgery within the nationally specified waiting time benchmark for their clinically assigned urgency category. These are: • Category 1: 30 days • Category 2: 90 days • Category 3: 365 days
Denominator:	Count (#) of patients who were admitted for elective surgery, within the same urgency category.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH • BHFLHN: Gawler, South Coast, Mount Barker, Angaston, Kapunda, Kangaroo Island, Strathalbyn • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla, Quorn • LCLHN: Mt Gambier, Bordertown, Millicent, Naracoorte • RMCLHN: Riverland (Berri), Murray Bridge, Renmark, Loxton, Waikerie • YNLHN: Port Pirie, Balaklava, Clare, Crystal Brook, Jamestown, Wallaroo
Benchmarks:	<table><tr><td>Category 1 Target</td><td>100%</td></tr><tr><td>Category 2 Target</td><td>≥97%</td></tr><tr><td>Category 3 Target</td><td>≥95%</td></tr></table> Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Elective Surgery Waiting List (ESWL) was previously known as the Elective Surgery Booking List (BLIS)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Waiting time is determined as the time elapsed (in days) from the date the patient was added to the waiting list for their procedure to the date they were removed from the waiting list. > Days when the patient was 'not ready for surgery' are subtracted from the total count of days waited and is calculated by subtracting the date(s) the person was recorded as 'not ready for surgery' from the date(s) the person was subsequently recorded as again being 'ready for surgery'. > If, at any time since being added to the waiting list the patient has been assessed to fall within a less urgent clinical category for the same elective procedure than the category at removal, then the count of days waited at the less urgent clinical category should be subtracted from the total count of days waited. > In cases where there has been only one category reassignment (i.e., to the more urgent category attached to the patient at removal) the count of days at the less urgent clinical urgency category should be calculated by subtracting the date the patient was added to the list from the date the patient's urgency category was reassigned. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one category reassignment date from the subsequent category reassignment date, and then adding the days together. > When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore, at the removal date, the patient's waiting time includes the count of days waited on an elective surgery waiting list, before, during and after any cancelled surgery admission. > Excludes people who are not ready for surgery (deferred).
Related Information:	> National Healthcare Agreement: PI 20b–Waiting times for elective surgery: proportion seen on time, 2022 https://meteor.aihw.gov.au/content/740843 > Australian Health Performance Framework: PI 2.5.3–Waiting times for elective surgery: proportion admitted within clinically recommended time, 2020. https://meteor.aihw.gov.au/content/728361 > Service Agreements 2024-25 SA Health

Elective Surgery Overdue Patients

Identifying and definitional attributes

Short Name:	ES Overdue: All ES Overdue: Cat 1 ES Overdue: Cat 2 ES Overdue: Cat 3
Tier:	Monitor Monitor Monitor Monitor
KPI ID:	TAC-ES-M-8 TAC-ES-M-9 TAC-ES-M-10 TAC-ES-M-11
Description:	Count (#) of patients classified as ready for surgery on the elective surgery waiting list who, at the census date, are overdue for surgery according to the clinically recommended wait times for their assigned urgency category.
Computation:	Count (#)

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH • BHFLHN: Gawler, South Coast, Mount Barker, Angaston, Kapunda, Kangaroo Island, Strathalbyn • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla, Quorn • LCLHN: Mt Gambier, Bordertown, Millicent, Naracoorte • RMCLHN: Riverland (Berri), Murray Bridge, Renmark, Loxton, Waikerie • YNLHN: Port Pirie, Balaklava, Clare, Crystal Brook, Jamestown, Wallaroo
Benchmarks:	Category 1 Target: 0 Category 2 Target: 0 Category 3 Target: 0 Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Count (#)
Data Type:	Integer

Unit of Measure:	Person
Data Source:	Elective Surgery Waiting List (ESWL) was previously known as the Elective Surgery Booking List (BLIS)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Data can only be provided as a point in time measure. > A patient is overdue when they are: • assigned as Category 1 and waiting time >30 days; or • assigned as Category 2 and waiting time >90 days; or • assigned as Category 3 and waiting time >365 days. > Waiting time is determined as the time elapsed (in days) from the date the patient was added to the waiting list for their procedure to the date they were removed from the waiting list. > Days when the patient was deemed 'not ready for surgery' are subtracted from the total count of days waited and is calculated by subtracting the date(s) the patient was recorded as 'not ready for surgery' from the date(s) the patient was subsequently recorded as again being 'ready for surgery'. > In cases where there has been only one category reassignment (i.e., to the more urgent category attached to the patient at removal) the count of days at the less urgent clinical urgency category should be calculated by subtracting the date the patient was added to the list from the date the patient's urgency category was reassigned. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one category reassignment date from the subsequent category reassignment date, and then adding the days together. > When a patient is admitted from an elective surgery waiting list but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue. Therefore, at the removal date, the patient's waiting time includes the count of days waited on an elective surgery waiting list, before, during and after any cancelled surgery admission. > Excludes people who are not ready for surgery (deferred). If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at removal, then the number of days waited at the less urgent clinical urgency should be subtracted from the total number of days waited.
Related Information:	> National Healthcare Agreement: PI 20b–Waiting times for elective surgery: proportion seen on time, 2022 https://meteor.aihw.gov.au/content/740843 > Australian Health Performance Framework: PI 2.5.3–Waiting times for elective surgery: proportion admitted within clinically recommended time, 2020 https://meteor.aihw.gov.au/content/728361 > Service Agreements 2024-25 SA Health

Elective Surgery Treat in Turn

Identifying and definitional attributes

Short Name:	ES Treat in Turn
Tier:	Monitor
KPI ID:	TAC-ES-M-12
Description:	Percentage (%) of patients admitted and treated in turn if every patient was treated strictly in the order in which they were placed on the elective surgery waiting list. Applicable to Urgency Category 2 and Urgency Category 3 only.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of the top (X) records with the longest TinTWaitDays who were admitted where (X) = total admissions within the reporting period. To derive the numerator, the list of patients admitted and treated within the reporting period is combined with the patients remaining ready for surgery on the Elective Surgery Waiting list (ESWL) for each relevant urgency category on the last day of the reporting period. TinTWaitDays for this cohort is then calculated by increasing the length of wait (LOW) for admitted patients by the difference between their removal date and the last day of the reporting period and using the LOW for patients remaining on the ESWL. LOW is defined as: Number of days between Date Added and Removal Date less any days spent as Urgency Category 4. The list is then ordered in descending order of TinTWaitDays, and the number of patients who were admitted and treated within the top (X) patients are counted (where (X) = total admissions within the reporting period).
Denominator:	Count (#) of patients admitted and treated in the reporting period.

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH • BHFLHN: Angaston, Gawler, Kangaroo Island, Kapunda, Mount Barker, South Coast, Strathalbyn • EFNLHN: Ceduna, Port Lincoln • FUNLHN: Port Augusta, Quorn, Whyalla • LCLHN: Bordertown, Millicent, Mount Gambier, Naracoorte • RMCLHN: Loxton, Murray Bridge, Renmark, Riverland, Waikerie • YNLHN: Balaklava, Clare, Crystal Brook, Jamestown, Northern Yoke (Wallaroo), Port Pirie, Southern Yorke (Yorketown)
Benchmarks:	n/a
Representation Class:	Percentage (%)
Data Type:	Real

Unit of Measure:	Episode
Data Source:	Sunrise/PAS sites – data extracted from BLIS Elective Surgery
Frequency of Reporting:	Monthly (i.e. July data reported in August)
Notes:	> Performance is calculated for Category 2 and Category 3 patient cohorts only. This measure is not applicable for Category 1 patients. > Performance is calculated at the lowest level (Site, Specialty and Category) and Specialty (ie Cat 2 and 3 combined) and Site level (i.e. all specialties at a site) performance derived based on aggregation of the numerator and denominator. > Performance is not reported (shown as N/A) where there were fewer than 5 admissions in a reporting period. > Performance data is not cumulative and is reported for month to date (MTD) only.
Related Information:	> Service Agreements 2024-25 SA Health

Specialist Care

Outpatients - LHN Tier 2 clinics with long wait(s)

Identifying and definitional attributes

Short Name:	Outpatient Clinics Maximum Wait Time
Tier:	Tier 2
KPI ID:	TAC-SC-T2-1
Description:	Specialist Outpatient Clinics in Metropolitan Hospitals with maximum wait times exceeding 4 years (48 Months) for an initial appointment for patients that are routine or non-urgent or on a waiting list and have not been given an appointment.
Computation:	Reduce maximum wait time to < 4 years (48 Months)

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- SALHN: FMC, NHS
- NALHN: LMH, MH
- WCHN: WCH

OP Clinics per LHN

Benchmarks:

Target	≤4yrs (48 Months)	>4 (48 Months) and ≤4.5yrs (54 Months)	>4.5yrs (54 Months)
Performance Score	2.5	1.25	0

Representation Class:	Maximum
Data Type:	Real
Unit of Measure:	Time (Months)
Data Source:	Non Admitted Patient Domain
Frequency of Reporting:	Quarterly (i.e., July – September data reported in October)

Notes:

> The indicator provides maximum waiting times for reported specialist clinics in metropolitan hospitals for patients that are routine or non-urgent or are on a waiting list and have not been given an appointment. These patients are considered 'unscheduled'. Patients who have been given an appointment are excluded.

> All urgent (category 1) patients are given an appointment and are therefore not added to the outpatient waiting list.

> All Tier 2 OP Clinics are included.

Related Information:

> Specialist Outpatient Waiting Time Report | SA Health

> Service Agreements 2024-25 SA Health

Productivity and Efficiency

Finance

End Of Year Net Variance to Budget ($m)	
Identifying and definitional attributes	
Short Name:	EOY Variance to Budget
Tier:	Tier 1
KPI ID:	PE-F-T1-1 (a) to (d)
Description:	End of year forecasted expenditure of providing services for a given period, minus the end of year adjusted budget for the same period
Computation:	Variance
More Information	
Scope:	Data is reported for: • CALHN • NALHN • SALHN • WCHN • BHFLHN • FUNLHN • EFNLHN • LCLHN • RMCLHN • YNLHN • DHW (including Drug and Alcohol Services South Australia) • South Australian Ambulance Services • State-wide Clinical Support Services
Benchmarks:	Target: ≤0% (5) | ≤+1% (2.5) | >+1% (0) Performance Score
Representation Class:	Dollar
Data Type:	Real
Unit of Measure:	Monetary amount
Data Source:	SHARP
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:	> Net Grant Funded Services impact. > For monthly reporting, indicator data is disaggregated to show the following elements: (a) End of year Projection Net Variance to Budget (b) Expenditure Variance to Budget (c) Revenue (All) Variance to Budget (d) Revenue (Earned) Variance to Budget > A percentage calculation is also available in the monthly workbooks. > End of year budget variance KPI to factor in activity variance to cap and other agreed external cost pressures: a) Activity to Cap Variance – *Need to determine target and methodology.* b) Depreciation of Assets
Related Information:	> Service Agreements 2024-25 SA Health

Commissioned Activity

Commissioned Activity – NWAUs and Separations	
Identifying and definitional attributes	
Short Name:	Overall NWAU activity to CAP Inpatient Acute Admitted - SEPS Inpatient Sub-Acute - SEPS Inpatient Acute Admitted – NWAUs Inpatient Sub-Acute - NWAUs Inpatient Admitted Mental Health – SEPS Inpatient Admitted Mental Health NWAUs Emergency Department - Presentations Emergency Department - NWAUs Outpatients - Service Events Outpatients - NWAUs
Tier:	Tier 1 Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator Supplementary Indicator
KPI ID:	PE-CA-T1-1 PE-CA-S-1 PE-CA-S-2 PE-CA-S-3 PE-CA-S-4 PE-CA-S-5 PE-CA-S-6 PE-CA-S-7 PE-CA-S-8 PE-CA-S-9 PE-CA-S-10
Description:	Variance in actual activity to commissioned levels of activity.
Computation:	(Numerator/Denominator)*100
Numerator:	Overall NWAU activity to CAP: Actual total activity National Weighted Activity Units (NWAUs) minus the commissioned cap for total activity NWAUs. Inpatient Acute Admitted - SEPS: Actual inpatient acute separations minus the commissioned cap for inpatients acute separations. Inpatient Sub-Acute - SEPS: Actual inpatient sub-acute separations minus the commissioned cap for inpatient sub-acute separations.

	Inpatient Acute Admitted - NWAUs: Actual inpatient acute admitted NWAUs minus the commissioned cap for inpatient acute admitted NWAUs. Inpatient Sub-Acute - NWAUs: Actual inpatient sub-acute NWAUs minus the commissioned cap for inpatient sub-acute NWAUs. Inpatient Admitted Mental Health - SEPS: Actual inpatient mental health separations minus the commissioned cap for inpatients mental health separations. Inpatient Admitted Mental Health - NWAUs: Actual inpatient mental health admitted NWAUs minus the commissioned cap for inpatient mental health admitted NWAUs. Emergency Department - Presentations: Actual emergency department (ED) presentations minus the commissioned cap for ED presentations. Emergency Department - NWAUs: Actual ED NWAUs minus the commissioned cap for ED NWAUs. Outpatients - Service Events: Actual outpatient service events minus the commissioned cap for outpatient service events. Outpatients - NWAUs: Actual outpatient NWAUs minus the commissioned cap for outpatient NWAUs.
Denominator:	Overall NWAUS activity to CAP: Commissioned cap for total activity National Activity Weighted Units (NWAUs). Inpatient Acute Admitted - SEPS: Commissioned cap for inpatients acute separations. Inpatient Acute Admitted - NWAUs: Commissioned cap for inpatient acute admitted NWAUs. Inpatient Sub-Acute - SEPS: Commissioned cap for inpatient sub-acute separations. Inpatient Sub-Acute - NWAUs: Commissioned cap for inpatient sub-acute NWAUs. Emergency Department - Presentations: Commissioned cap for emergency department (ED) separations. Emergency Department - NWAUs: Commissioned cap for ED NWAUs. Outpatients - Service Events: Commissioned cap for outpatient service events. Outpatients - NWAUs: Commissioned cap for outpatient NWAUs.
More Information	
Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN • FUNLHN • EFNLHN • RMCLHN • LCLHN • YNLHN • Wellbeing SA

<table>
<tr><td>Benchmarks:</td><td>
<table>
<tr><td>Target</td><td>≥ -0.5% and ≤+2%</td><td>≥ -1% and <-0.5%,
> +2% and ≤ +2.5%</td><td>< -1%, > +2.5%</td></tr>
<tr><td>Performance Score</td><td>5</td><td>2.5</td><td>0</td></tr>
</table>
</td></tr>
<tr><td>Representation Class:</td><td>Percentage (%)</td></tr>
<tr><td>Data Type:</td><td>Real</td></tr>
<tr><td>Unit of Measure:</td><td>Services Type</td></tr>
<tr><td>Data Source:</td><td>Overall NWAUs Actual to CAP:
NWAUs: Casemix Performance Monitoring and Reporting (PMR) monthly report
Acute/Sub-Acute/Emergency/Outpatients Activity:
Commissioning Report (monthly coded)
NWAUs: Casemix Performance Monitoring and Reporting (PMR) monthly report</td></tr>
<tr><td>Frequency of Reporting:</td><td>Monthly (i.e., July data reported in August)</td></tr>
<tr><td>Notes:</td><td>> NWAUs are the National Weighted Activity Units.
> Inpatient overall admitted is the sum of acute and sub-acute/maintenance for separations and NWAUs respectively.
> In the monthly performance workbooks, for all inpatient admitted figures, the data for the latest reported month is based on estimated data, while data for the previous months is based on coded data. The following month, the estimated data is updated with coded data.
> The Commissioning Report only contains coded data. As such it has a lag of one month in data compared with the monthly performance workbooks (which has the estimated data for the latest month).
> The Department supplies the LHNs with end of year caps as part of the Service Agreements. The LHNs flow the caps monthly to derive monthly and year to date caps.</td></tr>
<tr><td>Related Information:</td><td>> Service Agreements 2024-25 SA Health</td></tr>
</table>

Comparison to National Efficient Price (%)

Identifying and definitional attributes

Short Name:	% of NEP
Tier:	Tier 2
KPI ID:	PE-CA-T2-1
Description:	Variance in adjusted cost per gross NWAU compared to the National Efficient Price against the commissioned cost per NWAU compared to the National Efficient Price.
Numerator:	Adjusted cost per gross NWAU
Denominator:	National Efficient Price Determination 2024-25
Computation:	Variance

More Information

Scope:

Data is reported for:

- CALHN
- SALHN
- NALHN
- WCHN
- BHFLHN
- FUNLHN
- EFNLHN
- RMCLHN
- LCLHN
- YNLHN

Benchmarks:

CALHN, NALHN, SALHN & WCHN:

Metro Target	≤100%	>100 and ≤102%	>102%
Regional Target	≤95% NEP	> 95% and ≤97%	>97%
Performance Score	2.5	1.25	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Monetary Amount
Data Source:	Department for Health and Wellbeing, Funding Models

Frequency of Reporting:	Quarterly
Notes:	> NWAU is the Nationally Weighted Activity Unit. > NEP is the National Efficient Price. The NEP Determination is provided by the Independent Hospital Pricing Authority (IHPA) for the current financial year. > An LHN's average cost per NWAU is the LHN's Adjusted Costs ($) over the LHN's Gross NWAUs. o The Adjusted Costs ($) are calculated from the actual activity cost ($) submitted by the LHN for the reporting period, less work in progress (WIP) patients, less out of scope (non-funded) products and costs. o The Gross NWAUs are calculated from the LHN's actual activity in NWAUs for the reporting period less NWAUs from separations resulting in a Hospital Acquired Complication (HAC).
Related Information:	> NWAU calculators | IHACPA > Service Agreements 2024-25 SA Health

Efficiency

Length of Stay Performance to National Benchmark (IHACPA)

Identifying and definitional attributes

Short Name:	LOS Performance to Benchmark
Tier:	Tier 1
KPI ID:	PE-E-T1-1
Description:	LOS Variance between Actual ALOS (Days) for a particular Australian Refined Diagnostic Relates Groups (A-DRG) Classification Version 11.0 and the ABF ALOS (as defined by IHACPA Admitted Acute Price Weights) for the referenced Australian Refined Diagnostic Relates Groups (A-DRG) Classification Version 11.0, represented as a rate.
Computation:	Numerator-Denominator
Numerator:	Sum of Actual Length of Stay Days by Australian Refined Diagnostic Relates Groups (A-DRG) Classification Version 11.0.
Denominator:	Sum of ABF Length of Stay Days by Australian Refined Diagnostic Relates Groups (A-DRG) Classification Version 11.0.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- SALHN: FMC, NHS
- NALHN: LMH, MH
- WCHN: WCH
- BHFLHN: Gawler, Mount Barker, South Coast
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mt Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Quarterly Meto Target	≤0	>0 and ≤1% of total occupied bed days	>Tolerance
Quarterly Regional Target	≤0	>0 and ≤50	>50
Performance Score	5	2.5	0

Representation Class:	Count
Data Type:	Real
Unit of Measure:	Bed days

Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Count of expected LOS days is based on the methodology, trim points, adjustments, and coefficients provided by IHPA. > ALOS Performance to Benchmark of less than 0.00 indicates that the count of patient days for a hospital is lower than would be expected for a particular DRG. A LOS Performance to Benchmark of greater than 0.00 indicates that the count of patient days for a hospital is higher than would be expected for a particular DRG. > Actual LOS (Days) excludes Hours (Days) in ICU. **Exclusion Criteria** > Non-acute episodes of care - separations which do not meet the criteria of Acute, Qualified Newborns and Hospital- -in the-Home (HITH) without Rehabilitation component (Episodes of Care=1,5,99 OR Episode of Care=7 AND Additional Diagnosis 1 <> Z878, I698, Z479, Z509 AND Additional Diagnosis 2 to 99<>Z509). > SRG 35 (Drug & Alcohol) & 37 (Psychiatry) as part of Australian Mental Health Care Classification (AMHCC) > Same day Scopes/Chemotherapy > Source of Referral = Contracted Service > Elective Short Stay Cancellations > Died or transferred within 2 days of admission > Same day DRG's Version 11.0 > Separations with LOS > 120 days. > Ungroupable DRG's (960Z, 961Z & 963Z) > Same day dialysis **Additional References** > Acute Admitted Price Weights – Australian Defined Diagnosis Related Groups (AR-DRG) Classification Version 11.0.
Related Information:	> Acute Admitted Price Weights – Australian Refined Diagnosis Related Groups (AR-DRG) Classification Version 11.0. Mental health care | IHACPA > Other metrics reported as part of this indicator include Above Benchmark Flag, Potential OBD saved, variation to ABF Bed Days, Above Lower Trim Point & Above Upper Trim Point. > Service Agreements 2024-25 SA Health

Nursing Hours per Patient Day

Identifying and definitional attributes

Short Name:	Nurse Hours / Patient Day
Tier:	Tier 2
KPI ID:	PE-E-T2-1
Description:	The average number (#) of direct nursing / midwifery hours a patient receives per day
Computation:	Sum (#) of direct nursing/midwifery hours / Sum (#) of Occupied Bed Days
Numerator:	Sum (#) of Nursing/Midwifery hours worked
Denominator:	Sum (#) of Occupied Bed Days

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH • SALHN: FMC, NHS • NALHN: LMH, MH • WCHN: WCH • BHFLHN: Gawler, Mount Barker, South Coast • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Northern Yorke (Wallaroo)
Benchmarks:	Nursing/Midwifery EA 2022; Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement (agd.sa.gov.au)
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Hours/Day
Data Source:	N/MHPPD Data Source – PROACT for Metropolitan Health Unit Sites & Regional Unit Sites with the exception of regional unit sites minimum staffed hospitals. Patient Activity Data Source – OBI (Operational Business Intelligence)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Excludes 'Standards based clinical areas' listed in Appendix 1 NMEA 2022 and outpatient/ambulatory services. o Emergency Departments (incl. Tertiary – Emergency Departments, Tertiary – Extended Short Care, General – Emergency Departments, Country – Emergency Departments, Country – Casualty).

- Intensive and Critical Care Units (incl. ICU, HDU, PICU & Critical Care Units).
- Endoscopy Units
- Perioperative Staffing (incl. Operating Rooms, Pre-Admission Areas, Day Surgery Units, Post-Anaesthetic Recovery Rooms & Cardiac Vascular Investigation Unit CVIU Catheter Labs).

> Nurses/midwives providing direct nursing care only are included for reporting purposes. This is inclusive of the hours provided by permanent/temporary (full time and part time), casual and agency, relieving pool, overtime and call back. Other indirect hours, are not included.

> Nursing/midwifery hours are calculated on the shift duration provided to the patient care area by the nurse/midwife (excluding any unpaid meal break) starting from the shift start time, regardless if the shift overflows to the next day or next roster.

> Non-productive hours relating to nurses/midwives on any type of paid leave are excluded from the N/MHPPD calculation (including, but not limited to personal/ carers' leave, annual leave, workers compensation, study leave, employer provided parenting leave, compassionate leave, family leave, parental leave, accrued day off, professional development leave, etc.)

> Patients on leave are not counted in the activity data.

> Qualified babies are included.

> N/MHPPD Data Dictionary;

Data Item	Definition
Productive Nursing/Midwifery Hours	The sum of direct, indirect and overtime hours
Direct Hours	The sum of nursing/midwifery hours that deliver direct patient care at any time.
Indirect Hours	The sum of nursing/midwifery hours that are not related to direct patient care.
Non-Productive Hours	The sum of any type of paid leave for nurses/midwives. This includes but is not limited to: annual leave, personal/carers leave, professional development leave, employer provided parenting leave, partner leave, programmed day off, etc.
Direct Nursing/Midwifery Hours per Patient Day	The average number of direct nursing/midwifery hours a patient received per Occupied Bed Day.
Occupied Bed Days	Daily bed census data averaged over a specified preceding period; either 14 or 28 days as applicable.
Expected Bed Days (in determining projected/base roster)	The number of beds that are expected to be occupied or utilised on a regular basis.
Average Daily Occupancy	The number of Occupied Bed Days divided by specified number of days the unit is open within a given timeframe (i.e. calendar month, year).
Clinical Nursing/Midwifery Specials	Patients that require 1:1 nursing/midwifery care following clinical assessment guidelines. Depending on patient mix, acuity and patient numbers within the ward/unit this may or may not be able to be accommodated within the N/MHPPD. Additional resources may be required consistent with professional judgement of N/MUM or equivalent (Refer NMEA 2022 clause 3.1.13).
Skill Mix	Ratio of Registered Nurse/Midwife (RN/M) to Enrolled Nurse/Assistant in Nursing/Midwifery In health unit sites (other than regional unit sites) the skill mix for inpatient units is 70:30 registered nurse/midwives to enrolled nurses/assistant in nursing/midwifery.

		Graduate nurses/midwives are to be included in the RN/M ratio but are not, unless otherwise agreed between the parties, to be rostered as the only registered nurse/midwife in a health unit site or patient care area in the first 6 months of employment.
	Application of N/MHPPD	Multiply the N/MHPPD for the patient care area by the number of beds that are expected to be occupied or utilised on a regular basis for the period for which staffing is to be determined and then multiply the product by the number of days in the period within which the hours must be balanced. This informs the base roster.
Related Information:	>	Nursing & Midwifery EA 2022 Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement (agd.sa.gov.au)

Mental Health – Acute Average Length of Stay (Hospital or "Non-Linked" ALOS) - Adult

Identifying and definitional attributes

Short Name:	MH Acute ALOS
Tier:	Monitor
KPI ID:	PE-E-M-1
Description:	Average length of stay of in-scope overnight separations from acute psychiatric inpatient public hospital services.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of psychiatric care days for acute admitted patient mental health care service unit(s) during the reference period.
Denominator:	Count (#) separations occurring within the reference period having psychiatric care days in an acute admitted patient mental health care service unit(s).

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH, GLN
- NALHN: LMH, MH
- SALHN: FMC, NHS
- WCHN: WCH
- BHFLHN: Glenside Rural and Remote Ward
- RMCLHN: Riverland
- LCLHN: Mount Gambier
- FUNLHN: Whyalla

Benchmarks:

Adult Wards*	≤14 Days
Older Persons Wards	≤40 Days
Child & Adolescent Wards	≤11 Days

Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
*BHFLHN (R&R Glenside) have a target of ≤16 Days to account for extended Length of Stay for consumers who are transported to Adelaide from Regional locations and must get medically cleared through the RAH (other metro hospitals) prior to being admitted to Glenside.

Representation Class:	Mean (average)
Data Type:	Real
Unit of Measure:	Days
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)/ Community Mental Health Systems (CBIS, CCCME)
Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)

Notes:	> Includes: • Episodes where Psychiatric Care Days > 0 (meaning overnight ward is a designated mental health ward). • Separations for clients remaining admitted for longer than 12 months. • Mental health treatment in regional hospitals where Integrated Mental Health Inpatient Units (IMHIUs) are operational. • Forensic wards included in KPI analysis. • "Acute" mental health episodes (where separations have the Last Mental Health Ward indicated as "acute"). • Specialist adult wards - Jamie Larcombe Centre (Veterans) and Ward 4G (Eating Disorders, Anxiety, Gambling). > Excludes: • Separations where hospital admission date is equal to hospital separation date. • Separations where length of stay is one night only and procedure codes for ECT or TMS are recorded. • Separations where the Last Mental Health Ward is a non-acute designated mental health ward. • Separations where mental health treatment is occurring within general wards. • Patient leave days (based on hours of leave as per standard CDW methodology) and Hospital at Home days from the occupied bed days' calculation. > Admitted Patient Care, CDW bundling rules must be applied to ensure episodes are not wrongly included or excluded. • "State" bundled episodes should be used for psychiatric hospitals (Glenside, James Nash House) to accurately process administrative separations between Acute and Non-acute wards (and sub-type of MH Care Type) • "National" bundled episode should be used for general hospitals with acute MH wards to accurately exclude internal transitions from one MH sub-care-type to another within a ward > Total length of stay in a ward within a single hospital stay needs to be counted as one separation even if, for example, the EoC changes from MH Acute to MH Rehabilitation or MH Maintenance. > Ward level attributes the numerator/denominator based on Last Mental Health Ward (rather than Ward on Discharge which may not be a mental health ward). This also supports correct attribution to LHN, e.g., Glenside Rural and Remote ward is governed by BHFLHN not CALHN, whereas Glenside might be counted as a "CALHN hospital". > Specialist adult wards to be included in future analysis, with a specific benchmark to be determined: • SALHN – Jamie Larcombe Centre (Veterans). • SALHN – Ward 4G (Eating Disorders, Anxiety, Gambling). • WCHN – Helen Mayo House (Perinatal; excludes patients less than 16 years of age).
Related Information:	> KPIs for Australian Public Mental Health Services: PI 04J – Average length of acute mental health inpatient stay, 2024 > https://meteor.aihw.gov.au/content/783643 > Service Agreements 2024-25 SA Health

Overnight Maintenance Care Occupied Beds per Day Rate (#)

Identifying and definitional attributes

Short Name:	Overnight Maintenance Care Bed Day Rate
Tier:	Monitor
KPI ID:	PE-E-M-2
Description:	Overnight Maintenance Care Bed Days used in Metropolitan Hospitals per day (represented as a rate). Excludes Maintenance Care Contracted Separations.
Computation:	(Numerator/Denominator)
Numerator:	Count (#) of Overnight Maintenance Care Bed Days in Metropolitan Hospitals in Month (Reporting Period)
Denominator:	Count (#) of Days in Month (Reporting Period)

More Information

Scope:	Data is reported for: • CALHN: Hampstead, RAH, Repat Health CALHN, TQEH • NALHN: LMH, MH • SALHN: FMC (Incl. Repat), NHS
Benchmarks:	n/a
Representation Class:	Rate (No.)
Data Type:	Real
Unit of Measure:	Occupied Beds per Day
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)
Notes:	**Inclusion Criteria** > Overnight Separations ONLY. > Maintenance Care Type ONLY. > Metropolitan Hospitals ONLY. > Standard ISAAC Public Sub Setting Rules are applied. > Bed Days calculated upon discharge and totality of bed days assigned to month of discharge. > Excludes Maintenance Care Contracted Separations.
Related Information:	> Service Agreements 2024-25 SA Health

Overnight Contracted Maintenance Care Occupied Beds per Day Rate (#)

Identifying and definitional attributes

Short Name:	Overnight Contracted Maintenance Care Bed Day Rate
Tier:	Monitor
KPI ID:	PE-E-M-2
Description:	Overnight Maintenance Care Contracted Bed Days used in Metropolitan Hospitals per day (represented as a rate). Includes Maintenance Care Contracted Separations ONLY.
Computation:	(Numerator/Denominator)
Numerator:	Count (#) of Overnight Maintenance Care Contracted Bed Days in Metropolitan Hospitals in Month (Reporting Period)
Denominator:	Count (#) of Days in Month (Reporting Period)

More Information

Scope:	Data is reported for: • CALHN: Hampstead, RAH, Repat Health CALHN, TQEH • NALHN: LMH, MH • SALHN: FMC (Incl. Repat), NHS
Benchmarks:	n/a
Representation Class:	Rate (No.)
Data Type:	Real
Unit of Measure:	Occupied Beds per Day
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)
Notes:	**Inclusion Criteria** > Overnight Separations ONLY. > Maintenance Care Type ONLY. > Metropolitan Hospitals ONLY. > Standard ISAAC Public Sub Setting Rules are applied. > Bed Days calculated upon discharge and totality of bed days assigned to month of discharge. > Includes Maintenance Care Contracted Separations ONLY.

Related Information:	>	Service Agreements 2024-25 SA Health

Quality of Health Information

Complexity Index

Identifying and definitional attributes

Short Name:	Complexity Index
Tier:	Tier 1 - Regional Tier 2 - Metro
KPI ID:	PE-QHI-T1-1 PE-QHI-T2-1
Description:	The average costliness of Admitted Acute patients with a DRG Code eligible for a NWAU weighting
Computation:	(Numerator/Denominator)
Numerator:	The sum of the number of Admitted Acute NWAUs during the reporting period.
Denominator:	The sum of the number of Acute admitted patients who have had a separation during the reporting period with DRGs which have a NWAU rating greater than 0.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- NALHN: LMH, MH
- SALHN: FMC, NHS
- WCHN: WCH
- BHFLHN: Gawler, Mount Barker, South Coast
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mount Gambier
- RMCLHN: Riverland, Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Performing (Target): 2022/23 CAP Complexity

Target	≥0%	<0% and ≥ -5%	< -5%
Metro Performance Score	2.5	1.25	0
Regional Performance Score	5	2.5	0

2024-25 Admitted Acute CAP Complexity Ratio (NWAU Ratio)

Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Data supplied by Funding Models
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Related Information:	>	Service Agreements 2024-25 SA Health

Coding Timeliness (Metro)

Identifying and definitional attributes

Short Name:	Coding Timeliness
Tier:	Tier 2
KPI ID:	PE-QHI-T2-2
Description:	The proportion of all separations, which have been clinically coded at the time of the planned Admitted Patient Care submission cut off (census date).
Computation:	(Numerator/Denominator)*100
Numerator:	Count of separations which have been coded for the reporting period at the census date. - EPAS sites – count of records with a 'coded and complete' record status - Non−EPAS sites – count of records with a valid diagnosis recorded.
Denominator:	Count of separations, irrespective of the status of clinical coding for the reported period where separation data is not null.

More Information

Scope:	Data is reported for: • CALHN • NALHN • SALHN • WCHN
Benchmarks:	

Target	≥95%	90%	85%	80%	75%	<75%
Performance Score	2.5	2	1.5	1	0.5	0

Representation Class:	Percentage
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Operational Business Intelligence (OBI)
Frequency of Reporting:	Monthly (1 Month Lag i.e., July data reported in September)
Notes:	> Includes all Metropolitan Public Hospitals (excl. Glenside & Pregnancy Advisory Centre). > Southern Districts is not included as part of Flinders Medical Centre for this indicator. > Excludes 'end of quarter' (Nature of Separation = 'E') records, administrative separations (Nature of Separation = 'A') records for neonates (Episode of care qualified ('6') or unqualified ('5') and unmapped Episode of Care types for Flinders Medical Centre. > This indicator relates to the completeness of the Admitted Activity data (ISAAC) at the time of expected submission (census date). > Further development is required to achieve a coding timeliness measure at the time of actual submission/extraction.

Related Information:	>	Service Agreements 2024-25 SA Health

Critical Errors - Admitted Patient Care

Identifying and definitional attributes

Short Name:	Critical Errors - Admitted
Tier:	Tier 2 - Regional Monitor - Metro
KPI ID:	PE-QHI-T2-3 PE-QHI-M-1
Description:	Proportion (%) of active admitted patient records that produce a critical error in the Admitted Patient Care system (formerly known as ISAAC).
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of active admitted patient records that produce a critical error in the Admitted Patient Care system.
Denominator:	Count (#) of all active admitted patient records in the Admitted Patient Care system.

More information

Scope:

Data is reported for:

- CALHN
- SALHN
- NALHN
- WCHN
- BHFLHN
- EFNLHN
- FUNLHN
- LCLHN
- RMCLHN
- YNLHN

Benchmarks:

Regional Target	≤1%	>1% and ≤2%	>2%
Performance Score	2.5	1.25	0

Metro Target	≤1%

Note: Metro benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Separations
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)

Notes:	> 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 Affair 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). This includes specific rejected records relating to Edits: • 1131 • 1341 • 1351 • 1361. > Active admitted records used in the denominator calculation include all valid records and those records producing a critical error. > Critical errors are generated as part of the monthly refresh; corrections in the source will be reflected in a subsequent refresh.
Related Information:	> Admitted Patient Care: Data Elements 2023-24 > EDI - Data Requirements Bulletin 2023-24 > Service Agreements 2024-25 SA Health

Critical Errors - Emergency Department

Identifying and definitional attributes

Short Name:	Critical Errors - ED
Tier:	Monitor
KPI ID:	PE-QHI-M-2
Description:	Proportion (%) of emergency department (ED) records that produce a critical error due to invalid or inconsistent data.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of ED records with a URG code of either: • E1 • E2 • E3 • E5 • E6 • E7 • E8.
Denominator:	Count (#) of all ED records.

More information

Scope:	Data is reported for: • CALHN • NALHN • SALHN • WCHN • BHFLHN • EFNLHN • FUNLHN • LCLHN • RMCLHN • YNLHN
Benchmarks:	Target ≤1% Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Presentations
Data Source:	Central Data Warehouse (CDW): Casemix view
Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)

Notes:	> 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: • Non-admitted patient emergency department care National Minimum Data Set (NAPEDC NMDS) • Activity Based Funding (ABF) as provided by Independent Hospital Pricing Authority (IHPA). > Critical Errors consist of: • Invalid errors (where a reported value is not valid) • Inconsistent reporting errors (where a reported value is inconsistent with another reported value). > Invalid errors include invalid data for: • Mapped (National) Departure Status not 1,2,3,4,5,6,7 or 8 • Diagnosis Code invalid or not provided • Diagnosis Code doesn't map to Shortlist Diagnosis Code • Mapped (National) Type of Visit Code not 1, 2, 3 or 5. > Inconsistent reporting errors include: • Sex code not 1, 2 or 3 consistent with diagnosis code > Records that do not attract funding are excluded from the numerator and denominator, including records where: • URN, Presentation Date Time or Departure Date Time has not been provided • Departure Date Time provided is before Presentation Date Time • Seen by Date time is before Presentation Date Time or after Departure Date Time • Triage Category Code not 1, 2, 3, 4 or 5 • Seen by Date Time is null and Mapped (National) Departure status is not 4, 8 or 9. > All critical errors are to be reviewed by the hospital. > Critical errors are generated as part of the monthly refresh; corrections in the source will be reflected in a subsequent refresh.
Related Information:	> Service Agreements 2024-25 SA Health

Coding Timeliness (No Historical Update)

Identifying and definitional attributes

Short Name:	Coding Timeliness (NHU)
Tier:	Monitor
KPI ID:	PE-QHI-M-3
Description:	The proportion of all separations, which have been clinically coded at the time of the planned Admitted Patient Care submission cut off (census date). **No historical update of data is performed with only most recent month being updated.**
Computation:	(Numerator/Denominator)*100
Numerator:	Count of separations which have been coded for the reporting period at the census date (for the report month only). - EPAS sites – count of records with a 'coded and complete' record status - Non−EPAS sites – count of records with a valid diagnosis recorded.
Denominator:	Count of separations, irrespective of the status of clinical coding for the reported period where separation data is not null (for the reported month only).

More Information

Scope:	Data is reported for: • CALHN: RAH, TQEH, Hampstead, St M, RHP • NALHN: LMH, MH • SALHN: FMC, NHS, RGH • WCHN: WCH • BHFLHN: Gawler, Mount Barker, South Coast, Rural & Remote • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Whyalla, Port Augusta • LCLHN: Mount Gambier • RMCLHN: Riverland, Murray Bridge • YNLHN: Port Pirie, Northern Yorke • WSA: Wellbeing SA
Benchmarks:	Target: ≥95% (2.5) | 90% (2) | 85% (1.5) | 80% (1) | 75% (0.5) | <75% (0)
Representation Class:	Percentage
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Operational Business Intelligence (OBI)
Frequency of Reporting:	Monthly (1 Month Lag i.e., July data reported in September)
Notes:	> Includes all Metropolitan Public Hospitals (excl. Glenside & Pregnancy Advisory Centre). > Southern Districts is not included as part of Flinders Medical Centre for this indicator.

	> Excludes ‘end of quarter’ (Nature of Separation = ‘E’) records, administrative separations (Nature of Separation = ‘A’) records for neonates (Episode of care qualified (‘6’) or unqualified (‘5’) and unmapped Episode of Care types for Flinders Medical Centre. > This indicator relates to the completeness of the Admitted Activity data (ISAAC) at the time of expected submission (census date). > **No historical update of data is performed with only most recent month being updated.**

Safe and Effective Care

Safe Care

Healthcare Associated SAB Infection Rate

Identifying and definitional attributes

Short Name:	SAB Infection Rate
Tier:	Tier 1
KPI ID:	SEC-SC-T1-1
Description:	Patient episodes of healthcare associated Staphylococcus aureus bacteraemia (SAB) per 10,000 patient bed days.
Computation:	(Numerator/Denominator)*10,000
Numerator:	Count (#) of patient episodes of healthcare associated SAB.
Denominator:	Count (#) of bed days for all patients who were admitted for an episode of care.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- SALHN: FMC, NHS, RGH
- NALHN: LMH, MH
- WCHN: WCH
- BHFLHN: Angaston, Eudunda, Gawler, Gumeracha, Kangaroo Island, Kapunda, Mount Barker, Mount Pleasant, South Coast, Strathalbyn, Tanunda
- FUNLHN: Hawker, Port Augusta, Quorn, Roxby Downs, Whyalla
- EFNLHN: Ceduna, Cleve, Coober Pedy, Cowell, Cummins, Elliston, Kimba, Port Lincoln, Streaky Bay, Tumby Bay, Wudinna
- RMCLHN: Barmera, Riverland (Berri), Lameroo, Lower Murray (Tailem Bend), Loxton, Mannum, Meningie, Murray Bridge, Pinnaroo, Renmark, Waikerie
- LCLHN: Bordertown, Kingston, Millicent, Mount Gambier, Naracoorte, Penola
- YNLHN: Balaklava, Booleroo, Burra, Clare, Crystal Brook, Jamestown, Laura, Maitland, Orroroo, Peterborough, Port Broughton, Port Pirie, Riverton, Snowtown, Southern Yorke, Northern Yorke (Wallaroo)

Both ABF & Grant Funded Units are reportable.

Benchmarks:

Target	≤0.7	>0.7 and ≤1.0	>1.0
Performance Score	5	2.5	0

Representation Class:	Ratio
Data Type:	Real

Unit of Measure:	Disease Type
Data Source:	Operational Business Intelligence (OBI) plus manually supplied by RSS for Gawler, South Coast, Mount Barker, Murray Bridge, Ceduna and Wallaroo
Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)
Notes:	> A patient episode of bacteraemia (bloodstream infection) is defined as a positive blood culture for Staphylococcus aureus. For surveillance purposes, only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded. > A SAB specimen is healthcare associated if: • EITHER o the patient's first SAB blood culture was collected more than 48 hours after hospital admission or less than 48 hours after discharge • OR o the patient's first SAB blood culture was collected less than or equal to 48 hours after hospital admission and one or more of the following key clinical criteria was met for the patient-episode of SAB: 1. SAB is a complication of the presence of an indwelling medical device (e.g. intravascular line, haemodialysis vascular access, CSF shunt, urinary catheter). 2. SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site 3. SAB was diagnosed within 48 hours of a related invasive instrumentation or incision 4. SAB is associated with neutropenia (less than 1 x 109/L) contributed to by cytotoxic therapy. > Includes same-day patients, overnight admitted patients and unqualified newborns. > Excludes cases where a known previous positive test has been obtained within the last 14 days.
Related Information:	> National Healthcare Agreement: PI 22–Healthcare associated infections: Staphylococcus aureus bacteraemia, 2022 https://meteor.aihw.gov.au/content/740834 > National Healthcare Agreement: PB g–Better health services: the rate of Staphylococcus aureus (including MRSA) bacteraemia is no more than 1.0 per 10,000 occupied bed days for acute care public hospitals by 2020–21 in each state and territory, 2022 https://meteor.aihw.gov.au/content/740896 > Australian Health Performance Framework: PI 2.2.2–Healthcare-associated Staphylococcus aureus bloodstream infections, 2022 https://meteor.aihw.gov.au/content/778297 > Service Agreements 2024-25 SA Health

Hospital Acquired Complication Rate (incl. Sub-Acute Ep. Of Care)

Identifying and definitional attributes

Short Name:	HAC Rate
Tier:	Tier 1
KPI ID:	SEC-SC-T1-2
Description:	Percentage (%) of separations where one or more hospital-acquired complications (HAC) was reported at diagnosis level.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of separations where one or more HAC was reported at diagnosis level.
Denominator:	Count (#) of overnight episodes.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- NALHN: LMH, MH
- SALHN: FMC, NHS
- WCHN: WCH
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mount Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

CALHN & SALHN Target	≤4%	>4% and ≤4.5%	>4.5%
NALHN & WCHN Target	≤3%	>3% and ≤3.5%	>3.5%
Regional Target	≤1%	-	>1%
Performance Score	5	2.5	0

Representation Class:	Percentage
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Raw data utilises bundled data from Central Data Warehouse (CDW) Admitted Activity standard views (business sub-setting applied). Independent Hospital Pricing Authority (IHPA) and Australian Commission on Safety and Quality in Health Care hospital acquired complications (HACs) algorithm (toolkit version 1.1) then applied.
Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)

Notes:

> A HAC refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

> Diagnosis level refers to the sub-category of the HAC.

> Numerator includes;

- Acute, Sub-Acute and Mental Health Episodes of Care
- with at least one of the codes defining that diagnosis in the table below recorded as an additional diagnosis (i.e., NOT principal diagnosis)
- AND a condition onset flag (COF) code of 1 (Condition with onset during the episode of admitted patient care)
- AND any other criteria specified in 'Other associated codes' column of that diagnosis
- AND meeting the denominator criteria of:
- All separations, excluding separations with ANY of the following:
- - Same-day chemotherapy - and admission date = separation date
- - Same-day haemodialysis - and admission date = separation date
- - Care type is 'Newborn - unqualified days only ' - Care type = 7.3
- - Care type is 'Hospital boarder' - Care type = 10
- - Care type is 'Organ procurement-posthumous' - Care type = 9.

> Denominator excludes;

- data where HAC diagnosis code and/or the condition onset flag field(s) are incomplete
- Same-day chemotherapy - and admission date = separation date
- Same-day haemodialysis - and admission date = separation date
- Care type is 'Newborn-unqualified days only ' - Care type = 7.3
- Care type is 'Hospital boarder' - Care type = 10
- Care type is 'Organ procurement-posthumous' - Care type = 9.

> The HAC algorithm groups episode into the 16 different complications which occur during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

> Work is underway to implement version 2.0 of the toolkit into CDW

> The national list of HACs developed by the Australian Commission on Safety and Quality in Health Care is defined as:

Complication	Diagnosis
Pressure injury	> Stage III ulcer > Stage IV ulcer > Unspecified decubitus ulcer and pressure area > Unstageable pressure injury > Suspected deep tissue injury
Falls resulting in fracture or intracranial injury	> Intracranial injury > Fractured neck of femur > Other fractures
Healthcare-associated infection	> Urinary tract infection > Surgical site infection > Pneumonia > Blood stream infection > Infection or inflammatory complications associated with peripheral/central venous catheters > Multi-resistant organism > Infection associated with prosthetics/implantable devices > Gastrointestinal infections > Other high impact infections
Surgical complications requiring unplanned return to theatre	> Post-operative haemorrhage/haematoma requiring transfusion and/or return to theatre > Surgical wound dehiscence > Anastomotic leak > Vascular graft failure > Other surgical complications requiring unplanned return to theatre
Unplanned intensive care unit admission	> Unplanned admission to intensive care unit

Respiratory complications	>	Respiratory failure including acute respiratory distress syndrome requiring ventilation > Aspiration pneumonia > Pulmonary oedema
Venous thromboembolism	>	Pulmonary embolism > Deep vein thrombosis
Renal failure	>	Renal failure requiring haemodialysis or continuous veno-venous haemodialysis
Gastrointestinal bleeding	>	Gastrointestinal bleeding
Medication complications	>	Drug related respiratory complications/depression > Haemorrhagic disorder due to circulating anticoagulants > Movement disorders due to psychotropic medication > Serious alteration to conscious state due to psychotropic medication
Delirium	>	Delirium
Persistent incontinence	>	Urinary incontinence > Faecal incontinence
Malnutrition	>	Malnutrition > Hypo0.glycaemia
Cardiac complications	>	Heart failure and pulmonary oedema > Arrhythmias > Cardiac arrest > Acute coronary syndrome including unstable angina, STEMI and NSTEMI > Infective endocarditis
Third and fourth degree perineal laceration during delivery	>	Third and fourth degree perineal laceration during delivery
Neonatal birth trauma	>	Neonatal birth trauma > Hypoxic ischaemic encephalopathy

> ‘Unplanned intensive care unit admission’ is currently unmeasurable, as this data is not captured in the current dataset specification.

Related Information:

> Australian Commission on Safety and Quality in Health Care, Hospital-Acquired Complications. https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications

> Service Agreements 2024-25 SA Health.

> https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31-12th-edn Hospital-Acquired Complications (HACs) List - Specifications - Version 3.1 (12th edn) - NSQHS definition

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Hospital Hand Hygiene Compliance Rate - Overall

Identifying and definitional attributes

Short Name:	Hand Hygiene
Tier:	Tier 1
KPI ID:	SEC-SC-T1-3
Description:	Percentage (%) of correct hand hygiene actions undertaken for Moments 1-5.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of correct hand hygiene actions for Moments1-5 within a given period.
Denominator:	Count (#) of hand hygiene opportunities for Moments 1-5 observed within the same period.

More Information

Scope:

Data is reported for:

- CALHN
- SALHN
- NALHN
- WCHN
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mount Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke

Benchmarks:

Target	≥80%	<80% and >= 75%	<75%
Performance Score	5	2.5	0

Representation Class:	Ratio
Data Type:	Integer
Unit of Measure:	Episode
Data Source:	SA Health Hand Hygiene Australia (HHA) Compliance Application (HHCApp)
Frequency of Reporting:	3 Times per financial year July – October; November – March; April – June (1 Month lag i.e., July – October reported in November)

Notes:	> A moment or opportunity is defined as a point in patient care where the performance of hand hygiene is required to prevent the cross-transmission of potentially infective micro-organisms. The 5 moments are: 1. before touching a patient 2. before performing a procedure on a patient 3. after a procedure or a body fluid exposure risk 4. after touching a patient 5. after touching a patient's surroundings (note – reporting of Moment 5 is not included in a Local Health Network's Service Agreement for reporting but should still be monitored for compliance). > Correct hand hygiene opportunities relate to the count of hand hygiene actions where action code = 'R' (rub) or 'W' (wash). > Primary and ambulatory care settings e.g., SAAS, Dental, Mental Health, Community Health and aged care beds are not required to submit data using the national HHA moments audit tool to the HHA program, however these services are required to follow the SA Health Hand Hygiene Policy Directive and Guideline and should audit using the appropriate SA Health resources.
Related Information:	> Hand Hygiene Australia 5 Moments for Hand Hygiene Manual; Australian Commission for Safety and Quality in Healthcare. https://www.hha.org.au/hand-hygiene/5-moments-for-hand-hygiene > Service Agreements 2024-25 SA Health

Mental Health - Seclusion Per 1,000 Bed Days in Acute MH Wards

Identifying and definitional attributes

Short Name:	Rate of Seclusion
Tier:	Tier 1
KPI ID:	SEC-SC-T1-4
Description:	Rate per 1,000 bed days of mental health episodes where a seclusion event was recorded.
Computation:	(Numerator/Denominator)*1,000
Numerator:	Count (#) of mental health seclusion events.
Denominator:	Count (#) of mental health patient bed days.

More Information

Scope:

Data is reported for:

- CALHN
- SALHN
- NALHN
- WCHN
- BHFLHN: Glenside Rural and Remote Ward
- FUNLHN: Whyalla
- LCLHN: Mount Gambier
- RMCLHN: Riverland

Benchmarks:

Metro Target	≤5	6	7	8	9	>9
WCHN Target	≤8	9	10	11	12	>12
Regional Target	≤3	3.5	4	4.5	5	>5
Performance Score	5	4	3	2	1	0

Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Safety learning System (SLS) via Operational Business Intelligence (OBI)
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:

> A Mental Health patient is defined as a patient admitted to an acute mental health ward, including short stay.

> Excludes:

- Noarlunga Hospital's Hospital at Home program

	• WCH Helen Mayo House • Electro-Convulsion Therapy (ECT) wards • NALHN Aldgate ward (Aldgate data is made available in performance workbooks to provide visibility of seclusion rates only and does not contribute to NALHN's performance level). > Seclusion is defined as the confinement of the consumer/patient at any time of the day or night alone in a room or area from which free exit is prevented. > Measured via midnight occupancy snapshot.
Related Information:	> KPIs for Australian Public Mental Health Services: PI 15J – Seclusion rate, 2024 https://meteor.aihw.gov.au/content/783667 > Service Agreements 2024-25 SA Health

Healthcare Associated MRSA Infection Rate

Identifying and definitional attributes

Short Name:	MRSA Infection Rate
Tier:	Tier 2
KPI ID:	SEC-SC-T2-1
Description:	Patient episodes of healthcare associated Methicillin-resistant Staphylococcus aureus (MRSA) per 10,000 patient bed days.
Computation:	(Numerator/Denominator)*10,000
Numerator:	Count (#) of patient episodes of healthcare associated MRSA.
Denominator:	Count (#) of bed days for all patients who were admitted for an episode of care.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- SALHN: FMC, NHS, RGH
- NALHN: LMH, MH
- WCHN: WCH
- BHFLHN: Angaston, Eudunda, Gawler, Gumeracha, Kangaroo Island, Kapunda, Mount Barker, Mount Pleasant, South Coast, Strathalbyn, Tanunda
- FUNLHN: Hawker, Port Augusta, Quorn, Roxby Downs, Whyalla
- EFNLHN: Ceduna, Cleve, Coober Pedy, Cowell, Cummins, Elliston, Kimba, Port Lincoln, Streaky Bay, Tumby Bay, Wudinna
- RMCLHN: Barmera, Riverland (Berri), Lameroo, Lower Murray (Tailem Bend), Loxton, Mannum, Meningie, Murray Bridge, Pinnaroo, Renmark, Waikerie
- LCLHN: Bordertown, Kingston, Millicent, Mount Gambier, Naracoorte, Penola
- YNLHN: Balaklava, Booleroo, Burra, Clare, Crystal Brook, Jamestown, Laura, Maitland, Orroroo, Peterborough, Port Broughton, Port Pirie, Riverton, Snowtown, Southern Yorke, Northern Yorke (Wallaroo)

Both ABF & Grant Funded Units are reportable.

Benchmarks:

Metro Target	≤1.2	>1.2 and ≤1.3	>1.3
Regional target	≤0.4	>0.4 and ≤0.5	>0.5
Performance Score	2.5	1.25	0

Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Disease Type
Data Source:	Operational Business Intelligence (OBI) plus manually supplied by RSS for Gawler, South Coast, Mount Barker, Murray Bridge and Ceduna

Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)
Notes:	> MRSA infection (morbidity) rate is an indicator of the rate of preventable infection in the hospitals. This rate is not dependent on the degree of active screening for MRSA carriage undertaken by the individual hospitals, therefore is a more robust indicator of the burden of disease due to MRSA. > The MRSA infection rate is recommended as the primary performance indicator of MRSA control for external benchmarking purposes, as it is the least likely to be affected by changes over time in screening practices. > The infection (morbidity) rate includes all patients, both newly identified and known carriers. > A MRSA specimen is healthcare associated if: • EITHER o the episode occurred >48 hours after admission/delivery at your facility and was not present or incubating on admission • OR o within 48 hours of discharge/transfer • OR o the episode is epidemiologically linked to a previous admission/intervention. > Includes same-day patients, overnight admitted patients, Maintenance Care Consolidated Episode, Hospital at Home Consolidated Episode, Rehabilitation at Home Consolidated Episode and unqualified newborns.
Related Information:	> National Healthcare Agreement: PI 22–Healthcare associated infections: Staphylococcus aureus bacteraemia, 2022 https://meteor.aihw.gov.au/content/740834 > National Healthcare Agreement: PB g–Better health services: the rate of Staphylococcus aureus (including MRSA) bacteraemia is no more than 1.0 per 10,000 occupied bed days for acute care public hospitals by 2020–21 in each state and territory, 2022 https://meteor.aihw.gov.au/content/740896 > Australian Health Performance Framework: PI 2.2.2–Healthcare-associated Staphylococcus aureus bloodstream infections, 2022 https://meteor.aihw.gov.au/content/778297 > Service Agreements 2024-25 SA Health

Mental Health - Restraint Events Per 1,000 Bed Days

Identifying and definitional attributes

Short Name:	Mental Health Restraints
Tier:	Tier 2
KPI ID:	SEC-SC-T2-2
Description:	Rate per 1,000 bed days of mental health episodes where a restraint event was recorded.
Computation:	(Numerator/Denominator)*1,000
Numerator:	Count (#) of mental health restraint events.
Denominator:	Count (#) of number of mental health bed days.

More Information

Scope:

Data is reported for:

- CALHN
- SALHN
- NALHN
- WCHN
- BHFLHN: Glenside Rural and Remote Ward
- FUNLHN: Whyalla
- LCLHN: Mount Gambier
- RMCLHN: Riverland

Benchmarks:

Metro Target	≤9	10	11	12	13	>13
WCHN Target	≤15	17	19	21	23	>23
Regional Target	≤2	2.5	3	3.5	4	>4
Performance Score	2.5	2	1.5	1	0.5	0

Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Safety learning System (SLS) via Operational Business Intelligence (OBI)
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:

> A mental health patient is defined as a patient admitted to an acute mental health ward, including short stay.

> Excludes:

- Noarlunga Hospital's Hospital at Home program
- WCH Helen Mayo House

	• Rejected records > Electro-Convulsion Therapy (ECT) wards. > For this indicator, only mechanical and physical restraint events are included in the computation. Unspecified restraint events are not included. > Measured via midnight occupancy snapshot.
Related Information:	> KPIs for Australian Public Mental Health Services: PI 16J – Restraint rate, 2024 https://meteor.aihw.gov.au/content/783669 > Mental health seclusion and restraint NBEDS 2015-2022; Quality Statement. https://meteor.aihw.gov.au/content/index.phtml/itemId/775026 > Service Agreements 2024-25 SA Health

CHBOI 3d - In Hospital Mortality for Pneumonia

Identifying and definitional attributes

Short Name:	CHBOI - Pneumonia
Tier:	Monitor
KPI ID:	SEC-SC-M-1
Description:	In-hospital deaths of patients admitted for pneumonia
Computation:	The ratio of observed count (#) of in-hospital deaths to expected number of in-hospital deaths for pneumonia patients, multiplied by the national mortality rate for pneumonia patients
Numerator:	Observed count (#) of in-hospital deaths for pneumonia patients
Denominator:	Expected count (#) of in-hospital deaths for pneumonia patients

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN
Benchmarks:	Target: Inlier; Performance Score: 5 Target: Outlier; Performance Score: 0
Representation Class:	Ratio
Data Type:	Time Period
Unit of Measure:	Life event (e.g. birth, death)
Data Source:	Raw data utilises bundled data from Central Data Warehouse (CDW) Admitted Activity standard views (business sub-setting applied). Australian Commission on Safety and Quality in Health Care core, hospital-based outcome indicators (CHBOI) algorithm (version 3.1 released July 2021) is then applied.
Frequency of Reporting:	Monthly – 12 Month Rolling (1 month lag i.e., July data reported in September)
Notes:	> Inlier - reported pneumonia mortality is within the confidence limit of the national population mean for pneumonia mortality i.e., within the Expected pneumonia mortality rate. > Outlier - reported pneumonia mortality is outside the confidence limit of the national population mean for pneumonia mortality i.e., outside the Expected pneumonia mortality rate. > Observed count of in-hospital deaths is where the separation mode is documented as died. > Expected count of in-hospital deaths is the sum of the estimated probabilities of death for all separations meeting criteria, calculated using national risk-adjustment coefficients.

	> Australian Commission on Safety and Quality in Health Care core, hospital-based outcome indicators (CHBOI) algorithm contains a range of mortality indicators which have been developed to enhance safety and quality reporting and feedback. > Criteria: • Principal diagnosis is in the national list of the top 80% of diagnoses, by frequency of in-hospital death, in the latest reference period. • Age at date of admission is between 29 days and 120 years, inclusive. • Care type = acute care, geriatric evaluation and management and maintenance care. • Length of stay, including leave days, is between 1 and 365 days, inclusive. • Both emergency and elective admissions. > Exclusions: • Missing admission mode or sex. > Risk adjustment: • Age at admission (years) • Sex • Principal diagnosis code (mapped to national in-hospital mortality risk deciles) • Admission category: emergency, elective • Length of stay • Additional (comorbid) diagnoses (Charlson index) categorised into three categories • Referral Source: admitted patient transferred from another hospital. > A value of 100 indicates that the mortality rate is the same as the national rate for patients with similar characteristics to those treated. A value of more than 100 corresponds to a higher than expected mortality rate, while a value of less than 100 corresponds to a lower than expected mortality rate.
Related Information:	> National core, hospital-based outcome indicator specification (2021), Version 3.1, Australian Commission on Safety and Quality in Health Care (yet to be published). > Version 3.1 incorporates • ICD10 version change: from v.10 to v.11. • DRG version change: from v.9 to v.10. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-core-hospital-based-outcome-indicator-specification > Service Agreements 2024-25 SA Health

CHBOI 1 - Hospital Standardised Mortality Ratio

Identifying and definitional attributes

Short Name:	CHBOI HSMR
Tier:	Monitor
KPI ID:	SEC-SC-M-2
Description:	Ratio of the observed count (#) of hospital separations that end in the patient's death, to the count (#) of separations expected to end in death based on the patient's characteristics, for principal diagnoses accounting for 80% of in-hospital mortality.
Computation:	(Numerator/Denominator)*100
Numerator:	Observed count (#) of in-hospital deaths.
Denominator:	Expected count (#) of in-hospital deaths.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN
Benchmarks:	Target: Inlier; Performance Score: 5 Target: Outlier; Performance Score: 0
Representation Class:	Ratio
Data Type:	Time Period
Unit of Measure:	Life event (e.g., birth, death)
Data Source:	Raw data utilises bundled data from Central Data Warehouse (CDW) Admitted Activity standard views (business sub-setting applied). Australian Commission on Safety and Quality in Health Care core, hospital-based outcome indicators (CHBOI) algorithm (version 3.1 released July 2021) is then applied.
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> For reporting, an LHN's reported Hospital Standardised Mortality Ratio (HSMR) is identified as an inlier or outlier. > Inlier - reported HSMR is within the confidence limit of the national population mean for HSMR i.e., within the Expected HMSR rate. > Outlier - reported HSMR is outside the confidence limit of the national population mean for HSMR i.e., outside the Expected HMSR rate. > Observed count of in-hospital deaths is where the separation mode is documented as died. > Expected count of in-hospital deaths is the sum of the estimated probabilities of death for all separations meeting criteria, calculated using national risk-adjustment coefficients.

	> Australian Commission on Safety and Quality in Health Care core, hospital-based outcome indicators (CHBOI) algorithm contains a range of mortality indicators which have been developed to enhance safety and quality reporting and feedback. > Criteria: • Principal diagnosis is in the national list of the top 80% of diagnoses, by frequency of in-hospital death, in the latest reference period. • Age at date of admission is between 29 days and 120 years, inclusive. • Care type = acute care, geriatric evaluation and management and maintenance care. • Length of stay, including leave days, is between 1 and 365 days, inclusive. • Both emergency and elective admissions. > Exclusions: • Missing admission mode or sex > Risk adjustment: • Age at admission (years) • Sex • Principal diagnosis code (mapped to national in-hospital mortality risk deciles) • Admission category: emergency, elective • Length of stay • Additional (comorbid) diagnoses (Charlson index) categorised into three categories • Referral Source: admitted patient transferred from another hospital. > A value of 100 indicates that the mortality rate is the same as the national rate for patients with similar characteristics to those treated. A value of more than 100 corresponds to a higher than expected mortality rate, while a value of less than 100 corresponds to a lower than expected mortality rate.
Related Information:	> National core, hospital-based outcome indicator specification (2021), Version 3.1, Australian Commission on Safety and Quality in Health Care (yet to be published). > Version 3.1 incorporates • ICD10 version change: from v.10 to v.11. • DRG version change: from v.9 to v.10. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-core-hospital-based-outcome-indicator-specification > Service Agreements 2024-25 SA Health

CHBOI 3b - In Hospital Mortality of Patients Admitted for Stroke

Identifying and definitional attributes

Short Name:	CHBOI - Stroke
Tier:	Monitor
KPI ID:	SEC-SC-M-3
Description:	In-hospital deaths of patients admitted for Stroke
Computation:	The ratio of observed count (#) of in-hospital deaths to expected number of in-hospital deaths for stroke patients, multiplied by the national mortality rate for stroke patients
Numerator:	Observed count (#) of in-hospital deaths for stroke patients
Denominator:	Expected count (#) of in-hospital deaths for stroke patients

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN
Benchmarks:	Target: Inlier Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Ratio
Data Type:	Time Period
Unit of Measure:	Life event (e.g., birth, death)
Data Source:	Raw data utilises bundled data from Central Data Warehouse (CDW) Admitted Activity standard views (business sub-setting applied). Australian Commission on Safety and Quality in Health Care core, hospital-based outcome indicators (CHBOI) algorithm (version 3.1 released July 2021) is then applied.
Frequency of Reporting:	Monthly – 12 Month Rolling (1 month lag i.e., July data reported in September)
Notes:	> Inlier - reported stroke mortality is within the confidence limit of the national population mean for stroke mortality i.e., within the Expected stroke mortality rate. > Outlier - reported stroke mortality is outside the confidence limit of the national population mean for stroke mortality i.e., outside the Expected stroke mortality rate. > Observed count of in-hospital deaths is where the separation mode is documented as died. > Expected count of in-hospital deaths is the sum of the estimated probabilities of death for all separations meeting criteria, calculated using national risk-adjustment coefficients.

	> Australian Commission on Safety and Quality in Health Care core, hospital-based outcome indicators (CHBOI) algorithm contains a range of mortality indicators which have been developed to enhance safety and quality reporting and feedback. > Criteria: • Principal diagnosis is in the national list of the top 80% of diagnoses, by frequency of in-hospital death, in the latest reference period. • Age at date of admission is between 29 days and 120 years, inclusive. • Care type = acute care, geriatric evaluation and management and maintenance care. • Length of stay, including leave days, is between 1 and 365 days, inclusive. • Both emergency and elective admissions. > Exclusions: • Missing admission mode or sex. > Risk adjustment: • Age at admission (years) • Sex • Principal diagnosis code (mapped to national in-hospital mortality risk deciles) • Admission category: emergency, elective • Length of stay • Additional (comorbid) diagnoses (Charlson index) categorised into three categories • Referral Source: admitted patient transferred from another hospital. > A value of 100 indicates that the mortality rate is the same as the national rate for patients with similar characteristics to those treated. A value of more than 100 corresponds to a higher than expected mortality rate, while a value of less than 100 corresponds to a lower than expected mortality rate.
Related Information:	> National core, hospital-based outcome indicator specification (2021), Version 3.1, Australian Commission on Safety and Quality in Health Care (yet to be published). > Version 3.1 incorporates • ICD10 version change: from v.10 to v.11. • DRG version change: from v.9 to v.10. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-core-hospital-based-outcome-indicator-specification > Service Agreements 2024-25 SA Health

Rate Of Surgical Site Infection: Hip Replacement

Identifying and definitional attributes

Short Name:	Rate of SSI: HPRO
Tier:	Monitor
KPI ID:	SEC-SC-M-4
Description:	Rate of episodes where there was a surgical site infection post hip replacement, per 100 procedures.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patient episodes of surgical site infection (SSI) after hip replacement procedures during the reference period.
Denominator:	Count (#) of hip replacement procedures undertaken during the reference period.

More Information

Scope:	Data is reported for: • CALHN -TQEH, RAH • NALHN - LMH • SALHN - FMC • BHFLHN – Gawler, South Coast, Mt Barker • EFNLHN – Pt Lincoln, Ceduna • FUNLHN -Pt Augusta, Whyalla • LCLHN – Mt Gambier • RMCLHN – Riverland, Murray Bridge • YNLHN – Pt Pirie, Northern Yorke (Wallaroo)
Benchmarks:	N/A
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manually supplied by Infection Control Service Communicable Disease Control Branch SA Department for Health and Wellbeing
Frequency of Reporting:	Quarterly (4month lag i.e., July – September data reported in January)
Notes:	> A surgical site infection (SSI) is an infection that develops as a direct result of an operative procedure. These infections are associated with increased morbidity and mortality, increased length of stay and higher healthcare costs. > SSI rates will have a reporting lag time of 3 months due to follow up surveillance periods. > SSI should only be reported by the hospital where the procedure was undertaken.

Related Information:	> Australian Commission on Safety and Quality in Health Care, Approaches to Surgical Site Infection Surveillance – For acute care settings in Australia, May 2017, ACSQHC, Sydney. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approaches-surgical-site-infection-surveillance-acute-care-settings-australia > National Safety and Quality Health Service Standards (second edition) This document presents the second edition of the National Safety and Quality Health Service (NSQHS) Standards released in November 2017 and updated in May 2021. > National Safety and Quality Health Service Standards (second edition) | Australian Commission on Safety and Quality in Health Care > SA Health Surgical Site infection (SSI) Surveillance > Service Agreements 2024-25 SA Health

Rate Of Surgical Site Infection: Lower Segment Caesarean Section

Identifying and definitional attributes

Short Name:	Rate of SSI: CSEC
Tier:	Monitor
KPI ID:	SEC-SC-M-5
Description:	Rate of episodes where there was a surgical site infection after lower segment caesarean section, per 100 procedures.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patient episodes of surgical site infection (SSI) after lower segment caesarean sections during the reference period.
Denominator:	Count (#) of lower segment caesarean sections undertaken during the reference period.

More Information

Scope:	Data reported for: • NALHN – LMH, MH • SALHN - FMC • WCHN • BHFLHN – Gawler, South Coast, Mt Barker • EFNLHN – Pt Lincoln, Ceduna • FUNLHN -Pt Augusta, Whyalla • LCLHN – Mt Gambier • RMCLHN – Riverland, Murray Bridge • YNLHN – Pt Pirie, Northern Yorke (Wallaroo)
Benchmarks:	N/A
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Person
Data Source:	Manually supplied by Infection Control Service Communicable Disease Control Branch SA Department for Health and Wellbeing
Frequency of Reporting:	Quarterly (4 month lag i.e., July – September data reported in January)
Notes:	> A surgical site infection (SSI) is an infection that develops as a direct result of an operative procedure. These infections are associated with increased morbidity and mortality, increased length of stay and higher healthcare costs. > SSI rates will have a reporting lag time of 1 month due to follow up surveillance periods. > SSI should only be reported by the hospital where the procedure was undertaken.

Related Information:	> Australian Commission on Safety and Quality in Health Care, Approaches to Surgical Site Infection Surveillance – For acute care settings in Australia, May 2017, ACSQHC, Sydney. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approaches-surgical-site-infection-surveillance-acute-care-settings-australia > Australian Commission on Safety and Quality in Health Care, Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated Infections, 2012 ACSQHC, Sydney. https://www.safetyandquality.gov.au/sites/default/files/migrated/Standard3_Oct_2012_WEB.pdf > SA Health Surgical Site infection (SSI) Surveillance > Service Agreements 2024-25 SA Health

Sentinel Events

Identifying and definitional attributes

Short Name:	Sentinel Events
Tier:	Monitor
KPI ID:	SEC-SC-M-6
Description:	Count (#) of sentinel events within reporting period.
Computation:	Count (#)

More Information

Scope:	Data reported for: • CALHN • NALHN • SALHN • WCHN • BHFLHN • EFNLHN • FUNLHN • LCLHN • RMCLHN • YNLHN • SAAS • SCSS
Benchmarks:	Target: 0 Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Count (#)
Data Type:	Integer
Unit of Measure:	Episode
Data Source:	Operational Business Intelligence (OBI) - Sunrise/PAS sites Chiron, Homer
Frequency of Reporting:	Monthly (i.e.,1 month lag- July Data Reported in September)
Notes:	> List of sentinel events: • Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death. • Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death. • Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death. • Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death. • Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death. • Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward.

	• Medication error resulting in serious harm or death. • Use of physical or mechanical restraint resulting in serious harm or death. • Discharge or release of an infant or child to an unauthorised person. • Use of an incorrectly positioned oro- or naso- gastric tube resulting in serious harm or death.
Related Information:	> Australian Commission on Safety and Quality in Health Care, Australian sentinel events list > Australian Sentinel Events List (version 2) Specifications | Australian Commission on Safety and Quality in Health Care > Service Agreements 2024-25 SA Health

Rate Of Surgical Site Infection: Knee Replacement

Identifying and definitional attributes

Short Name:	Rate of SSI: KPRO
Tier:	Monitor
KPI ID:	SEC-SC-M-7
Description:	Rate of episodes where there was a surgical site infection post knee replacement, per 100 procedures.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patient episodes of surgical site infection (SSI) after knee replacement procedures during the reference period.
Denominator:	Count (#) of knee replacement procedures undertaken during the reference period.

More Information

Scope:	Data is reported for: • CALHN -TQEH, RAH • NALHN - LMH • SALHN - FMC • BHFLHN – Gawler, South Coast, Mt Barker • EFNLHN – Pt Lincoln, Ceduna • FUNLHN -Pt Augusta, Whyalla • LCLHN – Mt Gambier • RMCLHN – Riverland, Murray Bridge • YNLHN – Pt Pirie, Northern Yorke (Wallaroo)
Benchmarks:	N/A
Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manually supplied by Infection Control Service Communicable Disease Control Branch SA Department for Health and Wellbeing
Frequency of Reporting:	Quarterly (4 month lag i.e. July – September data reported in January)
Notes:	> A surgical site infection (SSI) is an infection that develops as a direct result of an operative procedure. These infections are associated with increased morbidity and mortality, increased length of stay and higher healthcare costs. > SSI rates will have a reporting lag time of 3 months due to follow up surveillance periods. > SSI should only be reported by the hospital where the procedure was undertaken.

Related Information:	> Australian Commission on Safety and Quality in Health Care, Approaches to Surgical Site Infection Surveillance – For acute care settings in Australia, May 2017, ACSQHC, Sydney. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approaches-surgical-site-infection-surveillance-acute-care-settings-australia > National Safety and Quality Health Service Standards (second edition) This document presents the second edition of the National Safety and Quality Health Service (NSQHS) Standards released in November 2017 and updated in May 2021. > National Safety and Quality Health Service Standards (second edition) | Australian Commission on Safety and Quality in Health Care > SA Health Surgical Site infection (SSI) Surveillance > Service Agreements 2024-25 SA Health

Hospital Acquired Complication Rate (Acute Ep. Of Care ONLY)

Identifying and definitional attributes

Short Name:	HAC Rate (Acute Only)
Tier:	Monitor
KPI ID:	SEC-SC-M-8
Description:	Percentage (%) of acute separations where one or more hospital-acquired complications (HAC) was reported at diagnosis level.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of acute separations where one or more HAC was reported at diagnosis level.
Denominator:	Count (#) of acute overnight episodes.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- NALHN: LMH, MH
- SALHN: FMC, NHS
- WCHN: WCH
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mount Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

CALHN & SALHN Target	≤4%	>4% and ≤4.5%	>4.5%
NALHN & WCHN Target	≤3%	>3% and ≤3.5%	>3.5%
Regional Target	≤1%	-	>1%
Performance Score	5	2.5	0

Representation Class:	Percentage
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Raw data utilises bundled data from Central Data Warehouse (CDW) Admitted Activity standard views (business sub-setting applied). Independent Hospital Pricing Authority (IHPA) and Australian Commission on Safety and Quality in Health Care hospital acquired complications (HACs) algorithm (toolkit version 1.1) then applied.
Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)

Notes:

- A HAC refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.
- Diagnosis level refers to the sub-category of the HAC.
- Numerator includes;
  - Acute & Mental Health Episodes of Care ONLY
  - with at least one of the codes defining that diagnosis in the table below recorded as an additional diagnosis (i.e., NOT principal diagnosis)
  - AND a condition onset flag (COF) code of 1 (Condition with onset during the episode of admitted patient care)
  - AND any other criteria specified in 'Other associated codes' column of that diagnosis
  - AND meeting the denominator criteria of:
  - All separations, excluding separations with ANY of the following:
  - - Same-day chemotherapy - and admission date = separation date
  - - Same-day haemodialysis - and admission date = separation date
  - - Care type is 'Newborn - unqualified days only ' - Care type = 7.3
  - - Care type is 'Hospital boarder' - Care type = 10
  - - Care type is 'Organ procurement-posthumous' - Care type = 9.
- Denominator excludes;
  - data where HAC diagnosis code and/or the condition onset flag field(s) are incomplete
  - Same-day chemotherapy - and admission date = separation date
  - Same-day haemodialysis - and admission date = separation date
  - Care type is 'Newborn-unqualified days only ' - Care type = 7.3
  - Care type is 'Hospital boarder' - Care type = 10
  - Care type is 'Organ procurement-posthumous' - Care type = 9.
- The HAC algorithm groups episode into the 16 different complications which occur during a hospital stay and for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.
- Work is underway to implement version 2.0 of the toolkit into CDW
- The national list of HACs developed by the Australian Commission on Safety and Quality in Health Care is defined as:

Complication	Diagnosis
Pressure injury	> Stage III ulcer > Stage IV ulcer > Unspecified decubitus ulcer and pressure area > Unstageable pressure injury > Suspected deep tissue injury
Falls resulting in fracture or intracranial injury	> Intracranial injury > Fractured neck of femur > Other fractures
Healthcare-associated infection	> Urinary tract infection > Surgical site infection > Pneumonia > Blood stream infection > Infection or inflammatory complications associated with peripheral/central venous catheters > Multi-resistant organism > Infection associated with prosthetics/implantable devices > Gastrointestinal infections > Other high impact infections
Surgical complications requiring unplanned return to theatre	> Post-operative haemorrhage/haematoma requiring transfusion and/or return to theatre > Surgical wound dehiscence > Anastomotic leak > Vascular graft failure > Other surgical complications requiring unplanned return to theatre
Unplanned intensive care unit admission	> Unplanned admission to intensive care unit

Respiratory complications	> Respiratory failure including acute respiratory distress syndrome requiring ventilation > Aspiration pneumonia > Pulmonary oedema
Venous thromboembolism	> Pulmonary embolism > Deep vein thrombosis
Renal failure	> Renal failure requiring haemodialysis or continuous veno-venous haemodialysis
Gastrointestinal bleeding	> Gastrointestinal bleeding
Medication complications	> Drug related respiratory complications/depression > Haemorrhagic disorder due to circulating anticoagulants > Movement disorders due to psychotropic medication > Serious alteration to conscious state due to psychotropic medication
Delirium	> Delirium
Persistent incontinence	> Urinary incontinence > Faecal incontinence
Malnutrition	> Malnutrition > Hypo0.glycaemia
Cardiac complications	> Heart failure and pulmonary oedema > Arrhythmias > Cardiac arrest > Acute coronary syndrome including unstable angina, STEMI and NSTEMI > Infective endocarditis
Third and fourth degree perineal laceration during delivery	> Third and fourth degree perineal laceration during delivery
Neonatal birth trauma	> Neonatal birth trauma > Hypoxic ischaemic encephalopathy

> 'Unplanned intensive care unit admission' is currently unmeasurable, as this data is not captured in the current dataset specification.

Related Information:

> Australian Commission on Safety and Quality in Health Care, Hospital-Acquired Complications. https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications

> Service Agreements 2024-25 SA Health.

> https://www.safetyandquality.gov.au/publications-and-resources/resource-library/hospital-acquired-complications-hacs-list-specifications-version-31-12th-edn
Hospital-Acquired Complications (HACs) List - Specifications - Version 3.1 (12th edn) - NSQHS definition

Consumer's Experience of Care

Consumer Experience: Involved in Decision Making
Consumer Experience: Being Heard – Listened To

Identifying and definitional attributes

Short Name:	Consumer Experience: Involved in Decisions Consumer Experience: Being Heard
Tier:	Tier 1 Tier 2
KPI ID:	SEC-CEC-T1-1 SEC-CEC-T2-1
Description:	Percentage (%) of positive feedback from a selection of questions from the Australian Hospital Patient Experience Question Set (AHPEQS).
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of respondents who: • Mostly or always felt they were involved as much as they wanted in making decisions about treatment and care. • Mostly or always felt their views and concerns were listened to.
Denominator:	Count (#) of all respondents.

More Information

Scope:	Data is reported for: • CALHN • SALHN • NALHN • WCHN • BHFLHN: Gawler, South Coast, Mount Barker • EFNLHN: Port Lincoln, Ceduna • FUNLHN: Port Augusta, Whyalla • LCLHN: Mount Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Northern Yorke (Wallaroo)
Benchmarks:	Consumer Experience: Involved in Decisions Target: ≥85% / <85% and ≥80% / <80% Performance Score: 5 / 2.5 / 0 Consumer Experience: Being Heard Target: ≥85% / <85% and ≥80% / <80% Performance Score: 2.5 / 1.25 / 0
Representation Class:	Percentage (%)

Data Type:	Real
Unit of Measure:	Person
Data Source:	SA Consumer Experience Surveillance System
Frequency of Reporting:	Quarterly (2 Month lag i.e., July – September data reported in December)
Notes:	> The survey is compiled of a random sample of discharged patients from all SA public hospitals.
Related Information:	> Australian Hospital Patient Experience Question Set (AHPEQS); Australian Commission on Safety and Quality in Health Care (ACSQHC). https://www.safetyandquality.gov.au/publications-and-resources/resource-library/australian-hospital-patient-experience-question-set-ahpeqs-technical-specifications > Service Agreements 2024-25 SA Health

Appropriateness of Care

Maternity - HAC Rate 3rd And 4th Degree Perineal Tears

Identifying and definitional attributes

Short Name:	HAC Rate 3rd and 4th Degree Perineal Tears
Tier:	Tier 1
KPI ID:	SEC-AC-T1-1
Description:	Rate of third and fourth degree perineal laceration occurred during vaginal delivery per 10,000 vaginal deliveries.
Computation:	(Numerator/Denominator)*10,000
Numerator:	Count (#) of separations where a 3rd and 4th degree perineal laceration during vaginal delivery was recorded.
Denominator:	Count (#) of separations where a vaginal delivery occurred.

More Information

Scope:

Data is reported for:

- SALHN
- NALHN
- WCHN
- BHFLHN: Gawler, Mount Barker, South Coast
- FUNLHN: Port Augusta, Whyalla
- EFNLHN: Port Lincoln, Ceduna
- RMCLHN: Riverland (Berri), Murray Bridge
- LCLHN: Mount Gambier
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Metro Target	≤320	≤ + 10%	> +10%
BHFLHN	≤210	≤ + 10%	> +10%
EFNLHN	≤160	≤ + 10%	> +10%
FUNLHN	≤160	≤ + 10%	> +10%
LCLHN	≤180	≤ + 10%	> +10%
YNLHN	≤200	≤ + 10%	> +10%
Performance Score	5	2.5	0

Representation Class:	Percentage
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC) and Operational Business Intelligence (OBI) - Sunrise/PAS sites Chiron, Homer and ATS - FMC

Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)

Notes:

> The numerator for HAC rate 3rd and 4th degree perineal tears during delivery is defined as separations:

- With at least one of the ICD-10-AM codes in Table A recorded as an additional diagnosis (i.e., NOT principal diagnosis) with ANY condition onset flag (COF).

Table A		
ICD-10-AM 11th Edition		
Code	Code	Description
O702	O70.2	Third degree perineal laceration during delivery
O703	O70.3	Fourth degree perineal laceration during delivery

- AND meeting the denominator criteria (as below).

> The denominator is defined as:

- All vaginal births - separations where an outcome of delivery was recorded using one of the diagnosis codes in Table B, and a caesarean delivery was not recorded (Table C).

Table B		
ICD-10-AM 11th Edition		
Code	Code	Description
Z370	Z37.0	Single live birth
Z371	Z37.1	Single stillbirth
Z372	Z37.2	Twins, both liveborn
Z373	Z37.3	Twins, one liveborn and one stillborn
Z374	Z37.4	Twins, both stillborn
Z375	Z37.5	Other multiple births, all liveborn
Z376	Z37.6	Other multiple births, some liveborn
Z377	Z37.7	Other multiple births, all stillborn
Z379	Z37.9	Outcome of delivery, unspecified

Table C	
ACHI 11th Edition	
Code	Description
16520-00[1340]	Elective classical caesarean section
16520-01[1340]	Emergency classical caesarean section
16520-02[1340]	Elective lower segment caesarean section
16520-03[1340]	Emergency lower segment caesarean section
16520-04[1340]	Elective caesarean section, not elsewhere classified
16520-05[1340]	Emergency caesarean section, not elsewhere classified

> Excludes separations with ANY of the following:

- Admission mode is 'Admitted patient transferred from another hospital'.
- Care type is 'Newborn—unqualified days only'
- Care type is 'Hospital boarder'
- Care type is 'Organ procurement-posthumous'.

> Unplanned intensive care unit admission' is currently unmeasurable, as this data is not captured in the current dataset specification.

> Work is underway to implement version 2.0 of the toolkit into CDW for 2022-23.

Related Information:	> Australian Commission on Safety and Quality in Health Care, Hospital-Acquired Complications. https://www.safetyandquality.gov.au/our-work/indicators/hospital-acquired-complications > Service Agreements 2024-25 SA Health

Mental Health - Post Discharge Community Follow Up Rate

Identifying and definitional attributes

Short Name:	MH Community Discharge
Tier:	Tier 1
KPI ID:	SEC-AC-T1-2
Description:	Percentage (%) of patients separated from an acute designated mental health ward who (or their Carer) received one or more mental health service contacts while in the community within 7 days following their discharge.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of separations from acute designated mental health wards with recorded community mental health service contact (patient or carer) dated within seven days of discharge.
Denominator:	Count (#) of separations from acute designated mental health wards.

More Information

Scope:

Data is reported for:

- CALHN
- NALHN
- SALHN
- WCHN
- BHFLHN: Glenside Rural and Remote Ward
- FUNLHN: Whyalla
- RMCLHN: Riverland (Berri)
- LCLHN: Mount Gambier

Benchmarks:

Target	≥80%	<80% and ≥75%	<75%
Performance Score	5	2.5	0

Representation Class:	Ratio
Data Type:	Real
Unit of Measure:	Service contact
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)/ Community Mental Health Systems (CBIS, CCCME)
Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)

Notes:

> Includes:
- All acute admitted mental health service units, including short-stay units and emergency acute mental health admitted units.
- Treatment in regional hospitals where designated acute mental health facilities are implemented (integrated units).
- Separation modes (Nature of Separation) 0, 1, 3, 4 representing more formal separation rather than transfers and patient self-discharge or death etc. 0 = Discharged on Leave; 1 = Home; 3 = Residential Aged Care Facility; 4 = Other Health Care Accommodation.

> Excludes:

	• Helen Mayo House patients aged less than 16. • Separations where hospital admission date is equal to hospital separation date. • Separations where length of stay is one night only and procedure codes for ECT or TMS are recorded. • Statistical and change of care type separations. • Separations that end by transfer to another acute or psychiatric hospital. • Separations that have Referral for Further Health Care = 11 (Residential mental health service). • Separations that end in death or left against medical advice/discharge at own risk • Separations that end by transfer to community residential mental health services. • Follow-up contacts occurring on the date of separation (i.e., follow-up is +1 to 7 days after separation date), based on differences in date (not time). > The following community mental health service contacts are excluded: • Mental health service contacts on the day of separations. • Contacts where a consumer does not participate. > Implementation of this indicator requires the capacity to track service use across inpatient and community boundaries and is dependent on the capacity to link patient identifiers. > For this indicator, when a mental health service organisation has more than one unit of a particular admitted patient care program, those units should be combined. > Linking of the Admitted Patient Care and CBIS information via the AltId records in CBIS and CCCME. > Mental Health Service Contacts are as per the NMDS for mental health and covers clinically significant contacts (e.g., excluding did-not-attends, administrative, health service, travel, measures, etc. type activities). > For CBIS: procedures 04 and below; procedure type 60.0000; and 80.9010 CAMHS Risk Assessment. > For CCC: procedures below 60 but also excluding 23.0000, 53.0000, 55.0000 and 58.0000. > Eligible contacts for all the types listed include those recorded by admitted patient and residential mental health services as well as those recorded by community mental health teams, while the consumer is in the community i.e., that do not occur within an admitted patient or residential mental health care episode. > Data is provided for both: • Client Participating only [participation status = 1 Yes regardless of value in Parent/Carer involved data item]. • Client Participating OR Parent/Carer involved. These results should be used for performance monitoring against targets, for all mental health wards regardless of target population (CAMHS, Older Persons, Forensic, General/Adult). > "Client Participating" or Parent/Carer contact are counted as an appropriate contact for reporting purposes. > Per national definition both Face-to-face and Phone contact modes are to be counted. > There are no catchment restrictions on community follow-up such that follow-up by any community team for any discharge is valid: not just follow-up within agency/region. Any follow-up is counted towards the discharging hospital/LHN. > Bundling rules as per Health Intelligence Portal are applied to ensure episodes are not wrongly excluded e.g., where unbundled episode ends due to change of care type from Mental Health Acute to Acute. The bundled episode is the correct counting unit for this indicator. > Mode of identification of mental health wards within scope is by nominated ward of discharge. These are specified in a separate list from this document. Note that the Psychiatric Care Days measure is not used in determining in-scope episodes for this measure; ward-on-discharge being a mental health ward is appropriate for this measure. > Data is to be reported at Hospital level and at individual Ward level. Where reported at Ward level, attribution of numerator/denominator is to be based on Ward on Discharge.
Related Information:	> KPIs for Australian Public Mental Health Services: PI 03J – National Mental Health Service Standards compliance, 2024 (aihw.gov.au) > Fifth National Mental Health and Suicide Prevention Plan Framework (aihw.gov.au) > Service Agreements 2024-25 SA Health

Aboriginal Patients Who Left Hospital Against Medical Advice

Identifying and definitional attributes

Short Name:	Aboriginal Health – Self Discharge
Tier:	Tier 1
KPI ID:	SEC-AC-T1-3
Description:	Percentage (%) of Aboriginal people who leave hospital against medical advice.
Computation:	Count (#) of overnight separations for patients who identify as Aboriginal and/or Torres Strait Islander where the nature of separation was leaving hospital against medical advice, divided by number of overnight separations for all patients who identify as Aboriginal and/or Torres Strait Islander. Represented as a percentage.
Numerator:	Count (#) of overnight separations for patients who identify as Aboriginal and/or Torres Strait Islander where the nature of separation was leaving hospital against medical advice.
Denominator:	Count (#) of overnight separations for all patients who identify as Aboriginal and/or Torres Strait Islander.

More Information

Scope:

Data is reported for:

- CALHN
- SALHN
- NALHN
- WCHN
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mount Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Target	≤3%	4%	5%	6%	7%	>7%
Performance Score	5	4	3	2	1	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Leaving hospital against medical advice is defined as departure code 8 (Self Discharge).

Related Information:	>	3.09 Discharge against medical advice - AIHW Indigenous HPF
	>	Service Agreements 2024-25 SA Health

Stroke Patients who Received Treatment in a Stroke Ward

Identifying and definitional attributes

Short Name:	Stroke Patients in a Stroke Ward
Tier:	Tier 1
KPI ID:	SEC-AC-T1-4
Description:	Proportion (%) of patients diagnosed with stroke (as indicated on the LHN Analytics and Reporting Service (LARS) Stroke Form (submitted by LHNs) whom spend any part of their episode in a designated stroke ward.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of separations with a diagnosis of stroke (as indicated on the LHN Analytics and Reporting Service (LARS) Stroke Form (submitted by LHNs) whom spend any part of their episode in a designated stroke ward.
Denominator:	Count (#) of separations with a diagnosis of stroke (as indicated on the LHN Analytics and Reporting Service (LARS) Stroke Form (submitted by LHNs).

More Information

Scope:	Data is reported for: • CALHN • NALHN • SALHN
Benchmarks:	
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Operational Business Intelligence (OBI) via LHN Analytics and Reporting Service (LARS) Stroke Form (submitted by LHNs)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Includes verified strokes (as indicated on the LHN Analytics and Reporting Service (LARS) Stroke Form (submitted by LHNs). > Only includes Acute Episode's of care. > A dedicated stroke unit is defined as a hospital unit/ward where the following criteria is met: • co-located beds within a geographically defined unit • dedicated, multidisciplinary team with members who have a special interest in stroke or rehabilitation and has access to regular professional development and education relating to stroke • the team that meets at least once per week to discuss patient care. > The percentage (%) of stroke patients who spent at least some time in a stroke unit is calculated as the number of strokes (as indicated on the verified stroke form) whom spent time in a stroke unit divided by the total number of stroke separations (as indicated on the verified stroke form).

Target	≥90%	80%	70%	60%	50%	<50%
Performance Score	5	4	3	2	1	0

	> Excludes: • Regional LHNs and WCHN. • Transient ischemic attack (TIA) separations. • Maintenance care. • Rehabilitation. • Hospital in the Home/Rehabilitation in the Home. • Geriatric Evaluation and Management.
Related Information:	> SA Health Stroke Management Procedures and Protocols: National Safety and Quality Standard: Quality Statement 3 – Time in Stroke Unit; CCS.Stroke.3a - Proportion of patients with a final diagnosis of acute stroke who have documented treatment in a stroke unit at any time during their hospital stay, in the reference Local Hospital Network (LHN) or other stroke network. Rationale: There is strong evidence that specialised stroke units, staffed with a multi-disciplinary team of stroke specialists, improve patient outcomes and reduce stroke mortality. > Service Agreements 2024-25 SA Health

Babies Pass Newborn Hearing Screening in Hospital

Identifying and definitional attributes

Short Name:	Newborn Hearing Screening Passed
Tier:	Tier 1
KPI ID:	SEC-AC-T1-5
Description:	Percentage (%) of Eligible Babies born who Pass a Newborn Hearing Screening in Hospital.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of Eligible Babies who Pass a Newborn Hearing Screening in Hospital.
Denominator:	Count (#) of Eligible Babies Born in Hospital who Completed a Newborn Hearing Screening in Hospital.

More Information

Scope:

Data is reported for:

- NALHN - LMH
- SALHN - FMC
- WCHN - WCH
- BHFLHN: Gawler, Kangaroo Island, Kapunda, Mount Barker, South Coast
- EFNLHN: Ceduna, Port Lincoln
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mount Gambier, Naracoorte
- RMCLHN: Riverland (Berri), Loxton, Murray Bridge
- YNLHN: Clare, Crystal Brook, Jamestown, Port Pirie, Northern Yorke

Benchmarks:

Target	≥80%	<80% and ≥75%	<75%
Performance Score	5	2.5	0

Representation Class:	Ratio
Data Type:	Integer
Unit of Measure:	Episode
Data Source:	eCHIMS (CaFHS database)
Frequency of Reporting:	Quarterly
Notes:	> Eligible - >34 Weeks Gestation, No Evidence of Atresia/Microtia

Related Information:	> South Australian Perinatal Practice Guideline https://www.sahealth.sa.gov.au/wps/wcm/connect/c7c5058a-bb8a-4538-a7e5-8f63b836322b/Newborn+Hearing+Screening+PPG+V_1.0.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-c7c5058a-bb8a-4538-a7e5-8f63b836322b-opYEM17 > Service Agreements 2024-25 SA Health > National Framework for Newborn Hearing Screening > National performance indicators to support neonatal hearing screening in Australia

Aged Care: Care Recipients who were Physically Restrained

Identifying and definitional attributes

Short Name:	Aged Care – Physical Restraint
Tier:	Tier 1
KPI ID:	SEC-AC-T1-6
Description:	Rate of care recipients who experienced a physical restraint
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients who experienced the use of a physical restraint during the assessment period.
Denominator:	Count (#) of care recipients assessed during the assessment period.

More Information

Scope:

Data is reported for:

- BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS
- EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS
- FUNLHN - Hawker MPS, Quorn MPS
- RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS
- LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS
- YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS

Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.

Benchmarks:

Target	≤17%	>17% and ≤19%	>19%
Performance Score	5	2.5	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program.

	> Restraint means any practice, device or action that interferes with a care recipient's movement for the primary purpose of influencing the care recipient's behaviour but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the care recipient. > Physical restraint includes all forms of restrictive practice, excluding chemical restraint, as follows: • mechanical restraint is a practice or intervention that is, or that involves, the use of a device to prevent, restrict or subdue a care recipient's movement for the primary purpose of influencing the care recipient's behaviour, but does not include the use of a device for therapeutic or non-behavioural purposes in relation to the care recipient • physical restraint is a practice or intervention that: a. is or involves the use of physical force to prevent, restrict or subdue movement of a care recipient's body, or part of a care recipient's body, for the primary purpose of influencing the care recipient's behaviour; but b. does not include the use of a hands-on technique in a reflexive way to guide or redirect the care recipient away from potential harm or injury if it is consistent with what could reasonably be considered to be the exercise of care towards the care recipient > Environmental restraint is a practice or intervention that restricts, or that involves restricting, a care recipient's free access to all parts of the care recipient's environment (including items and activities) for the primary purpose of influencing the care recipient's behaviour > seclusion is a practice or intervention that is, or that involves, the solitary confinement of a care recipient in a room or a physical space at any hour of the day or night where: i. voluntary exit is prevented or not facilitated; or ii. it is implied that voluntary exit is not permitted for the primary purpose of influencing the care recipient's behaviour. Exclusions • Care recipients who were absent from the service for the entire three-day assessment period are not required to be assessed.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. > National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Aged Care: Recipients who experienced one or more Falls (Major Injury)

Identifying and definitional attributes

Short Name:	Aged Care – Falls (Major)
Tier:	Tier 1
KPI ID:	SEC-AC-T1-7
Description:	Percentage (%) of care recipients who experienced a fall resulting in a major injury during the assessment period.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients who experienced a fall resulting in a major injury during the assessment period.
Denominator:	Count (#) of care recipients assessed during the assessment period.

More Information

Scope:

Data is reported for:

- BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS
- EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS
- FUNLHN - Hawker MPS, Quorn MPS
- RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS
- LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS
- YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS

Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.

Benchmarks:

Target	≤2%	>2% and ≤2.5%	>2.5%
Performance Score	5	2.5	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program.

	> A fall is an event that results in a person coming to rest inadvertently on the ground or floor or other lower level.
	> A fall resulting in major injury is a fall that meets the definition above and results in one or more of the following:
	  > Bone fractures.
	  > Joint dislocations.
	  > Closed head injuries with altered consciousness; and/or
	  > Subdural haematoma.
	> Exclusions
	  > Care recipients who were absent from the service for the entire quarter.
	  > Falls resulting in major injury that occurred while the care recipient was away from the service and not under direct supervision of service staff.

Related Information:	> National Aged Care Mandatory Quality Indicator Program. > National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Aged Care: Percentage of Care Recipients with Pressure Injuries, reported against six pressure injury stages

Identifying and definitional attributes

Short Name:	Aged Care - Pressure Injuries
Tier:	Tier 1
KPI ID:	SEC-AC-T1-8
Description:	Rate of care recipients who experienced a pressure injury
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients who experienced a pressure injury for the assessment period.
Denominator:	Count (#) of care recipients assessed for the assessment period.

More Information

Scope:

Data is reported for:

- BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS
- EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS
- FUNLHN - Hawker MPS, Quorn MPS
- RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS
- LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS
- YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS

Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.

Benchmarks:

Target	≤5.5%	>5.5% and ≤7.5%	>7.5%
Performance Score	5	2.5	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal

Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > A pressure injury is a localised injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, shear, or a combination of these factors. Previous terms used include pressure ulcer, bed sore and decubitus ulcer. > Six categories are measured and assessed in relation to pressure injuries: • Stage 1 pressure injuries: non-blanchable erythema of intact skin • Stage 2 pressure injuries: partial-thickness skin loss with exposed dermis • Stage 3 pressure injuries: full-thickness skin loss • Stage 4 pressure injuries: full-thickness loss of skin and tissue • Unstageable pressure injuries: obscured full-thickness skin and tissue loss • Suspected deep tissue injuries: persistent non-blanchable deep red, maroon or purple discolouration. > Every care recipient must be assessed for six stages of pressure injuries once each quarter. Residential care services should use the (National Pressure Ulcer Advisory Panel) NPUAP Pressure Injury Stages as a reference point. > Includes all respite care and end-of-life palliative care recipients. > The ICD-10-Australian Modified (AM) pressure injury classification system outlined in the Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline 2019 is the pressure injury classification system used for the purposes of the QI Program. > Exclusions • Care recipients who withheld consent to undergo an observation assessment for pressure injuries for the entire quarter • Care recipients who were absent from the service for the entire quarter
Related Information:	> National Aged Care Mandatory Quality Indicator Program. > National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Emergency Department Did Not Wait or Left at Own Risk – Aboriginal Health

Identifying and definitional attributes

Short Name:	Aboriginal Health - EDLAOR
Tier:	Tier 2
KPI ID:	SEC-AC-T2-1
Description:	Percentage (%) of emergency department (ED) Aboriginal and/or Torres Strait Islander patient presentations where the patient either did not wait to be seen or left at their own risk after treatment had been commenced.
Computation:	Count (#) of ED presentations where the Departure Status of the patient who identifies as Aboriginal and/or Torres Strait Islander was recorded as either did not wait or left at own risk after treatment commenced, divided by the count of ED presentations for patients who identify as Aboriginal and/or Torres Strait Islander, represented as a percentage.
Numerator:	Count (#) of ED presentations for patients who identify as Aboriginal and/or Torres Strait Islander where the patient Departure Status was either did not wait or left at own risk after treatment commenced.
Denominator:	Count (#) of ED presentations for patients who identify as Aboriginal and/or Torres Strait Islander.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- SALHN: FMC, NHS
- NALHN: LMH, MH
- WCHN: WCH
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mount Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Metro Target	≤7%	9%	11%	13%	15%	>15%
Regional Target	≤6%	7%	8%	9%	10%	>10%
Performance Score	2.5	2	1.5	1	0.5	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Emergency Department Data Collection (EDDC)

Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Left at own risk is defined as a patient who presents to ED and has a clerical and/or triage date/time recorded but leaves before treatment is completed or a medical decision is made. > Did not wait to be seen is defined as patient who did not wait to be seen by an ED clinician and/or meaningful treatment (as initiated by an ED Nurse) has not commenced. > Denominator includes patients who: • Left at own risk • Did not wait to be seen by a health care professional. > Data excludes patients classified as: • "Dead on Arrival, no resuscitation" • Presenting to the ED who require the intoxication treatment pathway (or Drug and Alcohol pathway). > Excludes Women's Assessment Unit at: • WCH • LMH
Related Information:	> 3.09 Discharge against medical advice - AIHW Indigenous HPF > Service Agreements 2024-25 SA Health

Rehabilitation - Timeliness of Care

Identifying and definitional attributes

Short Name:	Rehab Commencement < 1 Day
Tier:	Tier 2
KPI ID:	SEC-AC-T2-2
Description:	Proportion (%) of patients who commence a rehabilitation program within one day of being clinically ready for rehabilitation.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patients who commence a rehabilitation program within one day of being clinically ready for rehabilitation.
Denominator:	Count (#) of patients who commence rehabilitation on or after being clinically ready for rehabilitation.

More Information

Scope:

Data is reported for:

- CALHN
- SALHN
- NALHN

Benchmarks:

Target	≥80%	<80% and ≥75%	<75%
Performance Score	2.5	1.25	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	AROC extract file provided by each LHN
Frequency of Reporting:	Monthly (1 month lag i.e., July data reported in September)

Notes:

> This KPI is the same as AROC indicator – Rehabilitation Inpatient Commencement Within 1 Day Of Clinical Readiness.

> Clinically ready for rehabilitation defined in AROC data dictionary as:
A patient is “clinically ready for rehabilitation” when the rehabilitation physician, or physician with an interest in rehabilitation or delegate, deems the patient ready to start their rehabilitation program and have documented this in the patient’s medical record. Record the date patient is ready for rehabilitation and not the data rehabilitation starts.

> Numerator includes all separations from inpatient rehabilitation units (AROC pathway 3), where the AROC Episode begin date is less than or equal to the AROC Date Clinically Ready for Rehab date plus one day.

> Denominator includes all separations from inpatient rehabilitation units (AROC pathway 3), where the AROC Episode begin date is greater than or equal to the AROC Date Clinically Ready for Rehab date.

Related Information:	> Australian Commission on Safety and Quality in Health Care. Acute Stroke Clinical Care Standard 4 – Early Rehabilitation (2019). Acute Stroke Clinical Care Standard | Australian Commission on Safety and Quality in Health Care > AROC outcome targets: Reports and benchmarks - University of Wollongong - UOW > Service Agreements 2024-25 SA Health

Babies who Complete a Newborn Hearing Screening in Hospital

Identifying and definitional attributes

Short Name:	Newborn Hearing Screening Completed
Tier:	Tier 2
KPI ID:	SEC-AC-T2-3
Description:	% of Eligible Babies born who Complete a Newborn Hearing Screening in Hospital.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of Eligible Babies who Complete a Newborn Hearing Screening in Hospital.
Denominator:	Count (#) of Eligible Babies Born in Hospital.

More Information

Scope:

Data is reported for:

- NALHN - LMH
- SALHN - FMC
- WCHN - WCH
- BHFLHN: Gawler, Kangaroo Island, Kapunda, Mount Barker, South Coast
- EFNLHN: Ceduna, Port Lincoln
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mount Gambier, Naracoorte
- RMCLHN: Riverland (Berri), Loxton, Murray Bridge
- YNLHN: Clare, Crystal Brook, Jamestown, Port Pirie, Northern Yorke

Benchmarks:

Target	≥97%	<97% and ≥92%	<92%
Performance Score	2.5	1.25	0

Representation Class:	Ratio
Data Type:	Integer
Unit of Measure:	Episode
Data Source:	eCHIMS (CaFHS database)
Frequency of Reporting:	Quarterly
Notes:	> Eligible = >34 weeks, no evidence of atresia/microtia > Hearing screening completed as part of midwifery group practice is included as part of hospital admission

Related Information:	> Service Agreements 2024-2025 SA Health. > South Australian Perinatal Practice Guideline > National Framework for Newborn Hearing Screening > National performance indicators to support neonatal hearing screening in Australia

Aged Care: Unplanned Weight Loss (Significant)

Identifying and definitional attributes

Short Name:	Unplanned Weight Loss (Significant)
Tier:	Regional Tier 2
KPI ID:	SEC-AC-T2-4
Description:	Percentage (%) of care recipients who experienced significant unplanned weight loss equal to or greater than 5% over a three month period.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients who experienced significant unplanned weight loss equal to or greater than 5% for the assessment period
Denominator:	Count (#) of care recipients assessed during the assessment period.

More Information

Scope:

Data is reported for:

- BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS
- EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS
- FUNLHN - Hawker MPS, Quorn MPS
- RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS
- LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS
- YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS

Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.

Benchmarks:

Target	≤8%	>8% and ≤10%	>10%
Performance Score	2.5	1.25	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode

Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > Unplanned weight loss is where there is no written strategy and ongoing record relating to planned weight loss for the care recipient. > Significant unplanned weight loss is weight loss equal to or greater than 5% over a three month period. This is determined by comparing the last weight from the previous quarter and the last weight from the current quarter. Both these weights must be available to provide this result. > Excludes: Care recipients who: • withhold consent to be weighed at the starting and/or finishing weight collection dates; or • are receiving end-of-life care; or • did not have a finishing weight recorded for the current and/or previous quarter/s
Related Information:	> National Aged Care Mandatory Quality Indicator Program. > National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Aged Care: Medication Management – Antipsychotics

Identifying and definitional attributes

Short Name:	Aged Care - Antipsychotics
Tier:	Tier 2
KPI ID:	SEC-AC-T2-5
Description:	Percentage (%) of care recipients who have been prescribed antipsychotic medication.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients who have been prescribed antipsychotic medication.
Denominator:	Count (#) of care recipients assessed during the assessment period

More Information

Scope:

Data is reported for:

- BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS
- EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS
- FUNLHN - Hawker MPS, Quorn MPS
- RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS
- LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS
- YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS

Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.

Benchmarks:

Target	≤17%	>17% and ≤19%	>19%
Performance Score	2.5	1.25	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program.

	> Psychosis is characterised by symptoms such as delusions, hallucinations, and perceptual disturbances, and by the severe disruption of ordinary behaviours (adapted from the ICD-10-AM, 2017). > Medication is defined as a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical and/or mental welfare of people. It includes prescription and non-prescription medicines, including complementary health care products, irrespective of the administered route. > Exclusions > Care recipients admitted to hospital for the entire seven-day assessment period.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. > National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Orthogeriatric Time To Surgery < 36 Hrs

Identifying and definitional attributes

Short Name:	Orthogeriatric surgery < 36 hrs
Tier:	Monitor
KPI ID:	SEC-AC-M-1
Description:	Proportion (%) of orthogeriatric patients presenting with a hip fracture, for whom surgery is indicated, receiving surgery within 36 hours of presentation.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of separations in denominator where the patient underwent surgery within 36 hours of presentation.
Denominator:	Count (#) of separations in period from acute setting of geriatric patients with a hip fracture, on whom surgery was performed during the admission.

More Information

Scope:	Data reported for: • CALHN • SALHN • NALHN: LMH • LCLHN: Mount Gambier
Benchmarks:	Target: ≤90% Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Separations
Data Source:	Hospital PAS systems, Casemix data ORMIS (Operating Theatre data)
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:	> Numerator**:**
	• The day of presentation with a hip fracture is calculated as follows:
	  ○ Where source of referral = Inter-hospital transfer, the arrival date/time at the transferring hospital is used (if transferring hospital is a metropolitan public hospital or one of the 16 casemix regional hospitals).
	  ○ For other presentations, the emergency department (ED) presentation date/time is used (where a link to the ED episode has been achieved) or the admission date/time (where no link achieved). The end point is the first operation date for that patient during that admission. Note that this may return incorrect data for patients having multiple surgeries. Analysis shows that coding of surgical procedures in ORMIS is not currently of high enough quality to use for this indicator.

	> Denominator: • All separations in the period are counted where the following conditions are met: ○ The casemix record or the LARS record has a first operating theatre procedure date/time present. ○ Has an associated diagnosis (primary or secondary) in the range [S72.0x] or [S72.10, S72.11 or S72.2] – fracture of femur. ○ An external cause code indicating a fall is present in the coding for the admission [W00]-[W19]. ○ The patient is 65 years or older at time of admission or is aboriginal or Torres Strait islander and 50 years or older. ○ The patient had one of the following surgical procedures during the admission: ▪ 4751900 IF fracture trochanteric/subcapital femur ▪ 4752200 Hemiarthroplasty of femur ▪ 4752801 Open reduction fracture femur with IF ▪ 4753100 Closed reduction fracture femur with IF ▪ 4931500 Partial arthroplasty of hip ▪ 4931800 Arthroplasty of hip, unilateral.
Related Information:	> Australian Commission on Safety and Quality in Health Care, Indicator Specification: Hip Fracture Care Clinical Care Standard, September 2016. https://meteor.aihw.gov.au/content/index.phtml/itemId/696436 > Service Agreements 2024-25 SA Health

Neonatal - APGAR Score < 7 At 5 Minutes for Live Birth Term Infants

Identifying and definitional attributes

Short Name:	APGAR Score
Tier:	Monitor
KPI ID:	SEC-AC-M-2
Description:	Proportion (%) of live born babies at or after term (from 37 completed weeks gestational age) with an APGAR score of less than 7 at 5 minutes after birth.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of live babies born at or after term (from 37 completed weeks gestational age) with an APGAR score of less than 7 at 5 minutes.
Denominator:	Count (#) of live babies born at or after term (from 37 completed weeks gestational age).

More Information

Scope:	Data is reported for: • NALHN: LMH • SALHN: FMC • WCHN: WCH • BHFLHN: Gawler, Mt Barker, South Coast • EFHLHN: Port Lincoln, Ceduna • FUNLHN: Whyalla, Port Augusta • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Wallaroo, Clare
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	Pregnancy Outcomes Unit
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> The APGAR score is a system of assessing the baby's breathing, pulse, colour, movement and reflexes at 5 minutes after birth. It is a score out of 10, with higher scores indicating better condition of the baby. A score of less than 7 at 5 minutes after birth is an indicator of complications and of compromise for the baby.

Related Information:	> National Core Maternity Indicators: PI 04–Apgar score of less than 7 at 5 minutes for births at or after term, 2024 (aihw.gov.au) > Service Agreements 2024-25 SA Health

Obstetrics - Induction of Labour for Selected Primiparae

Identifying and definitional attributes

Short Name:	Induced Labour for Selected Primiparae
Tier:	Monitor
KPI ID:	SEC-AC-M-3
Description:	Proportion (%) of selected females who gave birth for the first time and who had labour induced.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of selected females who gave birth for the first time and who had labour induced.
Denominator:	Count (#) of all selected females.

More Information

Scope:	Data is reported for: • NALHN: LMH • SALHN: FMC • WCHN: WCH • BHFLHN: Gawler, Mt Barker, South Coast • EFHLHN: Port Lincoln • FUNLHN: Whyalla, Port Augusta • LCLHN: Mt Gambier • RMCLHN: Riverland (Berri), Murray Bridge • YNLHN: Port Pirie, Wallaroo, Clare
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	Pregnancy Outcomes Unit
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> Selected females' criteria are defined as females who gave birth for the first time and meet all of the following criteria: • aged between 20 and 34 • gestational age at birth between 37 and 41 completed weeks • pregnancy has one baby only (singleton) • the presentation of the baby is vertex (baby's head was at the cervix). > Excluded are those females who have given birth prior to the current pregnancy or do not meet the selected females' criteria. > A birth is defined as an event in which a baby comes out of the uterus after a pregnancy of at least 20 weeks gestation or weighing 400 grams or more. > Induction of labour is a set of procedures (pharmacological and/or instrumental) to start the uterus contracting and begin the process of labour.

	> Gestational age is a clinical measure of the duration of the pregnancy. For the National Perinatal Data Collection gestational age is reported as completed weeks.
Related Information:	> National Core Maternity Indicators: PI 05–Induction of labour for selected females giving birth for the first time, 2024 (aihw.gov.au) > Service Agreements 2024-25 SA Health

Planned C-Sections Performed At < 39 Weeks' Gestation Without an Obstetric or Medical Indication

Identifying and definitional attributes

Short Name:	Planned C-Section Performed at <39 weeks
Tier:	Monitor
KPI ID:	SEC-AC-M-4
Description:	Proportion (#) of women who gave birth by caesarean section at less than 39 completed weeks (273 days) gestation without an obstetric or medical indication.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of women who gave birth by caesarean section at less than 39 completed weeks (273 days) gestation without adequate obstetric/medical indication and where there was no established labour.
Denominator:	Count (#) of women who gave birth by caesarean section at less than 39 completed weeks (273 days) gestation and where there was no established labour.

More Information

Scope:	Data is reported for: • NALHN • SALHN • WCHN • BHFLHN • EFHLHN • FUNLHN • LCLHN • RMCLHN • YNLHN
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	Pregnancy Outcomes Unit
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September rata reported in November)
Notes:	> A birth is defined as the event in which a baby comes out of the uterus after a pregnancy of at least 20 weeks' gestation or weighing 400 grams or more. > Births included are caesarean deliveries (where there was no established labour) at less than 39 completed weeks (273 days). > 'Without adequate obstetric/medical indication' includes the following reasons for caesarean section: • previous caesarean section • previous severe perineal trauma • previous shoulder dystocia

	• maternal choice in the absence of any obstetric, medical, surgical, psychological indications. > Births excluded are: • caesarean deliveries at or after (i) 39 completed weeks (273 days) gestation, (ii) 37 completed weeks (259 days) gestation • where there was established labour • all vaginal deliveries • those delivered pre-term by caesarean section (where there was no established labour) with obstetric/medical indication (all reasons for caesarean section other than those listed previously). > Cells of less than 5 have been suppressed. This is the lowest level of suppression that all states and territories have agreed to for the release of data from the National Perinatal Data Collection. > Proportions have been suppressed where the denominator is less than 100, for reliability purposes.
Related Information:	> Australian Commission on Safety and Quality in Health Care, Early planned caesarean section without medical or obstetric indication special report. https://www.safetyandquality.gov.au/publications-and-resources/resource-library/fourth-atlas-healthcare-variation-2021-early-planned-births-full-chapter > Service Agreements 2024-25 SA Health

Palliative Care – Timeliness of Care

Identifying and definitional attributes

Short Name:	Pal Care -Timeliness of Care
Tier:	Monitor
KPI ID:	SEC-AC-M-5
Description:	Percentage (%) of palliative care patient episodes commenced within 2 days of the patient being ready for care.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of patient episodes that start on the day of, or the day after, the date the patient required palliative care.
Denominator:	Count (#) of all palliative care patient episodes within the reporting period.

More Information

Scope:	Data is reported for: • NALHN • SALHN • BHFLHN • EFNLHN • FUNLHN • LCLHN • RMCLHN • YNLHN
Benchmarks:	Target: ≤90% Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Palliative Care Outcomes Collaboration
Frequency of Reporting:	Quarterly (1 Month lag, July to September data reported in November)
Notes:	> Time from date ready for care to episode start reports responsiveness of palliative care services to patient needs. > Only includes episodes that have commenced in the reporting period. > Benchmark was set following feedback and subsequent consultation with PCOC participants. > Service providers acknowledge that, whilst there is wide variation in the delivery of palliative care across the country, access to palliative care should be measured based on patient need rather than service availability. As a result, services operating five days a week (Monday to Friday) are not distinguished from services operating seven days a week (all services are being benchmarked together).

Related Information:	> Palliative Care Outcomes Collaboration https://www.uow.edu.au/ahsri/pcoc/ > PCOC National Outcome Measures and Benchmarks https://documents.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow264946.pdf > Service Agreements 2024-25 SA Health

Aged Care: Unplanned Consecutive Weight Loss

Identifying and definitional attributes

Short Name:	Aged Care - Unplanned Weight Loss (Consecutive)
Tier:	Monitor
KPI ID:	SEC-AC-M-6
Description:	Percentage (%) of care recipients who experienced consecutive unplanned weight loss.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients who experienced consecutive unplanned weight loss for the reporting period.
Denominator:	Count (#) of care recipients assessed during the assessment period.

More Information

Scope:	Data is reported for: • BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS • EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS • FUNLHN - Hawker MPS, Quorn MPS • RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS • LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS • YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)

Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > Unplanned weight loss is where there is no written strategy and ongoing record relating to planned weight loss for the care recipient. > Consecutive unplanned weight loss is weight loss of any amount every month over three consecutive months of the quarter. This can only be determined if the care recipient is weighed on all three occasions within the quarter, and at the end of the previous quarter (previous quarter finishing weight). > Excludes: Care recipients who: • withhold consent to be weighed at the starting, middle and/or finishing weight collection dates; or • are receiving end-of-life care; or • do not have a previous, starting, middle and/or finishing weight recorded; • are excluded from assessments to determine whether there has been consecutive weight loss.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. > National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Aged Care: Recipients who experienced one or more Falls

Identifying and definitional attributes

Short Name:	Aged Care - Falls
Tier:	Monitor
KPI ID:	SEC-AC-M-7
Description:	Rate of care recipients who experienced a fall (one or more) during the assessment period.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients who experienced a fall (one or more) during the assessment period.
Denominator:	Count (#) of care recipients assessed during the assessment period.

More Information

Scope:	Data is reported for: • BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS • EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS • FUNLHN - Hawker MPS, Quorn MPS • RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS • LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS • YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > A fall is defined as an event that results in a person coming to rest inadvertently on the ground or floor or other lower level. > Exclusions • Care recipients who were absent from the service for the entire quarter.

Related Information:	> National Aged Care Mandatory Quality Indicator Program. > National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Aged Care: Medication Management - Polypharmacy

Identifying and definitional attributes

Short Name:	Aged Care - Polypharmacy
Tier:	Monitor
KPI ID:	SEC-AC-M-8
Description:	Percentage of care recipients who were prescribed nine or more medications.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients who have been prescribed nine or more medications.
Denominator:	Count (#) of care recipients assessed during the assessment period

More Information

Scope:	Data is reported for: • BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS • EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS • FUNLHN - Hawker MPS, Quorn MPS • RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS • LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS • YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > Medication is defined as a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise enhancing the physical and/or mental welfare of people. It includes prescription and non-prescription medicines, including complementary health care products, irrespective of the administered route. > Polypharmacy is defined as the prescription of nine or more medications which include an active ingredient to a care recipient.

	> Exclusions > Lotions, creams or ointments used in skin and wound care; > Dietary supplements, including those containing vitamins; > Short-term medications, such as antibiotics or temporary eye drops; and > PRN medications. > Different dosages of the same medicine must not be counted as different medications. > Care recipients who were a hospital admitted patient on the collection date.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. > National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Aged Care: Activities of Daily Living

Identifying and definitional attributes

Short Name:	Aged Care – Daily Living
Tier:	Monitor
KPI ID:	SEC-AC-M-9
Description:	Percentage of care recipients who experienced a decline in activities of daily living assessment total score of one or more points
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of Activities of Daily Living assessment scores from the current quarter
Denominator:	Count (#) of Activities of Daily Living assessment scores from the previous quarter

More Information

Scope:	Data is reported for: • BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS • EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS • FUNLHN - Hawker MPS, Quorn MPS • RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS • LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS • YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)

Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > The Barthel Index of Activities of Daily Living (ADL assessment) is the assessment tool used for the purposes of the QI Program > Exclusions: • Care recipients who are receiving end-of-life care • Care recipients who were absent from the service for the entire quarter • Care recipients who did not have an ADL assessment total score recorded for the previous quarter
Related Information:	> National Aged Care Mandatory Quality Indicator Program. National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care Barthel Index – Appendix A Barthel Index of Activities of Daily Living - Page 62 > Service Agreements 2024-25 SA Health

Aged Care: Incontinence Care

Identifying and definitional attributes

Short Name:	Aged Care – Incontinence Care
Tier:	Monitor
KPI ID:	SEC-AC-M-10
Description:	Percentage (%) of care recipients who experienced incontinence associated dermatitis (IAD)
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients with incontinence who experienced IAD
Denominator:	Count (#) of care recipients with incontinence

More Information

Scope:	Data is reported for: • BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS • EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS • FUNLHN - Hawker MPS, Quorn MPS • RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS • LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS • YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)

Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > Incontinence associated dermatitis (IAD) is defined in the Ghent Global IAD Categorisation Tool as a specific type of irritant contact dermatitis characterised by erythema and oedema of the peri-anal or genital skin. In some cases, IAD is accompanied by bullae, erosion or secondary cutaneous infection. > Exclusions: • Care recipients who are receiving end-of-life care • Care recipients who were absent from the service for the entire quarter • Care recipients who did not have an ADL assessment total score recorded for the previous quarter
Related Information:	> National Aged Care Mandatory Quality Indicator Program. National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Aged Care: Hospitalisation

Identifying and definitional attributes

Short Name:	Aged Care – Hospitalisation
Tier:	Monitor
KPI ID:	SEC-AC-M-11
Description:	Percentage (%) of care recipients who had one or more emergency department presentations.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients who had one or more emergency department presentations during the quarter
Denominator:	Count (#) of care recipients assessed for hospitalisation

More Information

Scope:	Data is reported for: • BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS • EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS • FUNLHN - Hawker MPS, Quorn MPS • RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS • LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS • YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)

Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > An emergency department presentation occurs when a care recipient presents to an emergency department or urgent care centre. This includes all emergency department presentations occurring in person, or via a technology enabled platform (e.g. telehealth or virtual). > A hospital admission occurs when a care recipient is accepted by a hospital inpatient speciality service for ongoing management. This includes all hospital admissions, planned or unplanned, of any length (e.g. same day or overnight), occurring in any location (e.g. hospital or hospital in the home). > Exclusions: • Care recipients who were absent from the service for the entire quarter
Related Information:	> National Aged Care Mandatory Quality Indicator Program. National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Aged Care: Staff Turnover

Identifying and definitional attributes

Short Name:	Aged Care – Turnover
Tier:	Monitor
KPI ID:	SEC-AC-M-12
Description:	Percentage (%) of staff turnover for staff who were employed at the start of the quarter as: – service managers – nurse practitioners or registered nurses – enrolled nurses – personal care staff or assistants in nursing
Computation:	Percentage (%) of staff turnover during the assessment quarter
Numerator:	Count (#) of Staff who stopped working during the assessment quarter
Denominator:	Count (#) of Staff who were employed at the start of the quarter

More Information

Scope:	Data is reported for: • BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS • EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS • FUNLHN - Hawker MPS, Quorn MPS • RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS • LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS • YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal

Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > Staff include: • **Service managers** is defined as staff who manage the operations of a residential aged care service. This includes leading staff teams to ensure the provision of quality care, in line with the aged care standards. • **Nurse practitioners** is defined as staff who are registered as nurse practitioners with the Nursing and Midwifery Board of Australia. • **Registered nurses** is defined as staff who are registered as registered nurses with the Nursing and Midwifery Board of Australia. • **Enrolled nurses** is defined as staff who are registered as enrolled nurses with the Nursing and Midwifery Board of Australia. • **Personal care staff** is defined as staff who provide personalised care in a direct care role to care recipients. Common duties include working under the guidance and supervision of medical professionals, monitoring and communicating care recipient's condition to the Director of Nursing, personal hygiene, providing meals and other health and wellness related activities in accordance with the care recipient's care plan. • **Assistants in nursing** is defined as staff who provide personalised nursing care in a direct care role to care recipients. Common duties include working under the guidance and supervision of medical professionals, monitoring and communicating care recipient's condition to the Director of Nursing, personal hygiene, providing meals and other health and wellness related activities in accordance with the care recipient's care plan.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Aged Care: Consumer Experience

Identifying and definitional attributes

Short Name:	Aged Care – Consumer Experience
Tier:	Monitor
KPI ID:	SEC-AC-M-13
Description:	Percentage (%) of care recipients who report 'good' or 'excellent' experience of the service utilising the Quality of Care Experience Aged Care Consumers© (QCE-ACC) tool
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients whose total score falls in the categories of Good (19-21) or Excellent (22-24)
Denominator:	Count (#) of care recipients who reported consumer experience through each completion mode of the QCE-ACC (self-completion, interviewer facilitated completion or proxy-completion).

More Information

Scope:	Data is reported for: • BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS • EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS • FUNLHN - Hawker MPS, Quorn MPS • RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS • LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS • YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)

Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > The Quality of Care Experience Aged Care Consumers © *Flinders University 2022* (QCE-ACC) tool was co-designed with older Australians to assess important aspects of consumer experience. The QCE-ACC is comprised of six questions focused on key attributes to the quality of care experience — respect and dignity, supported decision-making, skills of aged care staff, impact on health and wellbeing, social relationships and community connection, and confidence in lodging complaints. > QCE-ACC Scores are as follows: • **Excellent** consumer experience: where a care recipient scores between 22–24 • **Good** consumer experience: where a care recipient scores between 19–21 • **Moderate** consumer experience: where a care recipient scores between 14–18 • **Poor** consumer experience: where a care recipient scores between 8–13 • **Very poor** consumer experience: where a care recipient scores between 0–7 > Exclusions: • Care recipients who were absent from the service for the entire quarter • did not choose to complete the QCE-ACC for the entire quarter.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Aged Care: Quality of Life

Identifying and definitional attributes

Short Name:	Aged Care – Quality of Life
Tier:	Monitor
KPI ID:	SEC-AC-M-14
Description:	Percentage (%) of care recipients who report 'good' or 'excellent' quality of life utilising the Quality of Life Aged Care Consumers © (QCE-ACC) tool
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of care recipients whose total score falls in the categories of Good (19-21) or Excellent (22-24)
Denominator:	Count (#) of care recipients who reported consumer experience through each completion mode of the QCE-ACC (self-completion, interviewer facilitated completion or proxy-completion).

More Information

Scope:	Data is reported for: • BHFLHN – Eudunda Senior Citizens Hostel, Kapunda Homes, Strathalbyn and District Aged Care, Torrens Valley Aged Care, Kangaroo Island MPS • EFNLHN – Ceduna MPS, Coober Pedy MPS, Cleve MPS, Cowell MPS, Kimba MPS, Cummins MPS, Tumby Bay MPS, Elliston MPS, Streaky Bay MPS, Wudinna MPS • FUNLHN - Hawker MPS, Quorn MPS • RMCLHN - Bonney Lodge, Loxton District Nursing Home, Renmark Nursing Home, Meningie MPS, Tailem Bend MPS, Karoonda MPS, Lameroo MPS, Pinnaroo MPS, Waikerie MPS • LCLHN - Charla Lodge, Naracoorte Health Service, Sheoak Lodge, Kingston SE/Robe MPS, Penola MPS • YNLHN - Ira Parker Nursing Home, Jamestown Hospital & Health Service, Kara House, Melaleuca Crt Nursing Home, Nalya Lodge Hostel, Orroroo Community Home, Hammill House, Wakefield Aged Care Service, Burra MPS, Snowtown MPS, Crystal Brook MPS, Laura MPS Both Residential Aged Care (RAC) & Multi-Purpose Sites (MPS) are in-scope.
Benchmarks:	N/A
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Manual data collection via My Aged Care Portal
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)

Notes:	> Aligned with the National Aged Care Mandatory Quality Indicator program. > The Quality of Life Aged Care Consumers © Flinders University 2022 (QOL-ACC) tool was co-designed with older Australians to assess important aspects of quality of life. The QOL-ACC is comprised of six questions focused on six key attributes of quality of life — independence, mobility, pain management, emotional wellbeing, social relationships, and leisure activities/hobbies. > QOL-ACC Scores are as follows: • **Excellent** consumer experience: where a care recipient scores between 22–24 • **Good** consumer experience: where a care recipient scores between 19–21 • **Moderate** consumer experience: where a care recipient scores between 14–18 • **Poor** consumer experience: where a care recipient scores between 8–13 • **Very poor** consumer experience: where a care recipient scores between 0–7 > Exclusions: • Care recipients who were absent from the service for the entire quarter • did not choose to complete the QOL-ACC for the entire quarter.
Related Information:	> National Aged Care Mandatory Quality Indicator Program. National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A | Australian Government Department of Health and Aged Care > Service Agreements 2024-25 SA Health

Surgeries that commenced within the Emergency Surgery Category Timeframe (%)

Identifying and definitional attributes

Short Name:	Emergency Surgeries Commenced on Time
Tier:	Monitor
KPI ID:	SEC-AC-M-15 to SEC-AC-M-22
Description:	The percentage (%) of emergency surgeries which commenced within the required timeframe for the Emergency Surgery Clinical Priority Category (ESCPC) allocated for surgery.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of emergency surgeries that commenced within the ESCPC timeframe by ESCPC.
Denominator:	Count (#) of emergency surgeries by ESCPC.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- NALHN: LMH, MH
- SALHN: FMC, NHS
- WCHN: WCH
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mt Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Clinical Priority Category	Definition	ORMIS Code	Target
Category 1	Patient requires surgery within 30 minutes	0.5	≥ 80%
Category 2	Patient requires surgery within 1 hour	001	≥ 80%
Category 3	Patient requires surgery within 4 hours	004	≥ 80%
Category 4	Patient requires surgery within 12 hours	012	≥ 80%
Category 5	Patient requires surgery within 24 hours	024	≥ 80%
Category 6	Patient requires surgery within 72 hours	072	≥ 80%
Category 7	Patient requires surgery within 120 hours	120	≥ 80%

Representation Class:	Percentage (%)
Data Type:	Number
Unit of Measure:	Time
Data Source:	ORMIS

Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	Inclusions: > Emergency Operations in any theatre session with a clinical priority category of category 1, 2, 3, 4, 5, 6, 7 (inclusive). > Operations with a valid start time (‘wheels in’ time or anaesthetic start time, whichever is earlier). Exclusions > Cancelled operations. > Elective/Scheduled operations > Operations where operation booking requested field is either NULL or after the operation start time. Rationale Compliance with ESCPC timeframes is a useful measure to determine whether emergency surgery is being appropriately managed. This will ensure that patients requiring emergency surgery are treated according to clinical priorities and resources are allocated according to need. Additional Information Emergency surgery is defined as surgery to treat trauma or acute illness. While this predominantly occurs subsequent to an emergency attendance, it can also include unplanned surgery for patients who are already admitted and unplanned surgery for patients who are awaiting elective procedures. The patient’s surgery urgency category is assigned by a clinician at the time a theatre booking request is confirmed for an emergency procedure. The numerator is the number of emergency surgeries that commenced within the ESCPC timeframe. To determine if surgery is within the ESCPC timeframe, calculate minutes between operation booked (OPE_BOOK_REQUESTED) and operation start time (OPE_START_ TIME). OPE_START_TIME is a derived field - the earliest of OPE_ANAE_STRT and OPE_ARRIVE_THEATRE. If OPE_ANAE_STRT = ’1999-12-30’ or NULL then OPE_ANAE_START is replaced with OPE_ANAE_PTREADY. To calculate the numerator, sum the number of operations for each category, where time operation commenced minus time operation booked is within ESUC time frame. There may be other circumstances where emergency surgeries occur outside primary theatres and are therefore not recorded on ORMIS (For example: surgeries in the Emergency Department, endoscopy suite or cardiac catheter laboratory). The clinical reality of emergency surgery means ESCPC data is often entered retrospectively, leaving some room for data entry error. Some records are excluded where recorded times are invalid (e.g. where request time is later than operation start time. This may potentially influence the accuracy of the data if large numbers of operations are excluded.
Related Information:	

		CALHN	NALHN	SALHN	WCHN
Emergency Surgery Priority Categorisations	**Immediate / Within 15 minutes**				**000**: Cat 1 - Immediate Procedure
	Within 1 hour	**001 (E1) - Life Threatening** - Requires surgery within 1 hour - Immediate risk to life or limb	**001** - Immediately life threatening		**001**: Cat 2 - Within 1 hour
	Within 2 hours				
	Within 4 hours	**004 (E4) - Extremely Urgent** - Requires surgery within 4 hours - Physiologically stable but immediate risk to life or limb survival or systemic decompensation	**004** - Body part at risk		**004**: Cat 3 - Extremely urgent within 4 hours
	Within 6 hours				
	Within 8 hours				
	Within 12 hours	**012 (E12) - Urgent** - Requires surgery within 12 hours - Physiologically stable but surgical problem may undergo significant deterioration if untreated – **not in use**	**012** - Urgent		**012**: Cat 4 - Urgent deterioration within 12 hours
	Within 24 hours	**024 (E24) - Urgent (non-critical)** - Requires surgery within 24 hours - Stable condition.	**024** - Semi-urgent	**024** - Emergency Surgery	**024**: Cat 5 - Procedure within 24 hours
	Within 48 hours				
	Within 72 hours	**072 (E72) - Urgent (non-critical)** - Inpatient requires surgery within 72 hours - Stable condition			**072**: Cat 6 - Non-critical within 72 hours
	Within 120 hours (Ambulatory)	**120 - Urgent (non-critical)** - Ambulatory emergency surgery patient requires surgery/procedure within 120 hours as a day-case.			
	Within 10 days (Inpatient)				
	Within 10 days (Ambulatory)				
Emergency Obstetrics Priority Categorisations	**Within 30 minutes**	N/A	**0.5** - Category 1	**0.5** - Category 1 - patients require within 30 min of operation booking time.	**000** - Category 1
	Within 1 hour	N/A	**001** - Category 2	**001** - Category 2 - patients require within 1 hour of operation booking time.	**001** - Category 2
	Within 4 hours	N/A	**004** - Category 3	**004** - Category 3 - patients require within 4 hours of operation booking time.	**004** - Category 3
	Within 24 hours	N/A	**024** - Category 4	**024** - Category 4 - patients require within 24 hours of operation booking time.	**024** - Category 4

Number of Emergency Surgeries by Clinical Priority Category

Identifying and definitional attributes

Short Name:	Emergency Surgeries Completed
Tier:	Monitor
KPI ID:	SEC-AC-M-23 to SEC-AC-M-30
Description:	The number (#) of emergency surgeries by the Emergency Surgery Clinical Priority Category (ESCPC) allocated for surgery.
Computation:	Count (#) of emergency surgeries by ESCPC.

More Information

Scope:

Data is reported for:

- CALHN: RAH, TQEH
- NALHN: LMH, MH
- SALHN: FMC, NHS
- WCHN: WCH
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mt Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Clinical Priority Category	Definition	ORMIS Code
Category 1	Patient requires surgery within 30 minutes	0.5
Category 2	Patient requires surgery within 1 hour	001
Category 3	Patient requires surgery within 4 hours	004
Category 4	Patient requires surgery within 12 hours	012
Category 5	Patient requires surgery within 24 hours	024
Category 6	Patient requires surgery within 72 hours	072
Category 7	Patient requires surgery within 120 hours	120

Representation Class:	Count (#)
Data Type:	Integer
Unit of Measure:	Surgeries
Data Source:	ORMIS
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	Inclusions:

	> Emergency Operations in any theatre session with a clinical priority category of category 1, 2, 3, 4, 5, 6, 7 (inclusive). > Operations with a valid start time ('wheels in' time or anaesthetic start time, whichever is earlier). Exclusions > Cancelled operations. > Elective/Scheduled operations > Operations where operation booking requested field is either NULL or after the operation start time. Additional Information Emergency surgery is defined as surgery to treat trauma or acute illness. While this predominantly occurs subsequent to an emergency attendance, it can also include unplanned surgery for patients who are already admitted and unplanned surgery for patients who are awaiting elective procedures. The patient's surgery urgency category is assigned by a clinician at the time a theatre booking request is confirmed for an emergency procedure. There may also be circumstances where emergency surgeries occur outside primary theatres and are therefore not recorded on ORMIS (For example: surgeries in the Emergency Department, endoscopy suite or cardiac catheter laboratory). The clinical reality of emergency surgery means ESCPC data is often entered retrospectively, leaving some room for data entry error. Some records are excluded where recorded times are invalid (e.g. where request time is later than operation start time. This may potentially influence the accuracy of the data if large numbers of operations are excluded.
Related Information:	

Effectiveness of Care

Avoidable Hospital Readmissions

Identifying and definitional attributes

Short Name:	Avoidable Hospital Readmissions
Tier:	Tier 1
KPI ID:	SEC-EC-T1-1
Description:	Percentage (%) of inpatient separations meeting the avoidable hospital readmissions criteria.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of inpatient separations meeting the avoidable hospital readmissions criteria in the period.
Denominator:	Count (#) of inpatient separations in the same period.

More Information

Scope:

Data is reported for:

- CALHN
- SALHN
- NALHN
- WCHN
- BHFLHN: Gawler, South Coast, Mount Barker
- FUNLHN: Port Augusta, Whyalla
- EFNLHN: Port Lincoln
- RMCLHN: Riverland (Berri), Murray Bridge
- LCLHN: Mount Gambier
- YNLHN: Port Pirie

Benchmarks:

Target	≤2%	>2% and ≤2.5%	>2.5%
Performance Score	5	2.5	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:

> A hospital readmission occurs when a patient has been discharged from hospital and is admitted again within a certain time interval.

> Generally, hospital readmissions can be considered in two broad categories:

1. Readmissions that relate to routine care, for example those that relate to necessary treatments such as chemotherapy or dialysis, and are required to ensure safe clinical care;

2. Readmissions that are potentially avoidable.

> Reducing avoidable hospital readmissions (AHRs) supports better health outcomes, improves patient safety and leads to greater efficiency in the health system.

> The Australian Commission on Safety and Quality in Health Care defines an 'avoidable hospital readmission' as occurring when a patient who has been discharged from hospital (index admission) is admitted again within a certain time interval, and the readmission:

- Is clinically related to the index admission, and
- Has the potential to be avoided through improved clinical management and/or appropriate discharge planning in the index admission.

> Codes/conditions considered to be avoidable hospital readmissions and associated condition-specific time intervals were developed by the Australian Commission on Safety and Quality in Health Care and endorsed by the Australian Health Ministers' Advisory Council and are summarised in the table below. Associated avoidable hospital readmission numbers and ICD codes can be found here.

List of conditions considered to be avoidable hospital readmissions		
Readmission complication	**Readmission diagnosis**	**Interval (days)**
Pressure Injury	Stage III Ulcer	14
	Stage IV Ulcer	7
	Unspecified decubitus and pressure area	14
	Unstageable pressure injury	14
	Suspected deep tissue injury, depth unknown	14
Infections	Urinary Tract Infection	7
	Surgical Site Infection	30
	Pneumonia	7
	Blood stream infection	2
	Central line and peripheral line associated blood stream infection	2
	Multi-resistant organism	2
	Infection associated with devices, implants and grafts	90
	Infection associated with devices, implants and grafts in genital tract or urinary system	30
	Infection associated with peritoneal dialysis catheter	2
	Gastrointestinal infections	28
	Other high impact infections	2
Surgical Complications	Postoperative haemorrhage/haematoma	28
	Surgical wound dehiscence	28
	Anastomotic leak	28
	Cardiac vascular graft failure	28
	Pain following surgery	14
	Other surgical complications	28
Respiratory complications	Respiratory failure including acute respiratory distress syndromes	21
	Aspiration pneumonia	14
	Pulmonary oedema	30
	Movement disorders due to psychotropic medications	14
	Serious alteration to conscious state due to psychotropic medication	14
Venous thromboembolism	Venous thromboembolism	90

Renal failure	Renal failure	21
Gastrointestinal bleeding	Gastrointestinal bleeding	2
Medication complications	Drug-related respiratory complications/depression	2
	Hypoglycaemia	4
Delirium	Delirium	10
Cardiac complications	Heart Failure	30
	Ventricular arrhythmias and cardiac arrest	30
	Atrial tachycardia	14
	Acute coronary syndrome including unstable angina, STEMI and NSTEMI	30
Other	Constipation	14
	Nausea and vomiting	7

> Index admissions exclude separations with any of the following:
- Multi-purpose services and Mothercraft facilities.
- Hospital boarder, organ procurement, unqualified newborns (Care type: 9, 10, 7 with no qualified days).
- Not discharged alive (Nature of Separation: 5 or 6).
- Discharged against medical advice (Nature of Separation: 8).
- Admitted for same day and overnight chemotherapy and dialysis (DRG= R63Z, L61Z or L68Z, with length of stay < 2 days).
- Admitted for palliative care (Care type: 3).
- Admitted for oncology or haematology (any diagnosis: C00 to D89).
- Admitted for neonatal care (Care type: 7 with qualified days).

> Readmissions exclude separations with any of the following:
- Multi-purpose services and Mothercraft facilities.
- Not acute care type (Care type not 1).
- Non-emergency admission (Urgency status not 1)
- Admitted for same day and overnight chemotherapy and dialysis (DRG= R63Z, L61Z or L68Z, with length of stay < 2 days).
- Admitted for oncology or haematology (any diagnosis: C00 to D89).
- Admitted for childbirth (DRG: O01ABC, O02AB, O60ABC).
- Admitted for neonatal care (Care type: 7).

> A readmission is deemed as an avoidable hospital readmission if all the following are met:
- The index and readmission separations meet the respective exclusions criteria.
- The readmission has a Principal diagnosis on the 'Codes' list (and/or an additional diagnosis where specified).
- The readmission meets any additional criteria (where specified).
- The interval between the index admission and readmission (in days) is less than or equal to the interval specified.
  i.e., date of admission (of readmission) - date of separation (of index admission) ≤ interval.

Related Information:

> Australian Commission on Safety and Quality in Health Care: The National Health Reform Agreement Addendum reforms: Avoidable Hospital Readmissions.
Avoidable hospital readmissions | Australian Commission on Safety and Quality in Health Care

> Service Agreements 2024-25 SA Health

Emergency Department Unplanned Re-attendances within 48 hours

Identifying and definitional attributes

Short Name:	ED Unplanned Re-Attendances <48HR
Tier:	Tier 2
KPI ID	SEC-EC-T2-1
Description:	Proportion (%) of emergency department (ED) presentations identified as an unplanned re-attendance occurring within 48 hours of initial presentation.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of ED presentations identified as an unplanned attendance within 48 hours of initial presentation.
Denominator:	Count (#) of ED presentations where previous Departure Status is Not Stated, Unknown or Episode Complete.

More Information

Scope:

Data is reported for:

- CALHN: RAH, QEH
- SALHN: FMC, NHS
- NALHN: LMH, MH
- WCHN: WCH
- BHFLHN: Gawler, South Coast, Mount Barker
- EFNLHN: Port Lincoln, Ceduna
- FUNLHN: Port Augusta, Whyalla
- LCLHN: Mount Gambier
- RMCLHN: Riverland (Berri), Murray Bridge
- YNLHN: Port Pirie, Northern Yorke (Wallaroo)

Benchmarks:

Regional Target	≤4.5%	5.5%	6.5%	7.5%	8.5%	>8.5%
Performance Score	2.5	2	1.5	1	0.50	0

Metro Target	≤4.5%	>4.5% and ≤6.5%	>6.5%
Performance Score	2.5	1.25	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Episode
Data Source:	Admitted Patient Care, formerly Integrated South Australian Activity Collection (ISAAC)
Frequency of Reporting:	Monthly (i.e., July data reported in August)

Notes:	> Re-attendance is defined as the same patient presenting to the same hospital ED within 48 hours or less of the previous presentation. > Previous Departure Status must equal: • 98 (Not Stated) • 99 (Unknown) • 1 (Episode Complete: home) • 9 (Episode Complete: nursing home). > The Current Presentation excludes Visit Type of: • 3 (planned review) • 5 (planned admission). > Standard Emergency Department Business Rules are applied (refer to Appendix A).
Related Information:	> National Partnership Agreement on Improving Public Hospital Services: Unplanned re-attendances to the emergency department within 48 hours of previous attendances (aihw.gov.au) Service Agreements 2024-25 SA Health

People and Culture

Workforce

Employees with Excess Annual Leave Balance

Identifying and definitional attributes

Short Name:	Excess Leave
Tier:	Tier 1
KPI ID:	PC-WF-T1-1
Description:	Percentage (%) of employees with annual leave balance greater than or equal to 2 years entitlement (as recorded on LAC).
Computation:	(Numerator/Denominator)*100.
Numerator:	Employee headcount whose annual leave balance is greater than or equal to 2 years entitlement.
Denominator:	Employee headcount of employees eligible to annual leave that are not: • Terminated. • Seconded. • Non−employees. • Board and Committee members.

More Information

Scope:	Data is reported for: • CALHN • NALHN • SALHN • WCHN • BHFLHN • EFNLHN • FUNLHN • LCLHN • RMCLHN • YNLHN • BHFLHN: Rural Support Service (RSS) • South Australian Ambulance Service (SAAS) • State-wide Clinical Support Services (SCSS) • Drug and Alcohol Services South Australia (DASSA) • Department for Health and Wellbeing (DHW) • Commission on Excellence & Innovation in Health (CEIH) • Wellbeing SA (WSA) • State Total
Benchmarks:	

Target	≤5%	7%	9%	11%	13%	>13%
Performance Score	5	4	3	2	1	0

Representation Class:	Percentage (%)

Data Type:	Real
Unit of Measure:	Person
Data Source:	CHRIS21
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Employees as recorded in CHRIS21. > Leave balance (years) for annual leave is a derived figure dependent on an employee being paid a leave average or contract hours when on annual leave represented by a field in PYD for all awards (except SA Public Sector Salaried employees who are all paid contract hours when on leave – the Shared Sector Model). > Payment Type: • Contract Hours (Shared Sector Model): Considers the employee's total accrual in hours, any future leave bookings, the leave entitlement in weeks specified by an employee's industrial instrument, and the number of hours per week that they are contracted to work. • Average Hours: Considers an employee's total accrual in days, any future leave bookings, the leave entitlement in weeks specified by an employee's industrial instrument, and the number of days per week they are contracted to work.
Related Information:	> Service Agreements 2024-25 SA Health

Completion of Performance Reviews in line with the Commissioner's Determination

Identifying and definitional attributes

Short Name:	Performance Review Completion
Tier:	Tier 1
KPI ID:	PC-WF-T1-2
Description:	Percentage (%) of employees who have completed a Performance Review in the preceding 6 month period.
Computation:	(Numerator/Denominator)*100
Numerator:	Employee headcount where a Performance Review was completed in the prior 6-month period.
Denominator:	Employee headcount at the time of the extract that are not: • Terminated. • Position ended (with a POS end date 2 months before the reporting period date) and no current position. • Seconded to other agencies. • Non-employees. • Board and Committee members. • Absent on unpaid leave greater than 20 days for contracted staff. • Casual staff who have not been paid greater than 28days.

More Information

Scope:	Data is reported for: • CALHN: TEQH, RAH, CALHN Other • NALHN: LMHS, MH, NALHN Other • SALHN: FMC, RGH, NHS, SALHN Other • WCHN: WCH, WCHN Other • BHFLHN: Gawler, South Coast, Mount Barker, BHF Other • EFNLHN: Port Lincoln, Ceduna, EFN Other • FUNLHN: Port Augusta, Whyalla, FUN Other • LCLHN: Mount Gambier, LC Other • RMCLHN: Riverland (Berri), Murray Bridge, RMC Other • YNLHN: Port Pirie, Northern Yorke (Wallaroo) YN Other • BHFLHN: Rural Support Service • South Australian Ambulance Service (SAAS) • State-wide Clinical Support Services (SCSS) • Drug and Alcohol Services South Australia (DASSA) • Department for Health and Wellbeing (DHW) • Commission on Excellence & Innovation in Health (CEIH) • Wellbeing SA (WSA) • State Total
Benchmarks:	

Target	≥80%	70%	60%	50%	40%	<40%
Performance Score	5	4	3	2	1	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person
Data Source:	CHRIS21
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> An ended position is determined by an employee's POS end date being more than 2 months from the report date, i.e., for August data (compiled in September), employees who have a POS end date of 30 June and prior are excluded. > Performance reviews with a future date are excluded from the calculation. > Absent on unpaid leave greater than 20 days for contracted staff excluded from denominator. 20 days represents working days or 4 weeks. > Casual staff who have not been paid greater than 28 days excluded from denominator. 28 days represents 2 pay cycles, or 4 weeks. > Indicator aligns with the Officer for the Commissioner of Public Sector Employment reporting metrics.
Related Information:	> Guideline of the commissioner for public sector employment: Performance management and development (publicsector.sa.gov.au) > Service Agreements 2024-25 SA Health

Aboriginal or Torres Strait Islander Workforce Participation Rate

Identifying and definitional attributes

Short Name:	Indigenous Workforce Rate
Tier:	Tier 2
KPI ID:	PC-WF-T2-1
Description:	Percentage (%) of current employees who identify as being of Aboriginal or Torres Strait Islander origin.
Computation:	Employee headcount who identified as being of Aboriginal and/or Torres Strait Islander origin, in receipt of a pay summary that includes the last pay day of the month divided by total employee headcount, in receipt of a pay summary that includes the last pay day of the month. Represented as a percentage.
Numerator:	Employee headcount who identified as being of Aboriginal and/or Torres Strait Islander origin, in receipt of a pay summary that includes the last pay day of the month.
Denominator:	Employee headcount, in receipt of a pay summary that includes the last pay day of the month.

More Information

Scope:

Data is reported for:

- CALHN: TEQH, RAH, CALHN Other
- NALHN: LMHS, MH, NALHN Other
- SALHN: FMC, RGH, NHS, SALHN Other
- WCHN: WCH, WCHN Other
- BHFLHN: Gawler, South Coast, Mount Barker, BHF Other
- EFNLHN: Port Lincoln, Ceduna, EFN Other
- FUNLHN: Port Augusta, Whyalla, FUN Other
- LCLHN: Mount Gambier, LC Other
- RMCLHN: Riverland (Berri), Murray Bridge, RMC Other
- YNLHN: Port Pirie, Northern Yorke (Wallaroo) YN Other
- BHFLHN: Rural Support Service
- South Australian Ambulance Service (SAAS)
- State-wide Clinical Support Services (SCSS)
- Drug and Alcohol Services South Australia (DASSA)
- Department for Health and Wellbeing (DHW)
- Commission on Excellence & Innovation in Health (CEIH)
- Wellbeing SA (WSA)
- State Total

Benchmarks:

Metro Target	≥3%	2.5%	2%	1.5%	1%	<1.0%
Performance Score	2.5	2	1.5	1	0.5	0

Target	≤3%	<3% and >=1.5%	<1.5%
Performance Score	2.5	1.25	0

Representation Class:	Percentage (%)

Data Type:	Real
Unit of Measure:	Person
Data Source:	SHARP
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Related Information:	> Service Agreements 2024-25 SA Health

Staff Turnover Rate

Identifying and definitional attributes

Short Name:	Turnover Rate
Tier:	Tier 2
KPI ID:	PC-WF-T2-2
Description:	Percentage (%) of Staff Turnover Based on average total employee headcount and ongoing terminations for the previous 12 months
Computation:	(Numerator/Denominator)*100.
Numerator:	Count (#) of Ongoing Terminations for the previous 12 month period
Denominator:	Average No of Staff (Headcount) for the previous 12 month period

More Information

Scope:

Data is reported for:

- CALHN: TEQH, RAH, CALHN Other
- NALHN: LMHS, MH, NALHN Other
- SALHN: FMC, RGH, NHS, SALHN Other
- WCHN: WCH, WCHN Other
- BHFLHN: Gawler, South Coast, Mount Barker, BHF Other
- EFNLHN: Port Lincoln, Ceduna, EFN Other
- FUNLHN: Port Augusta, Whyalla, FUN Other
- LCLHN: Mount Gambier, LC Other
- RMCLHN: Riverland (Berri), Murray Bridge, RMC Other
- YNLHN: Port Pirie, Northern Yorke (Wallaroo) YN Other
- BHFLHN: Rural Support Service
- South Australian Ambulance Service (SAAS)
- State-wide Clinical Support Services (SCSS)
- Drug and Alcohol Services South Australia (DASSA)
- Department for Health and Wellbeing (DHW)
- Commission on Excellence & Innovation in Health (CEIH)
- Wellbeing SA (WSA)
- State Total

Benchmarks:

Metro Target	≤4%	5%	6%	7%	8%	>8%
Regional Target	≤7%	8%	9%	10%	11%	>11%
Performance Score	2.5	2	1.5	1	0.5	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Person

Data Source:	C21 - based on LHN and Medical, Nursing, Allied Health & All Other
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Average No of Staff excludes: • Non-employees • Board & Committee Members • Clinical Academics • Sessional employees • Secondments > Dependant on notification to and SSSA processing of terminations within a timely manner • Note data may include ended positions with the active employee count
Related Information:	> Service Agreements 2024-25 SA Health

Productive Overtime Hours Rate

Identifying and definitional attributes

Short Name:	Overtime Hours
Tier:	Tier 2
KPI ID:	PC-WF-T2-3
Description:	Percentage (%) of Productive Overtime Hours as proportion of total productive hrs.
Computation:	(Numerator/Denominator)*100.
Numerator:	Count (#) of Productive Overtime paid hours
Denominator:	Count (#) of Productive Ordinary paid hours

More Information

Scope:

Data is reported for:

- CALHN: TEQH, RAH, CALHN Other
- NALHN: LMHS, MH, NALHN Other
- SALHN: FMC, RGH, NHS, SALHN Other
- WCHN: WCH, WCHN Other
- BHFLHN: Gawler, South Coast, Mount Barker, BHF Other
- EFNLHN: Port Lincoln, Ceduna, EFN Other
- FUNLHN: Port Augusta, Whyalla, FUN Other
- LCLHN: Mount Gambier, LC Other
- RMCLHN: Riverland (Berri), Murray Bridge, RMC Other
- YNLHN: Port Pirie, Northern Yorke (Wallaroo) YN Other
- BHFLHN: Rural Support Service
- South Australian Ambulance Service (SAAS)
- State-wide Clinical Support Services (SCSS)
- Drug and Alcohol Services South Australia (DASSA)
- Department for Health and Wellbeing (DHW)
- Commission on Excellence & Innovation in Health (CEIH)
- Wellbeing SA (WSA)
- State Total

Benchmarks:

Metro Target	≤2.5%	>2.5% and ≤3.25%	>3.25%
Regional Target	≤1%	>1% and ≤1.5%	>1.5%
Performance Score	2.5	1.25	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Hour

Data Source:	SHARP - based on the RIAT Financial structure for LHN and Major Hospital via GL Seg2 Unit
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Productive Ordinary paid hours includes: • Allowance Codes with an FTE Category of PO Productive Ordinary - normal hours of work > Data Disaggregations are required for the following Operational Groups: • Medical Officers • Nurses/Midwives • Allied Health Professionals Other
Related Information:	> Service Agreements 2024-25 SA Health

Sick and Carers Leave Rate

Identifying and definitional attributes

Short Name:	Sick/Carers Leave Rate
Tier:	Tier 2
KPI ID:	PC-WF-T2-4
Description:	Percentage (%) of Unproductive Leave Paid Hours as proportion of Total Productive Ordinary Hours.
Computation:	(Numerator/Denominator)*100.
Numerator:	Count (#) of Sick and Carers Leave paid hours.
Denominator:	Count (#) of Productive Ordinary paid hours.

More Information

Scope:

Data is reported for:

- CALHN: TEQH, RAH, CALHN Other
- NALHN: LMHS, MH, NALHN Other
- SALHN: FMC, RGH, NHS, SALHN Other
- WCHN: WCH, WCHN Other
- BHFLHN: Gawler, South Coast, Mount Barker, BHF Other
- EFNLHN: Port Lincoln, Ceduna, EFN Other
- FUNLHN: Port Augusta, Whyalla, FUN Other
- LCLHN: Mount Gambier, LC Other
- RMCLHN: Riverland (Berri), Murray Bridge, RMC Other
- YNLHN: Port Pirie, Northern Yorke (Wallaroo) YN Other
- BHFLHN: Rural Support Service
- South Australian Ambulance Service (SAAS)
- State-wide Clinical Support Services (SCSS)
- Drug and Alcohol Services South Australia (DASSA)
- Department for Health and Wellbeing (DHW)
- Commission on Excellence & Innovation in Health (CEIH)
- Wellbeing SA (WSA)
- State Total

Benchmarks:

Target	≤4.5%	>4.5% and ≤5.5%	>5.5%
Performance Score	2.5	1.25	0

Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Hour
Data Source:	SHARP - based on the RIAT Financial structure for LHN and Major Hospital via GL Seg2 Unit

Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> Includes the following allowance code types: • SIC • PERS • FAML • SICW • PCPW > Sick and Carers Leave includes: • Total number of hours paid identified as FTE Category UL (Unproductive Paid Leave) Inclusive of Allowance Codes SIC, PERS, FAML, SICW & PCPW > Productive Ordinary Paid Hours includes: • Allowance Codes with an FTE Category of PO Productive Ordinary - normal hours of work > Data Disaggregation required for the following Operational Groups: • Medical Officers • Nurses/Midwives • Allied Health Professionals • Other
Related Information:	> Service Agreements 2024-25 SA Health

New Workplace Injury Claim Rate (per 1,000 FTE)

Identifying and definitional attributes

Short Name:	New Workplace Injury Claim Rate
Tier:	Tier 2
KPI ID:	PC-WF-T2-5
Description:	Count (#) of new workplace injury claims reported in the assessment period
Computation:	(Numerator/Denominator)*1000
Numerator:	Count (#) of new workplace injury claims reported in the assessment period (standardised as a rate per month).
Denominator:	Count (#) of full-time equivalent (FTE) Standard, in receipt of a pay summary that includes the last pay day of the reporting period.

More Information

Scope:

Data is reported for:

- CALHN: TEQH, RAH, CALHN Other
- NALHN: LMHS, MH, NALHN Other
- SALHN: FMC, RGH, NHS, SALHN Other
- WCHN: WCH, WCHN Other
- BHFLHN: Gawler, South Coast, Mount Barker, BHF Other
- EFNLHN: Port Lincoln, Ceduna, EFN Other
- FUNLHN: Port Augusta, Whyalla, FUN Other
- LCLHN: Mount Gambier, LC Other
- RMCLHN: Riverland (Berri), Murray Bridge, RMC Other
- YNLHN: Port Pirie, Northern Yorke (Wallaroo) YN Other
- BHFLHN: Rural Support Service
- South Australian Ambulance Service (SAAS)
- State-wide Clinical Support Services (SCSS)
- Drug and Alcohol Services South Australia (DASSA)
- Department for Health and Wellbeing (DHW)
- Commission on Excellence & Innovation in Health (CEIH)
- Wellbeing SA (WSA)
- State Total

Benchmarks:

Metropolitan Target	≤1.7	>1.7 and ≤1.9	>1.9
Regional Target	≤3.1	>3.1 and ≤3.5	>3.5
SAAS Target	≤8.5	>8.5 and ≤9.0	>9.0
SCSS Target	≤1.3	>1.3 and ≤1.5	>1.5
Performance Score	2.5	1.25	0

Target based upon baseline analysis.

Representation Class:	Ratio

Data Type:	Real
Unit of Measure:	Claims (per 1,000 FTE)
Data Source:	Self-Insurance Management System (SIMS)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Notes:	> The number of new workplace injury claims is calculated as the total number of new claims registered in the period, regardless of date of injury, determination or any other factor. This includes all claims whether accepted, rejected, pending determination or withdrawn. Every new claim has a 'Date Registered' date that does not change. > Numerator data is standardised as an average rate per month. > Denominator data is calculated as the full-time equivalent (FTE) Standard, in receipt of a pay summary that includes the last pay day of the reporting period
Related Information:	> Service Agreements 2024-25 SA Health

Gross Expenditure for Workplace Injury Claims

Identifying and definitional attributes

Short Name:	Expenditure for workplace injury claims
Tier:	Monitor
KPI ID:	PC-WF-M-1
Description:	Gross workers compensation expenditure
Computation:	Gross workers compensation expenditure financial year to date

More Information

Scope:	Data is reported for: • CALHN: TEQH, RAH, CALHN Other • NALHN: LMHS, MH, NALHN Other • SALHN: FMC, RGH, NHS, SALHN Other • WCHN: WCH, WCHN Other • BHFLHN: Gawler, South Coast, Mount Barker, BHF Other • EFNLHN: Port Lincoln, Ceduna, EFN Other • FUNLHN: Port Augusta, Whyalla, FUN Other • LCLHN: Mount Gambier, LC Other • RMCLHN: Riverland (Berri), Murray Bridge, RMC Other • YNLHN: Port Pirie, Northern Yorke (Wallaroo) YN Other • BHFLHN: Rural Support Service • South Australian Ambulance Service (SAAS) • State-wide Clinical Support Services (SCSS) • Drug and Alcohol Services South Australia (DASSA) • Department for Health and Wellbeing (DHW) • Commission on Excellence & Innovation in Health (CEIH) • Wellbeing SA (WSA) • State Total
Benchmarks:	Target: ≤ previous year Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Count (#)
Data Type:	Real
Unit of Measure:	Currency
Data Source:	Self-Insurance Management System (SIMS)
Frequency of Reporting:	Monthly (i.e., July data reported in August)
Related Information:	> Service Agreements 2024-25 SA Health

Research

Human Research Ethics Committees (HREC) applications approval within 60 calendar days for more than low risk applications

Identifying and definitional attributes

Short Name:	HREC Application Approval
Tier:	Monitor
KPI ID:	R-R-M-1
Description:	Proportion (%) of research proposals (excluding low to negligible risk) approved by the reviewing HREC within 60 calendar days from the HREC meeting submission closing date.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of research proposals approved within 60 days.
Denominator:	Count (#) of all research proposals approved during the reporting month.

More Information

Scope:	Data is reported for: • CALHN • SALHN • WCHN
Benchmarks:	Target: 95% Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Research Proposals
Data Source:	Manual data submission via Health Translation SA/DHW Office for Research
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> All data will be a manual count until the Research Management System is implemented. > Includes all submissions to the HREC – single site, multi-site, investigator initiated and commercial trials. > Excludes all submissions that are defined as quality improvement, audit or low to negligible risk.
Related Information:	> Service Agreements 2024-25 SA Health

SSA Approvals for Greater Than Low to Negligible Risk Applications

Identifying and definitional attributes

Short Name:	SSA Approvals
Tier:	Monitor
KPI ID:	R-R-M-2
Description:	Proportion (%) of site-specific applications (SSA) (excluding low to negligible risk) approved by the Research Governance Office (RGO) within 30 calendar days within the reporting month.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of SSAs approved within 30 days expressed.
Denominator:	Count (#) of SSAs received during the reporting month plus applications not yet approved from previous months.

More Information

Scope:	Data is reported for: • CALHN • SALHN • WCHN
Benchmarks:	Target: 95% Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Research Proposals
Data Source:	Manual data submission via Health Translation SA/DHW Office for Research
Frequency of Reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> All data will be a manual count until the Research Management System is implemented. > Includes all submissions to RGO – single site, multi-site, investigator initiated and commercial trials. > Excludes all submissions that are defined as quality improvement, audit or low to negligible risk.
Related Information:	> Service Agreements 2024-25 SA Health

Joint HREC/SSA Approvals for Low to Negligible Risk Applications

Identifying and definitional attributes

Short Name:	Joint HREC/SSA Approvals
Tier:	Monitor
KPI ID:	R-R-M-3
Description:	Proportion (%) of low to negligible risk (LNR) applications approved by the Research Governance Office (RGO) including ethics assessment if required, within 20 calendar days within the reporting month.
Computation:	(Numerator/Denominator)*100
Numerator:	Count (#) of LNR applications approved within 20 calendar days of receipt of the application.
Denominator:	Count (#) of LNR applications approved during the reporting month.

More Information

Scope:	Data is reported for: • CALHN • SALHN • WCHN
Benchmarks:	Target: 95% Note: Benchmarks are a guide only as Monitor KPI do not form part of the performance assessment process.
Representation Class:	Percentage (%)
Data Type:	Real
Unit of Measure:	Research Proposals
Data Source:	Manual data submission via Health Translation SA/DHW Office for Research
Frequency of reporting:	Quarterly (1 month lag i.e., July – September data reported in November)
Notes:	> All data will be a manual count until the Research Management System is implemented. > Includes all LNR applications. > Excludes all submission that are defined as higher than LNR.
Related Information:	> Service Agreements 2024-25 SA Health

Appendices

Appendix A: Emergency Department Business Rules and Assumptions

Details	
Overview:	For all Emergency Department KPIs there are standard business rules that are automatically applied.
Business rules:	Invalid records are excluded from the numerator and denominator. Records are deemed invalid when: > Presentation date or time is missing > Departure date or time is missing > Departure is before Presentation (length of stay < 0) > Triage Category is not 1, 2, 3, 4, or 5 > Presenting Problem is missing > Departure status is missing > Seen by is before presentation or after departure (time points out of sequence) > Seen by is missing and departure status not 6 (Did not Wait), 85 (Advised of Alternate Treatment Options) or 99 (Not Stated/Unknown) Data excludes records from Women's Assessment Units at: > WCH > LMH
More information	
Scope:	Business rules are applied to the following KPIs: > Emergency Department Length Of Stay Less Than Or Equal To 6 Hours (Non-Admitted & Admitted) > Emergency Department Seen On Time > Emergency Department Unplanned Re-Attendance Within 48 Hours