BRANZ

Burns Registry of Australia and New Zealand

DATA DICTIONARY

Version 2.0

Contents

General Methodology

The Burns Registry of Australia and New Zealand (BRANZ) data dictionary defines each of the items on which data is collected and provides information on how the required data is sourced and entered in the database. The dictionary consists of a contents page that groups data items according to data that is collected from the same source and refers to a particular phase of the patient's acute care. Data items are listed in the order in which they are entered on the database. The main text document provides detailed information about each data item using the following format:

Dataset

Content	A summary of the content of the dataset.
Collected by	The organisation(s) that routinely collects/reports the dataset.
Collected for	Patients for which the dataset is collected.
Data Source	Where the dataset can be obtained.
Database Location	Location(s) (table name) in the database where the data is stored.
Reporting guide	Additional Comments or assistance on interpreting, applying or reporting the dataset.

Data Item

Specification	
Definition	A definition of the data item collected.
Database name	The name given to the item within the database. This name does not start with a number or include spaces.
Collection	Whether the data item is Mandatory, Conditional, Optional or Calculated from other data items.
Data type	Type of data to be entered e.g. alphanumeric, numeric.
Form	The form in which the data is to be entered e.g. code, text.
Field size	The maximum number of characters the data item can take.
Layout	Format in which data is to be entered: N for numeric, A for alphanumeric values.
Code set	The reference database table name and set of codes used for the item where the form is Code.
Reporting guide	Additional Comments or assistance on interpreting, applying or reporting the data item or code set.

Administration	
Purpose	The purpose of collecting the data.
Data Users	The permitted users of the data.
Collection start	The date the data collection started for the item.
Definition source	The source that originally defined the item.
Code set source	The source that established the set of codes.

1.0 Patient Details

Content	Patient identifying and demographic data
Collected by	Participating Australian and New Zealand burns units
Collected for	All new patient burn events
Data source	Hospital Patient Management System or Medical Record
Database Location	tblPatient Table
Reporting Guide	Each patient record represents a new burn injury. If an individual sustains multiple burn injuries on different occasions, they are included as separate records

1.1 BRANZ Patient Identifier

Definition	A system generated value that uniquely identifies a Burn Registry of Australia and New Zealand (BRANZ) patient acute injury event.		
Database Name	PatientID	**Collection**	System generated
Data type	Numeric	**Form**	Integer
Field size	5	**Layout**	NNNNN
Code set	-		
Reporting guide	Begins at 10000 for patients from 1st July 2009 (with exception of small number of cases migrated across from old to new system)		
Purpose	The BRANZ Identifier is a unique number automatically assigned to new cases. The Identifier is the means by which the BRANZ staff can communicate with hospitals regarding cases submitted to the registry and also allows for the potential of data linkage.		
Data Users	Data collectors, BRANZ Staff, Epidemiologists		
Collection start	Jul 09 Note: Migrated data dates back to Jul-05, however not used in BRANZ reporting		
Definition source	ANZBA		
Code set source	-		

1.2 Date of Birth

Definition	The patient's date of birth		
Database Name	DOB	**Collection**	Mandatory
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY
Code set	A valid date.		
Reporting guide	DOB must be on or before the current date. Century (CC) can only be 18, 19, 20 or 99. If unknown, the date 09/09/9999 is used.		
Purpose	Date of birth is mandatory and is a key data point to help identify unique patients. When adding a new case, the patient's date of birth and date of injury are initially entered so the system can search existing records and check for duplicates. Even if the patient is already registered in the BRANZ (for a previous burn injury), the new burn injury is added as a new case. The cases cannot be linked in the registry because data is in a de-identified format (i.e. patient name, address and hospital number are excluded) and the data cannot be validated. If twins are in the same incident (i.e. same date of birth and date of injury) the case cannot be created from the front-end, and must be created by the BRANZ analyst.		

Data Users	Data collectors, BRANZ staff
Collection start	Jul-09 Note: Migrated data dates back to Jul-05, however not used in BRANZ reporting Jul-16 Note: Added a validation prompt "DOB is today's date, is this correct?"
Definition source	National Health Data Dictionary (NHDD)
Code set source	-

1.3 Date of Injury

Definition	Date of the burn injury		
Database Name	DOIJ	**Collection**	Mandatory
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY
Code set	-		
Reporting guide	A valid date before the current date. If the date is unknown, 09/09/9999 is recorded.		
Purpose	Date of injury is mandatory and is a key data point because it helps identify unique burn injury events. When adding a new case, the patient's date of birth and date of injury are initially entered so the system can search existing records and check for duplicates. Each burn injury event requires entering a new patient, new admission and new event data. Even if the patient is already registered in the BRANZ (for a previous burn injury), the new burn injury is added as a new case. The cases cannot be linked in the registry because data is in a de-identified format (i.e. patient name, address and hospital number are excluded) and the data cannot be validated. The date of injury also allows for calculation of age at date of injury (difference between Date of Birth and Date of Injury).		
Data Users	Data Collectors, BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09 Note: Migrated data dates back to Jul-05, however not used in BRANZ reporting		
Definition source	ANZBA		
Code set source	-		

1.4 Time of Injury

Definition	Time of the burn injury		
Database Name	DOIJ (TOIJ)	**Collection**	Mandatory
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	HH:NN:SS
Code set	-		
Reporting guide	**Midnight** Following international convention, midnight is either 23:59 of the preceding date or 00:01 of the following date (00:00 and 24:00 are not accepted). If time is not accurately known, the best estimate is used. If the time is unable to be estimated, 00:00:00 is recorded.		
Purpose	To calculate the time taken for a patient to be admitted to the BRANZ hospital from time of injury. Transfer times, particularly in major burns, is considered critical for the initial medical and surgical management of burn injuries.		

Data Users	Reporting, Epidemiologists
Collection start	Jul-09
Definition source	BRANZ
Code set source	BRANZ

1.5 Gender

Definition	Gender is the biological distinction between male and female		
Database Name	Gender	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpGender (reference table)		

Code	Description
1	Male
2	Female
3	Intersex or indeterminate
9	Not stated/inadequately described

Reporting guide	Gender should be retrieved from the hospital administrative dataset to ensure consistency with data collection. Gender is what the person considers themselves to be irrespective of anatomy or birth, it is usually unnecessary and may be inappropriate to ask a person their sex. Sex may be inferred from other cues such as observation, relationship to respondent, or first name. The term 'intersex' refers to a person, who, because of a genetic condition was born with reproductive organs or sex chromosomes that are not exclusively male or female and who identifies as being neither male nor female. Excludes: transgender, transsexual and chromosomally indeterminate individuals who identify with a particular sex (male or female).
Purpose	Patient identification. Service utilisation and epidemiological studies
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Jul-09 Note: Migrated data dates back to Jul-05, however not used in BRANZ reporting
Definition source	National Health Data Dictionary (NHDD)
Code set source	NHDD

1.6 Country of Birth

Definition	The country in which the person was born (Australian sites only)		
Database Name	COB	**Collection**	Australian sites only
Data type	Numeric	**Form**	Code
Field size	4	**Layout**	NNNN
Code set	tlkpCountry (reference table) – See SACC for full listing		

Code	Description
-1	Not Stated/ Inadequately Described
1	At Sea
2	Not elsewhere classified
1101	Australia
1201	New Zealand

Reporting guide	Enabled for Australian sites only. Data should be retrieved from the hospital administrative dataset to ensure consistency with data collection. The patient's country of origin is determined by Country of Birth for Australian sites and Ethnicity for New Zealand sites. Sourcing accurate data from different hospital administrative datasets is the reason for the difference in data collection methods.
Purpose	Demographic analysis e.g. study of burn prevalence and access to services by different population sub-groups.
Data Users	Reporting, Epidemiologists
Collection start	Jul-10 (data previously collected on Ethnicity and Oceanian fields for Aus. Sites)
Definition source	NHDD
Code set source	Australian Bureau of Statistics. Standard Australian Classification of Countries 2008 (SACC)

1.7 Indigenous Status

Definition	To identify if the patient is of Aboriginal, South Sea Islander or Torres Strait Islander descent (Australian sites only)		
Database Name	Oceanian	**Collection**	Australian sites only
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpOceanian (reference table)		

Code	Description	
0	Not Aboriginal/Torres Strait Islander descent	Not aboriginal or Torres Strait Islander descent
2	Australian Aboriginal	Person regarded as indigenous to the Australian continent, who identifies as an Aboriginal and is accepted as such by the community with which he/she is associated
3	Australian South Sea Islander	Australian descendant of people from the more than 80 islands in the Western Pacific – including the Solomon Islands and Vanuatu in Melanesia and the Loyalty Islands, Samoa, Kiribati, Rotuma and Tuvalu in Polynesia and Micronesia.
4	Torres Strait Islander	Person regarded as indigenous to the Torres Strait Islands, part of Queensland, Australia; who identifies as a Torres Strait Islander and is accepted as such by the community with which he/she is associated. The Torres Strait Islands are the islands directly to the north of Cape York, between Cape York and New Guinea.

Reporting guide	Enabled for Australian sites only. Data should be retrieved from the hospital administrative dataset to ensure consistency with data collection. Indigenous status is routinely collected by Australian hospitals as part of the National Minimum Data Set for admitted patient care. Also see 1.7 Country of Birth.
Purpose	Demographic analysis. For example, study of burn prevalence and access to services by different population sub-groups.
Data Users	Reporting, Epidemiologists
Collection start	Jul-09
Definition source	NHDD/BRANZ
Code set source	SACC/BRANZ

1.8 Ethnicity

Definition	The ethnic group or groups that a person identifies with or feels they belong to. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship (New Zealand sites only)		
Database Name	Ethnicity	**Collection**	New Zealand sites only
Data type	Numeric	**Form**	Code
Field size	4	**Layout**	NNNN
Code set	tlkpEthnicity (reference table)		

Code	Description	
1	Oceanian	Australian Peoples, New Zealand Peoples, Melanesian and Papuan, Micronesian, Polynesian
2	North West European	British, Irish, Western European, Northern European
3	Southern and Eastern European	Southern European, South Eastern European, Eastern European
4	North African and Middle Eastern	Arab, Jewish, Other North African and Middle Eastern
5	South East Asian	Mainland & Maritime South-East Asian
6	North East Asian	Chinese Asian, Other North-East Asian
7	Southern and Central Asian	Southern Asian, Central Asian
8	Peoples of the Americas	North American, South American, Central American, Caribbean Islander
9	Sub-Saharan African	Central and West African, Southern and East African
10	Not Stated/Inadequately described	Data not retrievable

Reporting guide	Enabled for New Zealand sites only. Data should be retrieved from the hospital administrative dataset to ensure consistency with data collection. The patient's country of origin is determined by Country of Birth for Australian sites and Ethnicity for New Zealand sites. Sourcing accurate data from different hospital administrative datasets is the reason for the difference in data collection methods.
Purpose	Demographic analysis. For example, study of burn prevalence and access to services by different population sub-groups.
Data Users	Reporting, Epidemiologists
Collection start	Jul-09
Definition source	NHDD/BRANZ
Code set source	Australian Bureau of Statistics. Standard Australian Classification of Countries 2008 (SACC) – Major Groups.

1.8.1 Oceanian Ethnicity

Definition	The Oceanian ethnicity sub-group that a person identifies with or feels they belong. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, nationality or citizenship (New Zealand sites only)		
Database Name	Oceanian	**Collection**	New Zealand sites only
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpOceanian (reference table)		

Code	Description
0	Not aboriginal or Torres Strait Islander descent
1	Australian
2	Australian Aboriginal
3	Australian South Sea Islander
4	Torres Strait Islander
5	New Zealander
6	NZ Maori
7	Pacific Island - not further determined
8	Samoan
9	Cook Island Maori
10	Tongan
11	Noumean
12	Other Pacific Island

Reporting guide	Conditional: **Ethnicity** = Oceanian (1) Note: Australian Indigenous status collected under codes 0 – 4 (also see 1.8 Indigenous Status)
Purpose	Demographic analysis. For example, study of burn prevalence and access to services by different population sub-groups.
Data Users	Reporting, Epidemiologists
Collection start	Jul-09
Definition source	NHDD/BRANZ
Code set source	NHDD/BRANZ

1.9 Residential Postcode

Definition	Numeric descriptor of the locality, suburb or place in which the patient usually resides. Non-residential postcodes (such as mail delivery centres) should not be used		
Database Name	ResPostcode	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	4	**Layout**	NNNN
Code set	For Australian postcodes, Refer to the Postcode/Locality/SLA reference file available from: http://auspost.com.au/products-and-services/download-postcode-data.html For New Zealand postcodes refer to: http://tools.nzpost.co.nz/tools/address-postcode-finder/ Other codes for use in this field: **Code** **Description** 1000 No Fixed Abode 8888 Overseas 9999 Unknown		
Reporting guide	Postcode is an important part of a dwelling's postal address and is one of a number of geographic identifiers that can be used to determine a geographic location. Postcodes cover most, but not all, of Australia; for example, western Tasmania is not covered by a postcode. Residential postcode should represent the patient's residential address; non-residential postcodes (such as mail delivery centres) should not be used. This data item may be used in the analysis of data on a geographical basis which involves a conversion from postcodes to the Australian Bureau of Statistics (ABS)		

	postal areas. This conversion results in some inaccuracy of information as postcodes do not have a geographic definition and boundaries are not well defined. However, in some data sets postcode is the only geographic identifier, therefore the use of other more accurate indicators (e.g. Statistical areas - SA) is not always possible. The ABS provides 'Postcode Indexes' that can be used to link data collected with a postcode to standard ABS geographic areas – for example, Statistical Divisions (SDs) and Remoteness Areas (RAs) within the Australian Standard Geographical Classification (ASGC) or Statistical Areas Level 4 (SA4s) and Greater Capital City Statistical Areas (GCCSAs) within the Australian Statistical Geography Standard (ASGS). This enables data to be directly compared with a range of other ABS data that is released on both the ASGC and the ASGS. For a full list of coding indexes available, please view the 'Correspondences' chapter of the ABS Statistical Geography website: http://www.abs.gov.au/geography Note (Australian Postcodes only): One postcode can be associated with multiple localities; however BRANZ data extracts only list one of these localities, the first by alphabetical order (Field: **AUSPostcodeD**). Caution should be exercised when analysing data and only referring to the **AUSPostcodeD** field. For example, postcode 3031 represents both suburbs Flemington and Kensington, however only Flemington is listed.
Purpose	Patient identification. Remoteness classification.
Data Users	Data collectors, BRANZ staff
Collection start	Jul-09 Note: Migrated data dates back to Jul-05, however not used in BRANZ reporting
Definition source	NHDD (Person (address) - Australian postcode)
Code set source	Australia Post (modified) New Zealand Post (modified)

1.9.1 Residential Postcode Sub-category

Definition	Drop down menu conditional to postcode 0822 in NT covers:		
Database Name	NTRegion	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpNTRegion		

Code	Description
1	Tiwi Islands
2	West Arnhem
3	East Arnhem
4	Roper / Gulf
5	Victoria / Daly
6	Barkly
7	Central Desert
8	MacDonnell (Alice Springs area)
-1	Not Stated/Inadequately described

Reporting guide	Drop down menu conditional to postcode 0822 in NT covers: • Tiwi Islands • West Arnhem • East Arnhem • Roper / Gulf

	• Victoria / Daly • Barkly • Central Desert • MacDonnell (Alice Springs area) FSH sites will supply a list of remote communities for further consideration and incorporation into BRANZ by Monash IT.
Purpose	Patient identification. Remoteness classification.
Data Users	Data collectors, BRANZ staff
Collection start	Jul-16
Definition source	
Code set source	

2.0 Admission

Definition	Hospital Admission data
Collected by	Participating Australian and New Zealand burns units
Collected for	All acute patient episodes of care – primary and readmissions
Data source	Hospital Medical Record
Database Location	tblAdmission Table
Reporting Guide	Readmissions pre-fixed by Readm

2.1 Hospital

Definition	Indicates the hospital campus with a designated Burns Service (BRANZ hospital)		
Database Name	HospitalID	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NNN
Code set	tlkpHosp (reference table – see Appendix)		

Code	Description	State	Abbreviated
1	Alfred Hospital	VIC	ALF
2	Fiona Stanley Hospital	WA	FSH
3	Middlemore Hospital	NZ	MDM
4	Women's and Children's Hospital	SA	WCH
5	Royal Darwin Hospital	NT	RDH
6	Princess Margaret Hospital for Children	WA	PMH
9	Royal Hobart Hospital	TAS	RHH
10	Royal Adelaide Hospital	SA	RAH
11	Concord Hospital	NSW	CCH
12	NSW Unspecified (cases entered pre-Jul 09 only)	NSW	NSW
13	Children's Hospital at Westmead	NSW	WMH
14	Lady Cilento Children's Hospital	QLD	LCC
16	Royal Children's Hospital	VIC	RCM
17	Royal North Shore Hospital	NSW	RNS
19	Royal Brisbane & Women's Hospital	QLD	RBW
21	Christchurch Hospital	NZ	CHC
22	Waikato Hospital	NZ	WKT
23	Hutt Hospital	NZ	HUT

Reporting Guide	
Purpose	To identify the reporting hospital/health service with a designated burn service

Data Users	BRANZ Staff, Reporting
Collection start	Jul-09 Note: Migrated data dates back to Jul-05, however not used in BRANZ reporting Jul-16 Note: RPH was renamed to FSH and RCQ to LCC
Definition source	BRANZ
Code set source	BRANZ

2.2 Presentation Type

Definition	Identifies if delivery service type is an episode of admitted patient care or an outpatient presentation		
Database Name	PresentationType	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpPresType (reference table)		

Code	Description
1	Inpatient Admission
2	Outpatient
3	Outpatient - Telehealth

Reporting guide	Outpatient (2) and Outpatient–Telehealth (3) only used for Outpatient data collection trial (commencing November 2010)
Purpose	To identify and separate inpatient and outpatient data. Inpatient Admission is the default option.
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Nov-10 Note: data mapped for admissions prior to this date as code '1 - inpatient' as outpatient data not previously collected.
Definition source	BRANZ
Code set source	BRANZ

2.3 Admission Date & Time

Definition	Date and Time patient was first registered or triaged (whichever comes first) in the Emergency Department or by admissions if direct admission to ICU or the ward		
Database Name	DOA	**Collection**	Mandatory
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set	-		
Reporting guide	Admission Date and Time should be retrieved from the hospital administrative dataset to ensure consistency with data collection. The date and time of admission is the time the patient presented to the BRANZ ED or Trauma Centre, or first registered if via outpatients or direct admission. Triage time on ambulance report is also an accurate source of this information. A valid date greater than or equal to the injury date and time and less than or equal to disposition date and time. If the date is unknown, 09/09/9999 is recorded. **Midnight**		

	Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted). If the time is unknown, 00:00 is recorded.
Purpose	Calculation of length of stay, time to admission from injury, time to burn surgeon assessment.
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Jul-09 Note: Migrated data dates back to Jul-05, however not used in BRANZ reporting
Definition source	NHDD
Code set source	-

2.4 Admission Type

Definition	Indicates whether the patient is admitted for an acute burn injury, readmitted as a consequence of the acute burn injury or transferred from another BRANZ hospital		
Database Name	AdmType	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpAdmType (reference table)		

Code	Description	
1	Acute admission	First admissions to a BRANZ hospital with a new burn injury.
2	Transfer from BRANZ hospital	Transferred from another BRANZ hospital
3	Readmission	Readmitted to the BRANZ hospital as a consequence of the original acute burn injury
4	Occurred during hospital admission	Burn injury occurred accidentally/iatrogenically whilst an inpatient for a separate medical/surgical/health concern

Reporting guide	The first admission must be within 28 days of the burn injury, with exception of hospital transfers **AdmSource** = Other Hospital (2) Readmissions must be within 28 days of the date of discharge from the first admission.
Purpose	Patient tracking from scene and between hospitals Reporting readmission rates
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Jul-09 Note: Reference Table modified Jul 10. Code 4 (readmission unplanned) deleted and data mapped to Code 3. Code 3 (readmission-planned) re-named to Readmission. Unplanned and unplanned readmission data mapped to UnexpectedComplication Jul-16 Note: Added Occurred during hospital admission as a new Admission Type
Definition source	BRANZ
Code set source	BRANZ

2.4.2 Transfer from BRANZ Hospital

Definition	Name of BRANZ hospital if patient was transferred from another BRANZ hospital		
Database Name	SourceHospID	**Collection**	Conditional when AdmType = 2
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NNN
Code set	tlkpHosp (reference table –see data item **HospitalID**)		

Reporting guide	Conditional: If **AdmType** = Transfer from BRANZ hospital (2). Otherwise report Not Applicable (-2) Report a valid code from the BRANZ Hospital Code Table.
Purpose	To identify the referring BRANZ hospital for patient tracking, and to link transfer cases within the registry
Collection start	Jul-09
Definition source	BRANZ
Code set source	BRANZ

2.5 Referral Source

Definition	Hospital, centre or person who referred the patient to the BRANZ hospital		
Database Name	AdmSource	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpAdmSource1 (reference table)		

the BRANZ Code	Description	
-2	Not Applicable	Not applicable
1	Scene of injury via ambulance	Transferred directly from (or near to) the scene of injury
2	Other hospital (specify)	Referred from another hospital
3	GP (Specify)	Referred from a General Practitioner (GP)
4	Self-presentation	Self-presentation, without a referral
5	Emergency Department	
6	Outpatients	Admitted via the BRANZ outpatient department
9	Other (Specify)	Other referral source not elsewhere classified

Reporting guide	Look at admission documentation to determine where the patient was referred from
Purpose	Patient tracking from scene and between hospitals
Collection start	Jul-09 Jul-16 Note: Outpatients Referral Source was added
Definition source	BRANZ
Code set source	BRANZ

2.5.2 Other Hospital

Definition	The name of the hospital transferring the patient to the BRANZ Hospital		
Database Name	OtherHospID	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpOtherHospital		

Code	Description	State
1	Auckland City Hospital	NZ
2	Bankstown Hospital	NSW
3	Bathurst Base Hospital	NSW
4	Bay Of Islands Hospital	NZ
5	Bendigo Base Hospital	VIC
6	Blacktown Hospital	NSW
7	Bowral Hospital	NSW
8	Bunbury Regional Hospital	WA
9	Campbelltown Hospital	NSW
10	Canberra Hospital	NSW
11	Canterbury Hospital	NSW
12	Cobram District Hospital	VIC
13	Coffs Harbour Base Hospital	NSW
14	Dandenong Hospital	VIC
15	Dubbo Base Hospital	NSW
16	Echuca Hospital	VIC
17	Fairfield Hospital	NSW
18	Flinders Medical Centre	SA
19	Frankston Hospital	VIC
20	Fremantle Hospital	WA
21	Geelong Hospital	VIC
22	Geraldton Hospital	WA
23	Golden Bay Community Health	NZ
24	Gosford Hospital	NSW
25	Goulbourn Valley Base Hospital	VIC
26	Griffith Base Hospital	NSW
27	Hawke's Bay	NZ
28	Hawkesbury Hospital	NSW
29	Hobart Private Hospital	TAS
30	Hornsby Ku-ring-gai Hospital	NSW
31	John Fawkner Private Hospital	VIC
32	John Hunter Hospital	NSW
33	Joondalup Private Hospital	WA
34	Kalgoorlie Hospital	WA
35	Katherine District Hospital	NT
36	Kununurra Hospital	WA
37	Launceston General Hospital	TAS
38	Liverpool Hospital	NSW
39	Lyell McEwin Hospital	SA
40	Mildura Base Hospital	VIC
41	Modbury Hospital	SA
42	Mount Druitt Hospital	NSW
43	Mount Gambier Hospital	SA
44	Murray Bridge Hospital	SA
45	Nelson Bay District Hospital	NSW
46	Nepean Hospital	NSW
47	Noarlunga Hospital	SA

48	Orange Health Services	NSW
49	Palmerston North Hospital	NZ
50	Peel Health Campus	WA
51	Port Macquarie Base Hospital	NSW
52	Maitland Hospital and Health	NSW
53	Manjimup Hospital	WA
54	Manning Base Hospital	NSW
55	Mater Children's Private Hospital	QLD
56	Port Pirie Hospital	SA
57	Prince of Wales Hospital	NSW
58	Queen Elizabeth Hospital	SA
59	Riverland General Hospital	SA
60	Rockingham General Hospital	WA
61	Royal Prince Alfred Hospital	NSW
62	Rutherglen Hospital	VIC
63	Sandringham Hospital	VIC
64	Shoalhaven District Memorial Hospital	NSW
65	St George Hospital	NSW
66	St Vincent's Hospital	VIC
67	Starship Children's Hospital	NZ
68	Sunshine Hospital	VIC
69	Sutherland Hospital	NSW
70	Swan District Hospital	WA
71	Sydney Children's Hospital	NSW
72	Tailem Bend District Hospital	SA
73	Tamworth Hospital	NSW
74	Taupo Hospital	NZ
75	Telstra Burns Reconstruction and Rehabilitation Unit	WA
76	The Royal Women's Hospital	VIC
77	Wagga Wagga Base Hospital	NSW
78	Waitekari Hospital	NZ
79	Westmead Hospital	NSW
80	Whyalla Hospital	SA
81	Wollongong Hospital	NSW
82	Wyong Hospital	NSW
99	Other	

Reporting guide	Review the transferring hospital documentation to determine which hospital transferred the patient to the BRANZ Hospital, select from the drop down menu
Purpose	To help to understand the incidence of burn injury, target education, QI and community awareness initiatives.
Data Users	BRANZ Hospitals, Health Departments, Researchers, Prevention Groups
Collection start	Jul-16 Note: All existing data with Referral source as 2, Other hospital has this field set to 99 for data consistency
Definition source	BRANZ
Code set source	

2.5.2.99 Referral Source - Other

Definition	Description of referral source (not elsewhere classified)		
Database Name	SourceOth	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	50	**Layout**	-
Code set	-		
Reporting guide	Conditional: If **AdmSource** = Other (9) or **OtherHospID** =99		
Purpose	To further describe the referral source		
Data Users	Data Collectors, BI-NBR Staff		
Collection start	Jul-09 Jul-16 Note: Added If OtherHospID = 99 then this field is required		
Definition source	BRANZ		
Code set source	-		

2.6 Initial presentation at referral centre date & time

Definition	Date and Time of initial presentation at Referral Centre (if patient was referred to BRANZ hospital from another hospital, GP or other source)		
Database Name	ReferralHospDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set	A valid date and time not less than the date and time of injury, with a valid 24-hour time (not 00:00 or 24:00)		
Reporting guide	Conditional: If **AdmSource** = Other Hospital (2), GP (3), or Other (9) Must be greater than or equal to the Time of Injury. **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).		
Purpose	Calculation of transfer time to burns unit		
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists		
Collection start	Apr-10		
Definition source	BRANZ		
Code set source	-		

2.7 Admitted via Outpatients

Definition	Identifies if patient was initially treated at the BRANZ hospital outpatient clinic and then later admitted via the clinic		
Database Name	Outpatients	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNo (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Conditional: If AdmSource = Other hospital (2), GP (3), Self-Presentation (4) or Other (9) Note: If coded YES (1), system validation will allow the date of the definitive burn wound assessment (AssessedDt) to be earlier than the date of admission
Purpose	Used for patient tracking and identification of burns unit referral source
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Apr-10
Definition source	BRANZ
Code set source	-

2.8 Burns Consult

Definition	Identifies if the patient is under a different clinical unit for the majority of the inpatient stay and the burns service are consulting on the management of the burn injury (i.e. burns consult)		
Database Name	BurnsAdmit	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description	
-1	Not stated/Inadequately described	Data not retrievable
0	No	Patient admitted under the Burns Unit and burns service is providing the predominant care during the episode of admitted patient care.
1	Yes	Patient is under a different clinical unit for the majority of the inpatient stay and the burns service are consulting on the management of the burn injury (i.e. burns consult).

Reporting guide	Identifies if another clinical unit (and not the burns service) are providing the predominant care during the episode of admitted patient care. In this scenario, the burn injury would usually be a secondary (vs. primary) admission diagnosis, however the burns service are consulting and involved in care of the burn injury. If the patient is transferred between units during the admission, the stay is considered a 'consult' if the number of inpatient days (under a different clinical unit) are greater than the number of days under the burns service.
Purpose	For data analyst to adjust for outcomes
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Apr-10
Definition source	BRANZ
Code set source	-

2.9 Predominant Care

Definition	Identifies clinical unit providing *predominant care* during episode of admitted patient care (if not the Burns Service)		
Database Name	Unit	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpUnit (reference table)		

Code	Description
-1	Not Stated/inadequately described
1	Oncology
2	Psychiatry
3	Haematology
4	Cardiac
5	Paediatric
6	Endocrinology
7	Trauma
8	Medical
9	Renal
10	Orthopaedic
11	Respiratory
12	Gen Medical
13	Gen Surgery
14	Neurology
16	Cardiothoracic
17	Dermatology
18	Plastics
99	Other

Reporting guide	Conditional: If **BurnsAdmit** = Yes (1)
Purpose	Data analysis such as for mortality and Length of Stay
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Apr-10
Definition source	BRANZ
Code set source	BRANZ

2.10 Insurance or Fund Source

Definition	The account classification for the episode of admitted patient care		
Database Name	Fund	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	3	**Layout**	NNN
Database location	tblAdmission Table		
Code set	tlkpFund (reference table)		

Code	Description	Country	
-1	Not stated/Inadequately described		Data not retrievable

1	Australian Health Care Agreements	AUS	A public patient who meets the criteria of an Australian resident and who receives care and treatment without charge in accordance with the Medicare Agreement. Australian Health Care Agreements should be recorded as the funding source for Medicare eligible admitted patients who elect to be treated as public patients. Includes: Public admitted patients in private hospitals funded by state or territory health authorities (at the state or regional level). Excludes: Inter-hospital contracted patients and overseas visitors who are covered by Reciprocal health care agreements and elect to be treated as public admitted patients.
2	Private health insurance	AUS	Private health insurance to cover hospital and medical bills (a public hospital patients can elect to use their health private health insurance). Excludes: overseas visitors for whom travel insurance is the major funding source.
3	Self-funded	AUS	Funded by the patient, by the patient's family or friends, or by other benefactors. Includes ineligible non-Australian resident who does not have private health insurance and self-funds the hospital stay.
4	Workers compensation	AUS	Insurance that provides wage replacement and medical benefits for employees who are injured in the course of employment
5	Motor vehicle third party personal claim	AUS	Personal injury claims for motor vehicle accidents that covers hospital and medical bills
6	Other compensation (eg. public liability, common law, medical negligence)	AUS	Other forms of insurance compensation such as public liability and common law medical negligence.
7	Department of Veterans Affairs	AUS	Charges are met by the Department of Veterans' Affairs.
8	Department of Defence	AUS	Charges are met by the Department of Defence.
9	Correctional facility	AUS	A person who is an admitted patient and is currently in the custody of Correctional Services (i.e. prisoner). Funding for these services is not provided by the Commonwealth through the Australian Health Care Agreement.
10	Other hospital or public authority (contracted care)	AUS	Includes: Patients receiving treatment under contracted care arrangements (Inter-hospital contracted patient).
11	Reciprocal health care agreements (with other countries)	AUS	Visitors to Australia who are ordinarily resident in a country with which Australia has a reciprocal health care agreement and provides for immediate necessary treatment but only as a public patient. The RHCA countries are: Finland, Italy (six month limit), Malta (six month limit), the Netherlands, New Zealand, Republic of Ireland, Sweden and the United Kingdom
12	Other	AUS	Other insurance or fund source, not elsewhere classified Includes: Overseas visitors for whom travel insurance is the major funding source.
19	Motor Vehicle Compensation (e.g. TAC in Victoria)	AUS	Provides compensation to transport accident victims such as the Transport Accident Commission (TAC) in Victoria which is a government-owned organisation.
101	Accident Compensation Corporation	NZ	The Accident Compensation Corporation (ACC) provides comprehensive, no-fault personal injury cover for all New Zealand residents and visitors to New Zealand.
102	Surgical Services Contract	NZ	Charges are met by Surgical Services contract
103	Other Private insurer	NZ	Covered by other private insurer not elsewhere classified

104	Ministry of Health	NZ	Charges are met by Ministry of Health
Reporting guide	Insurance or fund source should be retrieved from the hospital administrative dataset to ensure consistency with data collection. An expected funding source can be followed by a finalised actual funding source (for example, in relation to compensation claims) therefore the fund source should be retrieved as close to or after patient discharge.		
Purpose	Service utilisation and epidemiological studies		
Data Users	Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	NHDD/BRANZ		
Code set source	NHDD/BRANZ		

2.11 Branz inclusion criteria and Short Stay flag

Definition Identifies cases that meet the BRANZ inclusion criteria for inclusion in Bi-National reporting

Database Name	ShortStay	**Collection**	System generated
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Short Stay Flag	Short stay? Description	Included in BRANZ Reporting?	Criteria:
0	No	Yes	IF: A. Disposition from hospital = 8:Died B. Surviving admission > 24hrs AND BurnMgtYN=YES, NO or Unknown/Missing C. Surviving admission < 24hrs AND BurnMgtYN=YES
1	Yes	No	IF: A. Surviving admission where known LOS < 24hrs* AND BurnMgtYN is NO ** LOS <24hrs can only be confirmed where there is known admission and discharge date/time OR if patient is admitted and discharged on the same date. If patient admitted and discharged on consecutive days, and time of admission and/or time of discharge is unknown, case flagged as Unknown.*
-1	Unknown	No	IF: A. No discharge date entered B. Surviving admission where known LOS < 24hs AND BurnMgtYN NULL or -1 (Treatment page not entered or 'not stated/inadequately described ') C. Unconfirmed LOS < 24hrs (DOA and DOD consecutive days and TOA or TOD missing) AND BurnMgtYN = NULL or -1(Treatment

			page not entered or 'not stated/inadequately described ')
2	Not applicable	Not applicable	IF: A. Presentation Type 2 or 3 (Outpatient or Outpatient TeleHealth)* * Burns Management Procedure and Discharge Date not completed for Outpatient Presentations and do not need to be considered.

Reporting guide System generated flag. Only cases that meet the BRANZ criteria are included in Bi-National reporting as identified above. Cases that do not meet the BRANZ criteria can still be entered, however data is only for local reporting purposes.

Purpose Only cases that meet the BRANZ criteria are included in Bi-National reporting.

Data users Data Collectors, BRANZ Staff, Reporting, Epidemiologists

Collection start Jul-10
Note: data mapped for admissions prior to this date.

Definition source BRANZ

Code set source -

2.12 Was the Patient Readmitted within 28 days of discharge?

Definition	To determine the number of patients readmitted within 28 days of discharge		
Database Name	ReAdmYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND		

Code	Description
0	No
1	Yes

Reporting guide	Refer to patients admission History in the Medical Record, determine if the patient was readmitted within 28 days of the discharge from the initial acute burn admission
Purpose	Despite initial recovery from burn injury, many patients remain at risk of subsequent deterioration and this may result in readmission. Early identification of patients at the highest risk allows resources to be targeted appropriately and prevent avoidable morbidity and mortality.
Data Users	Reporting, Epidemiologists, Quality Improvement programs
Collection start	Jul-16
Definition source	BRANZ
Code set source	

2.13 Was the Readmission due to a Complication?

Definition	To determine if the admission was planned or due to a complication		
Database Name	ReadmissionResult	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
0	No
1	Yes
-1	Not stated/ Inadequately described

Reporting guide	Refer to readmission (within 28 days of discharge) medical notes. Determine if the readmission was planned, or whether it was unplanned and due to a complication. If unsure, clarify relevant cases with the BQIP Champion and relevant clinical expert
Purpose	Despite initial recovery from burn injury requiring burn unit admission, many patients remain at risk of subsequent deterioration and this may result in readmission. Early identification of patients at the highest risk would allow resources to be targeted appropriately and prevent avoidable morbidity and mortality.
Data Users	Reporting, Epidemiologists, Quality Improvement programs
Collection start	2010
Definition source	BRANZ
Code set source	

2.14 Readmission Reason

Definition	To identify the complication which caused readmission within 28 days of discharge. Select from the drop down menu found in Appendix 4		
Database Name	ReAdmComplicationType	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpReAdmComplicationType		

Code	Item	Description
1	Failed skin graft requiring regrafting	Patient readmitted for regrafting
2	Delayed wound healing requiring a skin graft	Patient readmitted for skin grafting of a wound expected to heal with conservative management
3	Wound infection requiring conservative management (includes failed Bioengineered skin substitute)	Patient readmitted for wound infection of any site, and managed conservatively (eg, antibiotics, dressings)
4	Wound infection requiring surgical management	Patient readmitted for wound infection of any site, which required surgical management
5	Bioengineered skin substitute – failed definitive treatment	Bioengineered products applied for definitive treatment (expectation to heal partial thickness burns) and patient discharged. Patient readmitted due to failure of definitive treatment, and subsequently requires further wound management

6	Bioengineered skin substitute – failed Trial of Life	Patient discharged with a bioengineered product insitu, to provide the wound the best chance of healing and determine areas required for subsequent skin grafting.
7	Failed discharge process	This includes any aspect of the discharge process including but not limited to inadequate pain management, unsafe for discharge, ongoing wound care requirements, specialist consultation, support services not organised, discharged home without medications,
-1	Not Stated/Inadequately described	
99	Other	Any other reason for readmission. Free text

Reporting guide	If the readmission (in less than 28 days of discharge) was due to a complication, select the complication reason from the drop down menu selection
Purpose	Despite initial recovery from burn injury, many patients remain at risk of subsequent deterioration and this may result in readmission. Early identification of patients at the highest risk allows resources to be targeted appropriately and prevent avoidable morbidity and mortality.
Data Users	Reporting, Epidemiologists, Quality Improvement programs
Collection start	Jul-16 Note: All existing data with Admission Type 3(Readmission) has 99 in this field for data consistency as Readmission reason was a required field previously but now only if Other (99) is selected in this field.
Definition source	BRANZ, QI Working Party
Code set source	

2.14.7 Readmission Reason –Failed Discharge Process

Definition	Reason for readmission relates to a failure of the discharge process		
Database Name	ReAdmReasonFailed	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	100	**Layout**	-
Code set	-		
Reporting guide	This is a free text field to capture details related to failed discharges which result in readmission. This includes any aspect of the discharge process including but not limited to inadequate pain management, unsafe for discharge, ongoing wound care requirements, specialist consultation, support services not organised, discharged home without medications etc. Enabled only when Reason for readmission from 2.13 is 7 (Failed Discharge Process)		
Purpose	To identify reasons for readmission that relate to a failed previous discharge, this information can assist burn services in improving their discharge processes and supports		
Data Users	Reporting, Epidemiologists, Quality Improvement programs		
Collection start	Jul-16		
Definition source	BRANZ		
Code set source			

2.14.99 Readmission Reason – Other

Definition	Reasons for readmission that is not available from the drop down menu options in 2.13		
Database Name	ReAdmReason	**Collection**	Conditional

Data type	Alphanumeric	**Form**	Text
Field size	100	**Layout**	-
Code set	-		
Reporting guide	This is a free text field to capture details related to readmission for complications within 28 days that are described in the drop down menu items of 2.13		
Purpose	To identify reasons for readmission, this information can assist burn services in improving their processes and improve patient outcomes		
Data Users	Reporting, Epidemiologists, Quality Improvement programs		
Collection start	Jul-16		
Definition source	BRANZ		
Code set source			

3.0 Injury event

Content	Injury Event Demographic data
Collected by	Participating Australian and New Zealand burns units
Collected for	All new patient burn events
Data source	Ambulance Patient Care Record and Referral Centres transfer notes (if applicable) and the Hospital Medical Record
Database Location	tblEvent Table

3.1 Cause 1

Definition	The primary cause of burn injury		
Database Name	Cause1	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpCause1 (reference table)		

Code	Description	Description Detail
-2	Not applicable	Not applicable
-1	Not stated/inadequately described	Data not retrievable
1	Chemical	Exposure of tissue to a corrosive substance such as a strong acid or base. Physical forms include solids, dusts, liquids, vapours and gases. The amount of tissue damage depends upon the nature of the agent, strength, concentration, quantity and duration of contact and extent of penetration to body.
2	Contact	Physical contact between the body and the hot object such as a hot iron or stovetop
3	Scald	Contact with wet heat such as boiling liquids or steam
4	Electrical	Exposure to an electric current flowing through tissues or bone. The type and voltage of the circuit, the pathway through the body, the duration and the resistance of the body will determine the severity of damage.
6	Flame	Direct contact with dry heat such as an open flame or fire
7	Friction	A form of heat generating abrasion caused by rapid movement between a person's skin and a hard surface.
8	Pressurised gas/air (non-flame)	Cold burn or frostbite from contact with pressurised gas/air. The gas/air is compressed in a cylinder and cold gas is released when the cylinder valve is opened

9	Radiant Heat (no contact to source)	Exposure to heat waves, a type of electromagnetic wave. These burn injuries differ from others as there is no contact between the body and the flame or with the hot surface.
10	Cooling	Cold contact burn or frostbite occurring when the skin is in touch with an extremely cold substance such as dry ice, liquid helium or liquid nitrogen.
99	Other specified cause	Other specified cause not elsewhere classified

Reporting guide	The primary cause is considered the main cause of burn injury and is routinely detailed in BRANZ reports.
Purpose	To enable injury cause categorisation and identify trends in the cause of injuries.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	2005
Definition source	BRANZ
Code set source	BRANZ

3.1.1 – 3.1.10 Cause 1 Sub-category

Definition	The primary sub-cause of burn injury		
Database Name	CauseSub1	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpCauseSub1		

Cause Code	Code Sub	Description Sub	Description Detail
	-2	Not applicable	Not applicable
Chemical (1)	0	Acid (specify)	Substance that neutralise alkalis, dissolves some metals, and turns litmus red; typically, a corrosive liquid. Includes sulphuric acid, hydrofluoric acid, vehicle battery, Dettol, nitric acid, hydrochloric acid
Chemical (1)	1	Alkali (specify)	Basic, ionic salt that neutralises or effervesces with acids and turns litmus blue; typically, a caustic or corrosive substance. Includes oven cleaner, potassium hydroxide, lime, cement, concrete, Drano, degreaser, caustic soda, bleach, alkaline solution, ammonia, potassium permanganate
Chemical (1)	2	Other (specify)	Chemical compound that is not an acid or alkali such as oxidizers, solvents and reducing agents.
Contact (2)	-1	Not stated/inadequately described	Hot surface contact, where source is unknown
Contact (2)	0	BBQ	Contact with any hot part of a barbecue (BBQ). Includes wood, gas or electric barbecues.
Contact (2)	1	Vehicle Exhaust	A vehicle includes bicycles, cars, motorcycles, trains, ships, boats, and aircraft. Includes campervan and caravan. Excludes lawnmower (coded as hot metal)
Contact (2)	2	Heater - Other/Unspecified	Contact with any part of a heater that is not elsewhere classified OR where the type of heater is unknown

Contact (2)	3	Coals/Ashes	The black or brownish-black sedimentary products of fire, incineration or combustion. Excludes Firesticks (coded as other)
Contact (2)	4	Hot Metal	Hot metal (not elsewhere classified). This includes lawnmower exhausts, metal pots/pans and the handles. Excludes melted hot metal(code as scald/molten metal)
Contact (2)	5	Stove top/cooktop	Burners from an oven range or the cook top of a stove.
Contact (2)	6	Iron	Hand-held implement with a flat steel base heated to smooth clothes and for other purposes
Contact (2)	7	Molten plastic/glue	Hot melted plastic or glue 'sticks' to the skin and is not readily removable.
Contact (2)	8	Stove/Oven door	Internal or external parts of the stove. Includes oven door and racks/heating elements within the oven. Excludes 'oven hotplate' (code as contact/hot plate on stove).
Contact (2)	8	Stove/Oven door internal	Internal or external parts of the stove. Includes oven door and racks/heating elements within the oven. Excludes 'oven hotplate' (code as contact/hot plate on stove).
Contact (2)	9	Stove/Oven door external	Internal or external parts of the stove. Includes oven door and racks/heating elements within the oven. Excludes 'oven hotplate' (code as contact/hot plate on stove).
Contact (2)	10	Other (specify)	Hot surfaces not elsewhere classified. Includes non-metal pots/pans and their handles, cupping treatment, firesticks, hot lamp, fireworks and electric blankets. Excludes electrical wires/cables etc where electrical burn injury(code as Electrical) and contact from hot food to skin (code as Scald/Food (liquid/solid)
Contact (2)	11	Cigarette	Ignited end of a cigarette.
Contact (2)	12	Heat pack	Types include the dual ice/heat packs and wheat bags, typically heated in the microwave. Purpose same as for hot water bottle.
Contact (2)	13	Hot water bottle	A container filled with hot water and sealed with a stopper, used to provide warmth or for the application of heat to a specific part of the body.
Contact (2)	14	Bitumen (tar)	Bitumen is a sticky, tar-like form of petroleum and is commonly used for road surfaces. hen hot bitumen contacts the skin, it cannot be forcibly removed and natural separation occurs within 72 hours. The terms bitumen and asphalt are mostly interchangeable, except where asphalt is used as an abbreviation for asphalt concrete.
Contact (2)	15	Heater - Electrical/gas	Contact with any part of an electrical or gas heater, including the screened barrier or glass panel in front of the heater.
Contact (2)	16	Hair wand/hair straightener	An electrical hand held appliance used to change the structure of the hair with heat
Contact (2)	17	Wax	Contact with hot wax such as from candles and hair removal wax. Candles are typically made from paraffin wax. Hair removal wax may be primarily beeswax, resin, or a sugar formulation.
Contact (2)	18	Heater - Wood	Contact with any part of a wood heater, including the screened barrier or glass panel in front of the heater. Types of wood heaters include: open fireplace,pot belly stoves; slow combustion and chiminea heaters
Contact (2)	19	Hot ground (eg. concrete, pavers, sand etc.)	Contact with a hot ground surface such as concrete, pavers and sand.

Scald (3)	-1	Not stated/inadequately described	Scald, where source is unknown
Scald (3)	1	Fat/Oil	Edible fats/oils used during cooking. Non-edible oils include petroleum-based liquids used as fuel or lubricant.
Scald (3)	2	Molten Metal	Metal that has been melted down
Scald (3)	3	Food (liquid/solid)	Scald from food – whether liquid or solid. Includes milk. Excludes liquids in cups (code as scald/hot beverage)
Scald (3)	4	Steam from Radiator (engine)	Steam (water vapour) burns from an engine radiator. When a vehicle overheats, the contents of the radiator are under tremendous pressure. If the radiator cap is opened, the boiling liquid and steam can erupt causing scald or steam burns.
Scald (3)	5	Steam Vaporiser	Scald/steam burns sustained when using a steam vaporiser machine or similar DIY alternatives. Commercial vaporisers are enclosed devices used to vaporise water/medicine by using a heating element to create steam for inhalation. The DIY alternative is using a bowl of boiling hot water, placing head over the bowl and covering the head with a towel to enclose the steam.
Scald (3)	6	Steam from other source	Steam (water vapour) burns from another source, not elsewhere classified.
Scald (3)	7	Syrup/sugary liquid (eg. Toffee)	Scald burns from a hot syrup or sugary liquid such as toffee. Excludes sugary liquid/formulation used for waxing (code as scald / wax)
Scald (3)	8	Hot beverages (eg. Tea/coffee)	A hot beverage is any liquid suitable for drinking and is contained within a cup or mug. Includes tea, coffee, hot chocolate, milk, water or soup. Excludes liquids that are not in a cup (if food type, code as Scald / Food liquid/solid). If in a thermos code as Scald / Thermos. If in a baby bottle, code as Scald / Other.
Scald (3)	9	Water from Basin/Sink/Bucket	Scald from hot water contained within a basin, sink or bucket.
Scald (3)	10	Water from radiator (engine)	Scald from the hot liquid of an engine radiator (also see Scald/Steam from radiator)
Scald (3)	11	Water from hot water bottle	Scald from hot liquid of a hot water bottle. Also see Contact/Hot water bottle
Scald (3)	12	Water from Saucepan/Kettle/Jug/ Billy/Urn/ Thermos	Scald from hot water contained within a saucepan, kettle, jug, billy, urn or thermos. Excludes liquid in a baby bottle, code as scald/other
Scald (3)	13	Water from Tap/Bath/Shower	Hot water scald from a tap, bath or shower.
Scald (3)	15	Other (specify)	Hot water scald not elsewhere classified. Includes water from microwave, water from high pressure hose/cylinder/pump, hot water system, baby bottle, vat of boiling water.
Electrical (4)	-1	Not stated/inadequately described	Electricity source is unknown
Electrical (4)	0	Lightning	Electrical burn sustained from a lightning strike
Electrical (4)	1	Low voltage (<415 volts)	Direct or indirect contact with a low voltage source (< 415 volts), including power cords, exposed wiring and misuse of electrical tools. Low voltage examples: alkaline battery 1.5v; car battery 12v; household/domestic voltage 230v.
Electrical (4)	3	High voltage (>415 volts, industrial)	High voltage sources (> 415 volts) typically found in commercial and industrial installations. For example,

			picking up live fallen overhead wires, cutting tree branches near high-voltage power lines and digging through an underground cable. The greater force can blow the person clear of the conductor.
Electrical (4)	5	Other (specify)	Electrical burns sustained from an unknown voltage source. Excludes electrical related fires resulting in flame burns (code as Flame/Electrical or if related to welding/grinding code as Flame/Welding, Grinding)
Flame (6)	-1	Not stated/inadequately described	Flame source unknown
Flame (6)	1	Campfire/bonfire/burnoff	Flame from a campfire, bonfire or burn off
Flame (6)	2	Candle	Flame from a candle
Flame (6)	3	Fireworks	Sparks/flame from fireworks. Fireworks are a class of explosive pyrotechnic devices.
Flame (6)	4	Gas/Gas Bottle	Flame burns sustained where gas liquid/vapour or a gas cylinder ignited/accelerated the fire as a result of coming in contact with an ignition source (open flame, spark or hot surface). Liquid petroleum gas (LPG) is a liquid form of butane, propane or pentane gas. LPG is used in the residential, commercial and automotive markets. It is most commonly used as a fuel for vehicles, for portable heating and cooking devices. NOTE: If gas is an accelerant to the fire, also code as an Accelerant (see 3.7 Accelerant Type)
Flame (6)	5	Electrical	Electrical related fires where the ignition source are sparks/flame from faulty electrical outlets and old wiring; problems with cords, plugs, switches, light fixtures and lamps/light bulbs. Excludes electric burns where no flame source (code as Electric), fires related to electric heaters (code as 'Heater other/unspecified') and welding/grinding related fires (code as Flame/Welding, Grinding)
Flame (6)	6	Fat/oil	Ignition of hot fat/oil (e.g. during cooking)
Flame (6)	7	Cigarette	Flame from a cigarette
Flame (6)	8	Lighter/matches	Flame from a lighter or match
Flame (6)	9	Heater - Other/Unspecified	Flame from an electrical heater, gas log fire or other type of heater not otherwise specified OR where the heater type is unknown (wood heaters classified elsewhere).
Flame (6)	12	Other (specify)	Flame burns not elsewhere classified. This includes open flame from a pilot light or gas stove, fire breathing, petrol bomb or cupping.
Flame (6)	13	Bushfire	Bushfires in Australia are generally defined as any uncontrolled, non-structural fire burning in a grass, scrub, bush or forested area.
Flame (6)	14	BBQ	Any flame related fires involving a BBQ.
Flame (6)	15	Heater - Wood (enclosed)	Enclosed wood heaters include Pot belly stoves and other similar units - enclosed heaters with glass panels, doors and ash removal trays; and Slow Combustion heaters – an airtight firebox.
Flame (6)	16	Heater - Fireplace (open)	Includes an Open Fireplace and Chiminea. A Chiminea heater is a freestanding front-loading fireplace or oven with a bulbous body and usually a vertical smoke vent or chimney.
Flame (6)	17	Welding/Grinding	Sparks/open flame from welding, grinding or use of an oxyacetylene torch. Grinding involves use of an angle

			grinder - a handheld power tool. Welding involves heating and joining metal parts. Excludes welding/grinding incidences where the primary injury was electrical and not flame related (code as Electrical)
Flame (6)	18	Vehicle Engine/Parts	Spark/Flame from a vehicle engine or other vehicle part. Includes car related fires such as motor vehicle campervan and caravan accidents. Exclude lawnmowers (code as Flame / other)
Flame (6)	19	Flame source unclear	Flame source unclear. Particularly where the circumstances are unclear such as house fires, self-harming or assault incidences
Friction (7)	-1	Not stated/inadequately described	Friction burn where cause unknown
Friction (7)	0	Friction via vehicle/motorbike	Friction burns related to a vehicle. For example, driver dragged along ground by motorbike. Includes bicycles, cars, motorbikes, trains, ships, boats, and aircraft. Excludes lawnmowers.
Friction (7)	1	Friction via treadmill	Friction burns related to the fast moving belt of treadmill. For example, slipping and falling off a treadmill or a child placing their hand on the rotating belt (and subsequently getting hand caught).
Friction (7)	2	Other (specify)	Other friction burn not elsewhere classified, such as material friction burns – 'rope burn' or 'carpet burn'
Friction (7)	3	Pushbike	Friction burns related to pushbikes. For example, cyclist dragged along ground under bike or some part of the body getting caught in the fast moving components of the pushbike such as the wheel, cables and chain ring.
Radiant Heat (9)	-1	Not stated/inadequately described	Radiation burn where source is unknown
Radiant Heat (9)	0	Solar (sunburn)	Radiation burns sustained from the UV rays of the sun (sunburn)
Radiant Heat (9)	2	Other (specify)	Radiation burns not elsewhere classified (e.g. sun lamps)
Radiant Heat (9)	3	Flame (eg. bushfire)	Radiation burns sustained from an open flame such as from a bushfire or burnoff
Radiant Heat (9)	4	Heater	Radiation burns sustained from a heater (e.g. sitting to close to a gas/electric heater)
Radiant Heat (9)	5	Radiotherapy	Radiation burns sustained as a result of radiotherapy. High exposure to X-rays during diagnostic medical imaging or radiotherapy can also result in radiation burns.

Reporting guide	Conditional: All Cause 1 codes have corresponding sub-causes apart from 'Pressurised gas/air (non-flame)' and 'other specified cause'
Purpose	To enable injury cause categorisation and identify trends in the cause of injuries.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-09 Jul-16 Updated look up table Code = 2 and CodeSub = 5 renamed to 'Stove top/cooktop' and Code 2 and CodeSub = 8 to 'Stove/Oven door-Internal'. Added Code = and CodeSub = 9 'Stove/oven door – external'
Definition source	BRANZ
Code set source	BRANZ

3.1.99 Cause 1 Other

Definition	Other primary cause or sub-cause (not elsewhere classified)		
Database Name	CauseOth1	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	100	**Layout**	-
Code set	-		
Reporting guide	Conditional: If the **Cause1** = Other (99) or the **CauseSub1**= Acid, Alkali or Other		
Purpose	To further describe the cause of burn injury		
Data Users	Data Collectors, BRANZ Staff		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

3.2 Cause 2

Definition	The secondary cause of burn injury (if more than one cause)		
Database Name	Cause2	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpCause1 (reference table) As for 3.1		
Reporting guide	The secondary cause defaults to not applicable (-2) as this data item is only applicable if there is more than one burn cause. The secondary cause is not reported in routine BRANZ reports or data requests.		
Purpose	To enable injury cause categorisation and identify trends in the cause of injuries.		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	2015		
Definition source	BRANZ		
Code set source	BRANZ		

3.2.1 – 3.2.10 Cause 2 Sub-category

Definition	The secondary cause sub-category of burn injury (if more than one cause)		
Database Name	CauseSub2	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpCauseSub1 (reference table). As for 3.1.1		
Reporting guide	Conditional: All Cause 1 codes have corresponding sub-causes apart from 'Pressurised gas/air (non-flame)' and 'other specified cause'		
Purpose	To enable injury cause categorisation and identify trends in the cause of injuries.		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09		

	Jul-16 Updated look up table Code = 2 and CodeSub = 5 renamed to 'Stove top/cooktop' and Code 2 and CodeSub = 8 to 'Stove/Oven door-Internal'. Added Code = and CodeSub = 9 'Stove/oven door – external'
Definition source	BRANZ
Code set source	BRANZ

3.2.99 Cause 2 Other

Definition	Other secondary burn cause or subcategory (not elsewhere classified)		
Database Name	CauseOth2	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	100	**Layout**	-
Code set	-		
Reporting guide	Conditional: If **Cause2** = 99 or **CauseSub2** = Acid, Alkali or		
Purpose	To further describe the cause of burn injury		
Data Users	Data Collectors, BRANZ Staff		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

3.3 Accelerant Involvement

Definition	Identifies if an accelerant was used to initiate or increase the spread of fire		
Database Name	Accel	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNoND (reference table)		

Code	Description
0	No
1	Yes
-1	Not stated/Inadequately described

Reporting guide	An accelerant is a substance, usually a flammable or combustible liquid, used intentionally or accidentally that caused a fire or flash resulting in burn injury. - Default to "No" if cause is not flame in 3.1: Cause1
Purpose	To enable injury cause categorisation and identify trends in the cause of injuries.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Apr-10 Note: data mapped for admissions prior to this date, based on available data, else 'not stated'
Definition source	BRANZ
Code set source	-

3.3.1 Accelerant Type

Definition	Identifies the type of accelerant used to initiate or increase the spread of fire.		
Database Name	AccelType	**Collection**	Conditional

Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpAccelType (reference table)		

Code	Description	
-1	Not stated/inadequately described	Data not retrievable
1	Methylated spirits	Used as a solvent (e.g. cleaning aid) and fuel for spirit burners and camping stoves
2	Petrol	Abbreviation of petroleum. A highly flammable, blended liquid composed of more than 300 volatile hydrocarbon compounds manufactured from the fractionation or distillation of petroleum. Its principal use is as a fuel in spark ignited, internal combustion engines. Exception: other types of fuel (e.g. diesel) should be coded as 'other'
3	Paint Stripper	Paint stripper (mineral spirits) are midrange petroleum distillates which is present in many paint thinners, oil base stains, dry cleaning solvents, and some brands of charcoal starter fluids.
4	Turpentine	Mineral turpentine, also known as turpentine or turps. A colourless, combustible liquid derived from steam distillation of wood from pine (conifer) trees. Turpentine is miscible in oils, ether, and chloroform. Principal uses are as a drying agent or as a solvent for thinners of paints, lacquers, varnishes and used in wax-based polishes and liniments. It is also used to manufacture certain linoleums, soap, ink, artificial camphor and rubber.
5	Aerosol can	Aerosol spray can is a type of dispensing system which creates an aerosol mist of liquid particles. The accelerant could be the actual spray can (e.g. thrown into fire) or the aerosol vapour mist sprayed from the can.
6	Kerosene	Kerosene is a combustible hydrocarbon liquid commonly used as a heating fuel and lighting device ('kerosene lamp') and widely used to power jet-engine aircraft. Similar action to petrol.
7	Aviation gas	An aviation fuel used to power piston-engine aircraft.
8	Other gas	
9	Other (specify)	Other accelerant not elsewhere classified. Includes gas (liquid or vapour)

Reporting guide	Conditional: If **Accel** = Yes (1) Materials with higher flash points are less flammable or hazardous than chemicals with lower flash points. Flammable and combustible liquids themselves do not burn. It is the mixture of their vapours and air that burns. For example, Gasoline, with a flashpoint of -40°C, is a flammable liquid. Even at temperatures as low as -40°C, it gives off enough vapour to form a burnable mixture in air.
Purpose	To enable injury cause categorisation and identify trends in the cause of injuries.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Apr-10 Note: data mapped for admissions prior to this date, based on available data, else 'not stated' Jul-16 Added Other gas '8' to drop down
Definition source	BRANZ
Code set source	-

3.3.1.9 Accelerant Other

Definition	Other type of accelerant type (not elsewhere classified)		
Database Name	AccelOther	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	100	**Layout**	-
Code set	-		
Reporting guide	Conditional: If **AccelType** = Other (9)		
Purpose	To further describe the accelerant type (not elsewhere classified)		
Data Users	Data Collectors, BRANZ Staff		
Collection start	Apr-10 Note: data mapped for admissions prior to this date, based on available data, else 'not stated'		
Definition source	BRANZ		
Code set source	-		

3.4 Clothing/bedding/curtains caught alight

Definition	Identifies if clothing, bedding or curtains caught alight during the incident		
Database Name	Clothing	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Bedding includes blankets, sheets, doona covers and bedspreads. - Default to "No" if cause is not flame in 3.1: Cause1
Purpose	To enable injury cause categorisation and identify trends in the cause of injuries.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Apr-10 Note: data mapped for admissions prior to this date, based on available data, else 'not stated'
Definition source	BRANZ
Code set source	-

3.5 Explosion/Flash occurred

Definition	Identifies if incident involved an explosion or flash fire		
Database Name	Explosion	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	An explosion or flash flame is coded if documented in the medical history. An *explosion or flash* is a rapid increase in volume and release of energy in an extreme manner, usually with the generation of high temperatures and the release of gases. - Default to "No" if cause is not flame in 3.1: Cause1
Purpose	To enable injury cause categorisation and identify trends in the cause of injuries
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Apr-10 Note: data mapped for admissions prior to this date, based on available data, else 'not stated'
Definition source	BRANZ
Code set source	-

3.6 House, building or vehicle fire

Definition	Identifies if the incident resulted in a house fire, other type of building fire or vehicle fire		
Database Name	HouseFire	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpFire (reference table)		

Code	Description
-1	Not Stated/Inadequately described
0	No
1	House Fire
2	Other building fire
3	Vehicle Fire

Reporting guide	A vehicle fire relates to any fire involving a vehicle. A house or building fire is coded if documented in the patient's history; further work is required on this definition. A house/building fire is more likely to be documented if there is structural damage and/or fire damage to fixed components of the house (walls, oven). If the fire is self-contained and/or involves unfixed components of the house (e.g. electrical appliances) and/or there is only minor damage (e.g. smoke stains), this wouldn't normally be considered a 'house fire'. - Default to "No" if cause is not flame in 3.1: Cause1
Purpose	To enable injury cause categorisation and identify trends in the cause of injuries.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Apr-10 Note: data mapped for admissions prior to this date, based on available data, else 'not stated'
Definition source	BRANZ
Code set source	BRANZ

3.7 Activity when Burn Injury Occurred

Definition	The execution of a task or action by an individual when the burn injury occurred		
Database Name	Activity	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpActivity1 (reference table)		

Code	Description	
-1	Not stated/inadequately described	Data not retrievable
0	Sports activity	Physical exercise with a described functional element such as: golf, riding, jogging, skiing, school athletics, swimming, trekking, water skiing.
10	Leisure activity (excluding sporting activity)	Hobby activities; leisure time activities with an entertainment element such as being at a cinema, a dance or party; participating in activities of a voluntary organisation.
11	Playing	An activity which is enjoyed alone or with others, most commonly associated with children activities
20	Working for income	Paid work for salary (manual) (professional), bonus and other types of income; transportation (time) to and from such activities.
30	Cooking/preparing food/drink	Unpaid duties involving cooking and/or preparation of food or drink
31	Cleaning	Unpaid duties involving cleaning
32	Gardening	Unpaid duties involving gardening
33	Household maintenance	Unpaid duties involving household maintenance (excluding cooking, cleaning and gardening – coded separately)
34	Other types of unpaid work (specify)	Unpaid domestic duties, such as: caring for children and relatives. Other duties for which income is not gained, such as: unpaid work in family business.
35	Near person preparing food/drink	Injury sustained as a result of being near a person who is cooking and/or preparing food or drink
36	Vehicle maintenance	Unpaid duties involving vehicle maintenance
40	Bathing	Bathing
41	Eating/drinking	Activities related to eating or drinking
42	Sleeping/resting	Activities related to sleeping and resting
43	Other vital activities (specify)	Other vital activities not elsewhere classified. This includes Personal hygiene and other personal activity.
50	Education	Formal education, learning activities, such as: attending school session or lesson, university, undergoing education.
91	Driving/Passenger	Activities related to driving a vehicle or being a passenger in a vehicle
92	Self-harming	Intentional, direct injuring of body tissue
93	Suspected illegal activity	An activity that is suspected to be prohibited or not authorised by law
99	Other specified activities	Other activity not elsewhere classified

Reporting guide	Report the first appropriate code listed in the table which best characterise the type of activity undertaken by the person at the time when the injury occurred.
Purpose	To enable injury activity categorisation and identify trends in the cause of injuries. Burns prevention campaigns.

Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-09
Definition source	NHDD (Activity when injured)
Code set source	NHDD/BRANZ

3.7.99 Activity Other

Definition	Other activity (not elsewhere classified)		
Database Name	ActivityOth	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	100	**Layout**	-
Code set	-		
Reporting guide	Conditional: If **Activity** = Other (99)		
Purpose	To further describe the Activity when it does not meet one of pre-defined values		
Data Users	Data Collectors, BRANZ Staff		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

3.8 Place where the burn injury occurred

Definition	The physical location of the person when the injury occurred		
Database Name	Place	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpPlace (reference table)		

Code	Description	Includes	Excludes
-1	Not stated/inadequately described	Data not retrievable	
0	Home (usual place of residence)	Where the patient normally resides. Includes house, home premises, farm house, institutional place of residence, apartment, boarding house, caravan park (resident), private: driveway to home, garage, garden/yard or home, path to home, swimming pool in private house, garden.	Abandoned or derelict house (99) Home under construction and not yet occupied (6)
1	Residential Institution	Residential institution that is not considered patient's 'usual place of residence (else code as 'home') Includes, orphanage, home for the sick, nursing home, old people's home, hospice, military camp, reform school, prison, pensioners home, dormitory.	Hospital (2)
2	School, other institution & public administrative area	Building (including adjacent grounds) used by the general public or by a particular group of the public such as: assembly hall, public hall, church, clubhouse, court house, post office, day care centre,	Hospital (2) Recreation area (8), Athletics and sports area (3), Trade or service area (5), Building under construction (6)

		preschool, youth centre, gallery, library, museum, cinema, theatre, opera house, concert hall, dance hall, school (public or private), college, university, institution for higher education, movie house, kindergarten, campus. Public health area including Hospital	Residential institution (1)
3	Sports or athletics area	Cricket ground, football, hockey field, riding school, basketball court, golf course, stadium, skating rink, tennis, squash court, swimming pool.	
4	Street and highway	Freeway, footpath, motorway, pavement, road.	Private driveway (0)
5	Trade and service area	Bank, petrol station, supermarket, airport, cafe, casino, garage (commercial), gas station, hotel, market, office building, radio or television station, restaurant, service station, shop (commercial), shopping mall, station (bus/rail), warehouse.	Garage in private home (0)
6	Industrial and construction area	Any building under construction, industrial yard, workshop, dry dock, dock yard, factory building/ premises, gasworks, oil rig & other offshore installation, power station (coal/nuclear/oil), shipyard. Mine, quarry, tunnel under construction.	
7	Farm	Farm buildings and land, ranch.	Farm house & home premises of farm (0)
8	Place for recreation	Place visiting for recreation purposes - public park, amusement park, forest, beach, pond, campsite, canal, caravan site, lake, marsh, mountain,	Athletics and sports area (3)
9	Other residence (e.g. friend's home)	Other home residence that is not the patient's normal place of residence. For example, friend or family's home.	
99	Other specified place	Abandoned or derelict house, military training ground, parking lot & parking place, prairie, public place NOS, railway line, river, sea, seashore, stream, swamp, water reservoir	

Reporting guide	Report the code which best characterises the location of the patient the time the injury occurred.
Purpose	To enable injury place categorisation and identify trends in the place of injuries. Burns prevention campaigns.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-09
Definition source	NHDD (Place of occurrence of external cause of injury)
Code set source	NHDD/BRANZ

3.8.0 Place Sub- Category

Definition	Place sub-category where the burn injury occurred		
Database Name	PlaceSub	**Collection**	Conditional
Data type	Numeric	**Form**	Code

Field size	2	**Layout**	NN
Code set	tlkpPlaceSub (reference table)		

Place Code	CodeSub	DescriptionSub
-1	-2	Not Applicable
0	0	Bathroom, toilet
0	1	Kitchen
0	2	Living room, playroom or family room
0	3	Bedroom
0	4	Laundry
0	5	Home office
0	6	Garden/yard
0	7	Driveway
0	8	Garage/shed
0	9	Other specified place
0	10	Unspecified part of building or grounds
1	-2	Not Applicable
2	0	School
2	1	Health service area
2	2	Building used by general public or public group
3	-2	Not Applicable
4	-2	Not Applicable
5	-2	Not Applicable
6	-2	Not Applicable
7	-2	Not Applicable
8	-2	Not Applicable
99	-2	Not Applicable

Reporting guide	Conditional: If **Place** = Home / usual place of residence (0) or **Place** = School, other institution & public administrative area - It is showing which Sub Codes are specific to the Place where the burn injury occurred Codes listed in table 3.8 above. For example Code 0 (Home –usual place of residence) has related sub-codes 1-10 from the kitchen …unspecified part of bldg. or grounds. Whereas other Codes such as 3(Sports and Athletics area) to 8 have no associated sub-codes and are therefore defaulted to “Not Applicable”
Purpose	To enable injury place categorisation and identify trends in the place of injuries. Burns prevention campaigns
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-09
Definition source	NHDD/BRANZ
Code set source	NHDD (Place of occurrence of external cause of injury)

3.8.0.9 Place sub- category - Other

Definition	Other place (not elsewhere classified)		
Database Name	PlaceOth	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	100	**Layout**	-
Code set	-		
Reporting guide	Conditional: If Place = Other (99)		
Purpose	To further describe the Place when it does not meet one of pre-defined values		

Data Users	Data Collectors, BRANZ Staff
Collection start	Jul-09
Definition source	BRANZ
Code set source	-

3.8.2.0 School (Place sub-category) – School

Definition	School type where the burn injury occurred at school		
Database Name	PlaceSchool	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpPlaceSchool (reference table)		

Code	Description
0	School, university
1	Day care, kindergarten
2	Other specified school, education area
3	Unspecified school, education area
4	Childcare/preschool

Reporting guide	Conditional: If **Place** = School, other institution & public administrative area (2) or sub-place is School (0)
Purpose	To enable injury place categorisation and identify trends in the place of injuries. Burns prevention campaigns.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-09 Jul-16 Note: Added Code 4 – childcare/preschool
Definition source	BRANZ
Code set source	BRANZ

3.9 Intent when Burn Injury Occurred

Definition	Clinician's assessment of the most likely human intent in the occurrence of the burn injury		
Database Name	Intent	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpIntent (reference table)		

Code	Description	
-1	Not stated/inadequately described	Data not retrievable
1	Accident - injury not intended	A specific, unpredictable, unusual or unintended external action which occurs in a particular time and place, with no apparent and deliberate cause but with marked effects. It implies a generally negative outcome which may have been avoided or prevented had circumstances leading up to the accident been recognised, and acted upon, prior to its occurrence
2	Intentional self-harm	Intentional, direct injuring of body tissue most often done without suicidal intentions, but could still result in death
3	Suspected Sexual assault	Suspected (or confirmed) assault of a sexual nature on another person, or any sexual act committed without consent.
4	Suspected maltreatment by parent	Suspected (or confirmed) child maltreatment includes abuse and neglect of a child under the age of 18 by a parent or caregiver, resulting in the child sustaining the burn injury Note: lack of supervision or unintentional neglectful behaviour(vs. intentional maltreatment) is normally coded as accident; unless there are exceptional circumstances where it can be coded as 'other specified intent' (requiring further description)
5	Suspected maltreatment by spouse or partner	Maltreatment includes abuse and neglect of a person by their spouse or partner, resulting in the patient sustaining the burn injury
6	Suspected other and unspecified assault	Includes homicide and injuries inflicted by another person with intent to injure or kill, by any means. Excludes injuries due to legal intervention or operations of war.
7	Event of undetermined intent	Available information is insufficient to enable a medical or legal authority to make a distinction between accident, self-harm and assault. Follow legal rulings when available.
9	Adverse effect or complications of medical and surgical care	Includes complications of medical devices; correct drug properly administered in therapeutic or prophylactic dosage as the cause of any adverse effect; misadventures to patients during surgical and medical care; surgical and medical procedures as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure; accidental overdose of drug or wrong drug given or taken in error.
99	Other specified intent	Other intent not elsewhere classified. Includes injuries due to operations of war and injuries inflicted by the police or other law-enforcing agents, including military on duty, in the course of arresting or attempting to arrest lawbreakers, suppressing disturbances, maintaining order, and other legal action Note: lack of supervision or unintentional neglectful behaviour (vs. intentional maltreatment) should be coded here

Reporting guide	The intent to produce the injury, not the intent to undertake an activity, which resulted in injury. The most appropriate option should characterise the role of intent in the occurrence of the injury on the basis of the information available at the time it is recorded.
Purpose	To categorise and identify trends in intent of burn injuries and inform burns prevention campaigns.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-09
Definition source	NHDD (External cause—human intent)

Code set source	NHDD/BRANZ

3.9.99 Intent - Other

Definition	Other intent (not elsewhere classified)		
Database Name	IntentOth	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	100	**Layout**	-
Code set	-		
Reporting guide	Conditional: If **Intent** = Other (99)		
Purpose	To further describe the intent when it does not meet one of pre-defined values		
Data Users	Data Collectors, BRANZ Staff		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

3.10 Injury Event Description

Definition	Patient's personal account or description of injury event		
Database Name	EventDesc	**Collection**	Mandatory
Data type	Alphanumeric	**Form**	Text
Field size	500	**Layout**	-
Code set	-		
Reporting guide	Briefly and concisely describe the injury event. Include: • Location - specific location of the person at the time the injury occurred. For example, in the bathroom of own home, workshop or local shops. • Activity - specific activity the person was undertaking at the time the injury occurred. For example, playing, working on a forklift or playing competition football • Product - specific product involved in the injury (where applicable). For example, 50mls brand name X medicine • Safety Equipment - safety devices in use or absent at the time the injury occurred (where applicable). For example, wearing steel capped work boots Additional Information to Include - nature of the injuries; what caused the injuries (subject), any other relevant information. **Examples** Refer to the VEMD Business Rules: Injury Surveillance (3-115) for examples of how the Injury Surveillance fields should be utilised.		
Purpose	The event detail helps to accurately describe the injury circumstance and is useful for injury prevention purposes. The narrative is very important to identify injury event features not captured by the coded data. Used for 'Key word' searches		
Data Users	Data Collectors, BRANZ Staff		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

3.11 Injury Event Postcode

Definition	Numeric descriptor of the locality, suburb or place where the burn injury occurred

Database Name	EventPostcode	**Collection**	Mandatory
Data type	Alphanumeric	**Form**	Name
Field size	4	**Layout**	NNNN
Database Location	Event Table		
Code set	For Australian postcodes refer to the Postcode/Locality/SLA reference file available from: http://www1.auspost.com.au/postcodes/index.asp?sub=2 For New Zealand postcodes refer to: http://tools.nzpost.co.nz/tools/address-postcode-finder/ Other codes for use in this field: **Code** **Description** 8888 Overseas 9988 Unknown in State/Country in which hospital resides 9999 Unknown outside State/ Country in which hospital resides		
Reporting guide	If postcode of injury is not recorded in the medical history (including the ambulance report), postcode of the referral centre (where applicable) should be used. See Residential Postcode for further information.		
Purpose	To enable mapping of locations with respect to the location of the treating hospital		
Data Users	Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	NHDD/BRANZ		
Code set source	Australia Post (modified) New Zealand Post (modified)		

3.12 Documented Suspicion of Alcohol/Drugs

Definition	Clinical documentation indicates there was confirmed or suspicion of alcohol and/or drugs contributing to the patient sustaining the burn injury; including adults or children who were burnt as an indirect result of the parent or caregiver being under the influence of drugs and/or alcohol		
Database Name	DrugAlcohol	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpDrugAlcohol (reference table)		

Code	Description
-1	Not stated/Inadequately described
1	Alcohol
2	Drugs
3	Alcohol and Drugs
4	None

Reporting guide	Clinical indicators such as blood alcohol readings can also be used to confirm the suspicion of alcohol or drug involvement; however this data is currently not recorded in the registry nor is it a requirement to meet the data item definition (i.e. clinical documentation to indicate confirmation or suspicion is sufficient). Drugs can be prescription or iliicit.
Purpose	To identify high risk behaviours associated with burn injury and to help inform burns prevention campaigns.
Data Users	BRANZ staff, Reporting, Epidemiologists

Collection start	Jul-09
Definition source	BRANZ
Code set source	BRANZ

4.0 First Aid

Content	Pre-hospital First Aid completed
Collected by	Participating Australian and New Zealand burns units
Collected for	All new patient burn events
Data source	Ambulance Patient Care Record and Referral Centres transfer notes (if applicable) and the Hospital Medical Record
Database Location	tblEventQI Table

4.1 Was any First Aid Applied?

Definition	Burn first aid involved cooling of the burn wound to minimise the impact of injury. Cooling mechanisms can include running water, submersion, spray, wet towels or hydrogels		
Database Name	FirstAidYN	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Documentation of all burn first aid maybe found in four locations of the medical record: refer to documentation from the Scene of injury, Ambulance Scene, Referral Centre and BRANZ Emergency Department.
Purpose	To identify if any first aid interventions were applied to burn in the community or healthcare setting prior to admission to the Burns Unit
Data Users	Researchers, Preventionists, Epidemiologists, BQIP
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

4.2 Was the first aid applied 20 minutes of cool running water within 3 hours of injury

Definition	Best practice for burns first aid is 20 minutes of cool running water within 3 hours of injury.		
Database Name	CoolWaterYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Documentation of all burn first aid maybe found in four locations of the medical record: refer to documentation from the Scene of injury, Ambulance Scene, Referral Centre and BRANZ Emergency Department.
Purpose	To identify how frequently the ANZBA recommendations for burn first aid were applied and inform burns prevention and first aid campaigns; burns management education and research in clinical outcomes.
Data Users	Researchers, Preventionists, Epidemiologists, BQIP
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

4.3 Additional information regarding first aid

Definition	Free text field to document any additional information regarding burn first aid		
Database Name	AddInfo	**Collection**	Mandatory
Data type	Alphanumeric	**Form**	Text
Field size	500	**Layout**	-
Code set	-		
Reporting guide	Analysis of this data is beyond the scope of BRANZ and would need to be analysed locally		
Purpose	This is a free text field for units to collect additional information about burn first aid.		
Data Users	Researchers, Preventionists, Epidemiologists, BQIP		
Collection start	Jul-16		
Definition source	BRANZ, QI Working Party		
Code set source			

5.0 Burn Wound Assessment

Content	Burn Wound Assessments undertaken by the burns team (Definitive
Collected by	Participating Australian and New Zealand burns units
Collected for	All new patient burn events
Data source	Ambulance Patient Care Record and Referral Centres transfer notes (if applicable) and the Hospital Medical Record
Database Location	tblAssessmentNew Table

5.1 Documented Inhalation Injury

Definition	Clinical documentation indicates the patient sustained an inhalation injury		
Database Name	Inhalation	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N

Code set	tlkpYesNoND (reference table)

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Clinical indicators such as bronchoscopy results can also be used to confirm the presence of an inhalation injury; however this data is currently not recorded in the registry nor is it a requirement to meet the data item definition (i.e. clinical documentation to indicate presence of an inhalation injury is sufficient).
Purpose	To identify presence of non-cutaneous burn and adjust for outcomes
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-09 Jul-16 Note: Previously this data item was in Event section in tblEvent. It is now in Assessment section. Data has been mapped to tblAssessmentNew.
Definition source	BRANZ
Code set source	-

5.2 Cutaneous Burn

Definition	Identifies whether the patient sustained a cutaneous burn (i.e. burns to skin), in addition to an inhalation injury		
Database Name	Cutaneous	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Conditional: If **Inhalation** = Yes (1). If there is no cutaneous burn, the burn wound assessment section is skipped. Selecting No will auto populate 'Not Applicable' for 5.3
Purpose	To identify presence of non-cutaneous burn and adjust for outcomes
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Apr-10 Note: data mapped for admissions prior to this date, based on available data, else 'not stated' Jul-16 Note: Previously this data item was in Event section in tblEvent. It is now in Assessment section. Data has been mapped to tblAssessmentNew.
Definition source	BRANZ
Code set source	-

5.3 Was the burn size documented?

Definition	Identifies if the burn size was documented, as represented by a code

Database Name	AssessYN	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	The definitive burn wound assessment is defined as the burn assessment documented by the most senior burns clinician within 72 hours of admission. This definition was developed by the registry's Steering Committee in an effort to standardise burn wound assessment data.
Purpose	To determine if Burn Wound assessment occurred within 72 hours of admission
Data Users	BRANZ staff, Reporting, Epidemiologists, Quality Improvement Programs
Collection start	Jul-09
Definition source	BRANZ
Code set source	-

5.4 Assessment Date/Time

Definition	Date and Time of burn wound assessment		
Database Name	AssessedDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set	A valid date and time not less than the date and time of injury, with a valid 24-hour time (not 00:00 or 24:00) **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted)		
Reporting guide	Conditional: If **AssessYN** = 1 The **Definitive** assessment must be greater than or equal to the date of admission, with exception if the patient was managed in ED or outpatients prior to admission (Outpatients = 1 OR EDOutPtMngmt = 1). The Referring centre and Ambulance assessment must be greater than or equal to the time of injury and earlier than the date of admission (reporting values -99999 to 0). The BRANZ ED assessment must be greater than or equal to the date of admission (reporting value 0 – 9999), however will likely change in the future to allow for ED assessments prior to the date of admission.		
Purpose	To calculate time to first and definitive assessment		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

5.5 Who completed the assessment?

Definition	The clinician who assessed the burn wound

Database Name	AssessedBy	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpAssessedBy (reference table)		

Code	Description
-1	Not stated/Inadequately described
1	Burns Surgeon
2	Burn Registrar
3	Burns Fellow
6	Clinical Nurse Consultant
10	Nurse Practitioner
99	Other

Reporting guide	Conditional: If **AssessYN** = 1
Purpose	To identify the highest designation of the clinician who assessed the burn wound. The definitive burn wound assessment is defined as the burn assessment documented by the most senior burns clinician within 72 hours of admission. This definition was developed by the registry's Steering Committee in an effort to standardise burn wound assessment data.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-09 Jul-16:Existing data with Burns CNC or NP (Code 6) is now renamed to CNC and added NP as Code 10
Definition source	BRANZ
Code set source	BRANZ

5.5.99 Who Completed the Assessment? – Other

Definition	The clinician who assessed the burn wound (not elsewhere classified)		
Database Name	AssessedByOth	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	100	**Layout**	AAA
Reporting guide	Conditional: If **AssessedBy** = Other (99)		
Purpose	To specify the clinician who assessed the burn wound if not elsewhere classified		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

5.6 Was there evidence in the medical history that an accepted diagram was used to accurately calculate %TBSA by the burn clinicians at the burn unit (E.g. Lund Browder or the Rule of Nine)

Definition	To determine if accepted tools to determine %TBSA were used in the assessment of the patient's burn %TBSA		
Database Name	DiagramUsedYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	There should be documentation in the medical record of the Lund Browder or Rule of Nine's Chart. Conditional: If **AssessYN** = 1 Burn Diagrams will be located in the initial assessment documentation, ED notes, surgical reports, refer to relevant clinical expert regarding where this documentation is located in the MR.
Purpose	Specialized burn care includes the estimation of %TBSA burns. The %TBSA burn is used to determine severity of burn and calculate fluid resuscitation requirements
Data Users	Quality Improvement Programs, BRANZ staff,
Collection start	Jul-16
Definition source	
Code set source	

5.7 Burn Depth Recorded

Definition	To determine if there was a documented burn depth assessment (additional to the % Total Burn Size)		
Database Name	DepthYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Conditional: If AssessYN = 1
Purpose	To identify the severity of the burn. Burns are described according to the depth of injury to the skin layers and determines the potential for successful wound healing. Burns are classified into superficial dermal, mid-dermal, deep-dermal and full thickness burns. The classification of burn depth is in line with the Emergency Management Severe Burns course as coordinated by the Australian and New Zealand Burns Association.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-09
Definition source	BRANZ
Code set source	BRANZ

5.8 % Superficial Dermal

Definition	Identifies if there were documented Superficial Dermal (SD) burns		
Database Name	DepthSuperYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N

Code set	tlkpYesNoDepth (reference table)

Code	Description	
-1	Not stated	Data not retrievable
0	No	No SD burns (depth value skipped)
1	Yes - % known	SD burns present and % value known
2	Yes - % unknown	SD burns present, % value unknown

Reporting guide	Conditional: If **DepthYN** =1
Purpose	To identify the severity of the burn. Superficial Dermal burns are the most superficial. Depth of injury to the skin layer is the epidermis & the superficial part of the dermis.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10 Note: data mapped for admissions prior to this date, where possible
Definition source	BRANZ
Code set source	BRANZ

5.8.1 % Superficial Dermal

Definition	The documented percentage value of Superficial Dermal burns		
Database Name	DepthSuper	**Collection**	Conditional
Data type	Numeric	**Form**	Decimal
Field size	4	**Layout**	NNN.NN
Code set	-		
Reporting guide	Conditional: If **DepthSuperYN** = 1. Permitted values: 0.01-100%		
Purpose	To record the percentage superficial burn depth for each burn wound assessment type.		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	BRANZ		

5.9 % Mid Dermal

Definition	Identifies if there were documented Mid Dermal (MD) burns		
Database Name	DepthMidYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoDepth (reference table)		

Code	Description	
-1	Not stated	Data not retrievable
0	No	No SD burns (depth value skipped)
1	Yes - % known	SD burns present and % value known
2	Yes - % unknown	SD burns present, % value unknown

Reporting guide	Conditional: If **DepthYN** =1

Purpose	To identify the severity of the burn. Mid Dermal burns are deeper than superficial burns. Depth of injury to the skin layer is the epidermis & half the dermis.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10 Note: data mapped for admissions prior to this date, where possible
Definition source	BRANZ
Code set source	BRANZ

5.9.1 % Mid Dermal

Definition	The documented percentage value of Mid Dermal burns		
Database Name	DepthMid	**Collection**	Conditional
Data type	Numeric	**Form**	Decimal
Field size	4	**Layout**	NNN.NN
Cod set	-		
Reporting guide	Conditional: If DepthMidYN = 1. Permitted values: 0.01-100%		
Purpose	To record the percentage mid dermal burn depth for each burn wound assessment type		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

5.10 % Deep Dermal

Definition	Identifies if there were documented Deep Dermal (DD) burns		
Database Name	DepthDeepYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoDepth (reference table)		

Code	Description	
-1	Not stated	Data not retrievable
0	No	No SD burns (depth value skipped)
1	Yes - % known	SD burns present and % value known
2	Yes - % unknown	SD burns present, % value unknown

Reporting guide	Conditional: If **DepthYN** = 1
Purpose	To identify the severity of the burn. Depth of deep dermal burns to the skin layer is the epidermis and majority of the dermis. Hair follicles are destroyed and nerve endings impaired.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10 Note: data mapped for admissions prior to this date, where possible
Definition source	BRANZ
Code set source	BRANZ

5.10.1 % Deep Dermal

Definition	The documented percentage value of Deep Dermal burns		
Database Name	DepthDeep	**Collection**	Conditional
Data type	Numeric	**Form**	Decimal
Field size	4	**Layout**	NNN.NN
Code set	-		
Reporting guide	Conditional: If **DepthDeepYN** = 1. Permitted values: 0.01-100%.		
Purpose	To record the percentage deep dermal burn depth for each burn wound assessment type.		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09 Note: definition change Jul-10 from 'deep dermal/full thickness' to 'deep dermal' only.		
Definition source	BRANZ		
Code set source	-		

5.11 % Full Thickness

Definition	Identifies if there were documented Full Thickness (FT) burns		
Database Name	DepthFullYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoDepth (reference table)		

Code	Description	
-1	Not stated	Data not retrievable
0	No	FT burns not present (depth value skipped)
1	Yes - % known	FT burns present and % value known
2	Yes - % unknown	FT burns present, % value unknown

Reporting guide	Conditional: If **DepthYN** = 1
Purpose	To identify the severity of the burn. Full Thickness burns are most severe classification of burn depth where all skin layers are destroyed, leaving no cells to heal the wound. Full thickness burns are likely to require surgical excision and skin grafting.
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10 Note: admissions prior to this date, data mapped based on ICD-10 diagnoses codes. Incomplete data.
Definition source	BRANZ
Code set source	BRANZ

5.11.1 % Full Thickness

Definition	The documented percentage value of Full Thickness burns		
Database Name	DepthFull	**Collection**	Conditional
Data type	Numeric	**Form**	Decimal

Field size	4	**Layout**	NNN.NN
Code set	-		
Reporting guide	Conditional: If **DepthFullYN** = 1. Permitted values: 0.01-100%. Note: Prior to Jul-10 Deep dermal and Full Thickness were combined.		
Purpose	To record the percentage full thickness burn depth for each burn wound assessment type.		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-10 Note: admissions prior this date, data mapped based on ICD-10 diagnoses codes. Incomplete data.		
Definition source	BRANZ		
Code set source	-		

5.12 % Total Burn Surface Area (TBSA%)

Definition	A percentage measure of burns of the skin		
Database Name	TBSA	**Collection**	Conditional
Data type	Numeric	**Form**	Decimal
Field size	4	**Layout**	NNN.NN
Reporting guide	Conditional: If **AssessYN** = 1		
Purpose	To record the percentage total burn surface area for each burn wound assessment type. Total Body Surface Area (TBSA) equates to 100%. Allowed values are 0.01 to 100. The value -1 is entered if the size is unknown. The two most common assessment tools used to assess the burn size are the 'Lund and Browder' and 'Rule of Nines' chart. As a general guideline the size of a person's hand print (palm and fingers) is approximately 1% of their TBSA		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

6.0 Body Region of Burn

Content	The region of the body where the burn injury was sustained.
Collected by	Participating Australian and New Zealand burns units
Collected for	All new patient burn events
Data source	Hospital Medical Record
Database Location	tblBurnLocation Table
Reporting Guide	-

6.1 Scalp

Definition	Body region of burn is the scalp		
Database Name	Scalp	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	-

6.2 Face/Ear

Definition	Body region of burn is the face/ear		
Database Name	Face	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	-

6.3 Eye(s)

Definition	Body region of burn is the eye(s)		
Database Name	Eye	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists

Collection start	Jul-10
Definition source	BRANZ
Code set source	-

6.4 Neck

Definition	Body region of burn is the neck		
Database Name	Neck	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
0	No
1	Yes
-1	Not stated/Inadequately described

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	-

6.5 Breast/Chest

Definition	Body region of burn is the breast and/or chest		
Database Name	Breast	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
0	No
1	Yes
-1	Not stated/Inadequately described

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	-

6.6 Trunk

Definition	Burn location is the Trunk (excluding breast/chest)		
Database Name	Trunk	**Collection**	Mandatory

Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpTrunk (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Front
2	Back
3	Front and Back

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	-

6.7 Buttock

Definition	Body region of burn is the Buttock(s)		
Database Name	Buttock	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	-

6.8 Perineum

Definition	Body region of burn is the perineum		
Database Name	Perineum	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
0	No
1	Yes
-1	Not stated/Inadequately described

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	-

6.9 Hand

Definition	Body region of burn is the hand(s)		
Database Name	Hand	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpExtremity (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Unilateral
2	Bilateral

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	BRANZ

6.10 Hand – Dorsal

Definition	Body region of burn is dorsal part of the hand(s)		
Database Name	HandDorsal	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpExtremity (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Unilateral
2	Bilateral

Reporting guide	-
Purpose	To identify where on the body the burn occurred

Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-16 Note: All existing data prior to this date has this field set to -1 - Not stated/Inadequately described
Definition source	BRANZ
Code set source	BRANZ

6.11 Hand – Palmar

Definition	Body region of burn is palmar part of the hand(s)		
Database Name	HandPalmar	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpExtremity (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Unilateral
2	Bilateral

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-16 Note: All existing data prior to this date has this field set to -1 - Not stated/Inadequately described
Definition source	BRANZ
Code set source	BRANZ

6.12 Foot

Definition	Body region of burn is the foot/feet		
Database Name	Foot	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpExtremity (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Unilateral
2	Bilateral

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10

Definition source	BRANZ
Code set source	BRANZ

6.13 Foot – Dorsum

Definition	Body region of burn is the dorsum part of the foot/feet		
Database Name	Foot	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpExtremity (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Unilateral
2	Bilateral

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-16 Note: All existing data prior to this date has this field set to -1 - Not stated/Inadequately described
Definition source	BRANZ
Code set source	BRANZ

6.14 Foot – Sole

Definition	Body region of burn is sole part of the foot/feet		
Database Name	Foot	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpExtremity (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Unilateral
2	Bilateral

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-16 Note: All existing data prior to this date has this field set to -1 - Not stated/Inadequately described
Definition source	BRANZ
Code set source	BRANZ

6.15 Lower Limb (Exc Foot)

Definition	Body region of burn is the lower limb excluding foot		
Database Name	LowerLimb	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpExtremity (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Unilateral
2	Bilateral

Reporting guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	BRANZ

6.16 Upper Limb (Exc Hand)

Definition	Body region of burn is the upper limb excluding hand(s)		
Database Name	UpperLimb	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpExtremity (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Unilateral
2	Bilateral

Reporting Guide	-
Purpose	To identify where on the body the burn occurred
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection Start	Jul-10
Definition Source	BRANZ
Code set source	BRANZ

7.0 Burns Treatment

Content	The treatment in theatre of burn wound
Collected by	Participating Australian and New Zealand burns units
Collected for	All acute admissions

Data source	Hospital Medical Record, Operation report
Database Location	tblBurnTreatmentTable
Reporting Guide	Coders should refer to the operation report for surgery detail performed in theatre.

7.1 Did the patient have an Escharotomy?

Definition	To determine if the patient had an Escharotomy. Escharotomy is an indicator of severity and possible complications such as infections. Escharotomy is a surgical procedure used to treat full-thickness circumferential burns. When required can be done as an emergency procedure outside theatre to restore circulation.		
Database Name	EscharYN	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND		

Code	Description
0	No
1	Yes
-1	Not stated/Inadequately described

Reporting guide	If the patient had an Escharotomy, it will be documented in: 1. Operation report 2. BRANZ ED notes 3. Transferring Hospital ED notes
Purpose	Escharotomy is an indicator of severity and possible complications such as infections.
Data Users	Researchers, burn quality improvement programs, BRANZ staff, educators
Collection start	Jul-16
Definition source	BRANZ
Code set source	BRANZ

7.2 Escharotomy - Date & Time

Definition	To determine the time and date the patient underwent Escharotomy		
Database Name	EscharDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set			
Reporting guide	If the patient had an Escharotomy, it will be documented in: 1. Operation report 2. BRANZ ED notes 3. Transferring Hospital ED notes		
Purpose	If circulation of breathing is compromised, Escharotomy should occur as soon as possible		
Data Users	Researchers, burn quality improvement programs, BRANZ staff, educators		
Collection start	Jul-16		
Definition source	BRANZ		
Code set source	BRANZ		

7.3 Escharotomy – Where was it Performed?

Definition	To determine where Escharotomy procedures were performed		
Database Name	EscharPerformed	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpEscharPerformed		

Code	Description
0	BRANZ Theatre
1	BRANZ ED
2	Transferring ED
99	Other
-1	Not stated/Inadequately described

Reporting guide	If the patient had an Escharotomy, it will be documented in: 1. Operation report 2. BRANZ ED notes 3. Transferring Hospital ED notes
Purpose	To determine where Escharotomy procedures were performed to inform the adequate apportion of educational resources.
Data Users	Researchers, burn quality improvement programs, BRANZ staff, educators
Collection start	Jul-16
Definition source	BRANZ
Code set source	BRANZ

7.3.99 Escharotomy – Where was it Performed? - Other

Definition	The location where escharotomy occurred (not elsewhere classified)		
Database Name	EscharPerformedOther	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	100	**Layout**	AAA
Reporting guide	Conditional: If **AssessedBy** = Other (99)		
Purpose	To specify the location where escharotomy occurred not elsewhere classified		
Collection start	Jul-16		
Definition source	BRANZ		
Code set source	-		

7.4 Did the Patient go to Theatre for Burn Wound Management?

Definition	To determine if the patient underwent a burn wound management procedure		
Database Name	BurnMgtYN	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Operation report details will be located in the patient's or electronic medical record
Purpose	To better understand burn wound management practices in the region and identify best practices.
Data Users	ANZBA's Burn Quality Improvement Program, Burn Service QIP, Researchers, Service Planners
Collection start	Jul-10 Note: admissions prior this date, mapped to appropriate option based on available ICD-10 theatre procedure codes and the (now redundant) 'Excision' and 'FirstExcisionDt' fields, else 'not stated'.
Definition source	
Code set source	

7.5 Debridement Only

Definition	The first time patient went to theatre for debridement only		
Database Name	DebriYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Operation report details will be located in the patient's medical record Determine if patient had a theatre procedure which involved debridement only
Purpose	To better understand burn wound management practices in the region and identify best practices.
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-10 (see note under BurnMgtYN)
Definition source	BRANZ, QI Working Party
Code set source	

7.6 What Type of Debridement was Performed?

Definition	Type of debridement used to prepare the burn wound bed		
Database Name	DebriType	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpDebriType		

Code	Description
0	Excisional debridement:
1	Scrub
2	Hydrodebridement
3	Dermabrasion
-1	Not stated/Inadequately described

Reporting guide	The operation notes should detail the type of debridement performed to clean/excise the burn. Different types of debridement include:

	1. **Excisional debridement:** Excision of burned tissue using a surgical instrument containing a blade (Braithwaite, Watson, Humby, Goulian, Weck, Dermatome). 2. **Scrub:** Rubbing a burn wound, often with gauze, to remove blisters and loose skin. 3. **Hydro-debridement:** Debridement using high pressure saline jet. 4. **Dermabrasion:** Debridement using a rapidly rotating burr
Purpose	To identify the types of debridement techniques used. The type of debridement performed is also indicative of depth. This information can identify if the debridement types make a difference to patient outcomes to identify best practices.
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16
Definition source	BRANZ
Code set source	BRANZ

7.7 Debridement Only - Date & Time

Definition	To determine the time and date the patient underwent the first debridement only procedure		
Database Name	DebriDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set			
Reporting guide	Paper or electronic operation reports will contain the details of the timing of surgical procedures performed.		
Purpose	To identify when the patient underwent the first debridement only procedure		
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners		
Collection start	Jul-10 (see note under BurnMgtYN)		
Definition source	BRANZ		
Code set source	BRANZ		

7.8 Temporary Skin Closure Product - First Theatre

Definition	Use of temporary skin closure products and associated debridement practices		
Database Name	DebriSkinYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Operation report details will be located in the patient's medical record. Temporary skin closure products include Biobrane.
Purpose	To better understand burn wound management practices in the region and identify best practices.

Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-10 (see note under BurnMgtYN)
Definition source	
Code set source	

7.9 What Type of Debridement was Performed?

Definition	Type of debridement used to prepare the burn wound bed		
Database Name	DebriSkinType	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpDebriType		

Code	Description
0	Excisional debridement:
1	Scrub
2	Hydrodebridement
3	Dermabrasion
-1	Not stated/Inadequately described

Reporting guide	The operation notes should detail the type of debridement performed to clean/excise the burn. Different types of debridement include: 5. **Excisional debridement:** Excision of burned tissue using a surgical instrument containing a blade (Braithwaite, Watson, Humby, Goulian, Weck, Dermatome). 6. **Scrub:** Rubbing a burn wound, often with gauze, to remove blisters and loose skin. 7. **Hydro-debridement:** Debridement using high pressure saline jet. 8. **Dermabrasion:** Debridement using a rapidly rotating burr
Purpose	To identify the types of debridement techniques used. The type of debridement performed is also indicative of depth. This information can identify if the debridement types make a difference to patient outcomes to identify best practices.
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16
Definition source	BRANZ
Code set source	BRANZ

7.10 Temporary Skin Closure Product - Date & Time

Definition	To determine the time and date the patient underwent the first temporary skin closure product procedure		
Database Name	DebriSkinDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set			
Reporting guide	Paper or electronic operation reports will contain the details of the timing of surgical procedures performed.		
Purpose	To identify when the patient underwent the first temporary skin closure product procedure		

Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-10 (see note under BurnMgtYN)
Definition source	BRANZ
Code set source	BRANZ

7.11 Dermal Reconstructive Product - First Theatre

Definition	Use of dermal reconstruction products and associated debridement practices		
Database Name	DebriDermalYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set			

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Operation report details will be located in the patient's or electronic medical record. Dermal reconstructive products include: 1. Integra 2. Biodegradable temporising Matrix (BTM) 3. Pelnac 4. Matriderm
Purpose	To better understand burn wound management practices in the region and identify best practices
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-10 (see note under BurnMgtYN)
Definition source	
Code set source	

7.12 What type of debridement was performed?

Definition	Type of debridement used to prepare the wound bed		
Database Name	DebriDermalType	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpDebriType		

Code	Description
0	Excisional debridement:
1	Scrub
2	Hydrodebridement
3	Dermabrasion
-1	Not stated/Inadequately described

Reporting guide	The operation notes should detail the type of debridement performed to excise the burn. Different types of debridement include: 1. **Excisional debridement:** Excision of burned tissue using a surgical instrument containing a blade (Braithwaite, Watson, Humby, Goulian, Weck, Dermatome).

	2. **Scrub:** Rubbing a burn wound, often with gauze, to remove blisters and loose skin. 3. **Hydro-debridement:** Debridement using high pressure saline jet. 4. **Dermabrasion:** Debridement using a rapidly rotating burr
Purpose	To identify the types of debridement techniques used. The type of debridement performed is also indicative of depth. This information can identify if the debridement types make a difference to patient outcomes to identify best practices.
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16
Definition source	BRANZ
Code set source	BRANZ

7.13 Dermal Reconstructive Product - Date & Time

Definition	To determine the time and date the patient underwent the first dermal reconstruction product procedure		
Database Name	DebriDermalDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set			
Reporting guide	Paper or electronic operation reports will contain the details of the timing of surgical procedures performed.		
Purpose	To identify when the patient underwent the first dermal reconstruction product procedure		
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service plannersskin cell		
Collection start	Jul-10 (see note under BurnMgtYN)		
Definition source	BRANZ		
Code set source	BRANZ		

7.14 Skin Cell Product - First Theatre

Definition	Use of skin cell product and associated debridement practices		
Database Name	DebriCellYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Operation report details will be located in the patient's or electronic medical record. Skin cell products include: 1. Cultured Epidermal autografts 2. ReCell
Purpose	To better understand burn wound management practices in the region and identify best practices

Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-10 (see note under BurnMgtYN)
Definition source	BRANZ
Code set source	BRANZ

7.15 What type of debridement was performed?

Definition	Type of debridement used to prepare the wound bed		
Database Name	DebriCellType	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpDebriType		

Code	Description
0	Excisional debridement:
1	Scrub
2	Hydrodebridement
3	Dermabrasion
-1	Not stated/Inadequately described

Reporting guide	The operation notes should detail the type of debridement performed to excise the burn. Different types of debridement include: 1. **Excisional debridement:** Excision of burned tissue using a surgical instrument containing a blade (Braithwaite, Watson, Humby, Goulian, Weck, Dermatome). 2. **Scrub:** Rubbing a burn wound, often with gauze, to remove blisters and loose skin. 3. **Hydro-debridement:** Debridement using high pressure saline jet. 4. **Dermabrasion:** Debridement using a rapidly rotating burr
Purpose	To identify the types of debridement techniques used. The type of debridement performed is also indicative of depth. This information can identify if the debridement types make a difference to patient outcomes to identify best practices.
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16
Definition source	BRANZ
Code set source	BRANZ

7.16 Skin Cell Product - Date & Time

Definition	To determine the time and date the patient underwent the first Skin cell product procedure		
Database Name	DebriCellDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set			
Reporting guide	Paper or electronic operation reports will contain the details of the timing of surgical procedures performed.		
Purpose	To identify when the patient underwent the Skin cell product procedure		

Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-10 (see note under BurnMgtYN)
Definition source	BRANZ
Code set source	BRANZ

7.17 Skin Grafting - First Theatre

Definition	Use of skin grafting to close wounds and associated debridement techniques		
Database Name	DebriGraftYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Operation report details will be located in the patient's or electronic medical record
Purpose	To better understand burn wound management practices in the region and identify best practices
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-10 (see note under BurnMgtYN)
Definition source	BRANZ
Code set source	BRANZ

7.18 What type of debridement was performed?

Definition	Type of debridement used to prepare the wound bed		
Database Name	DebriGraftType	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpDebriType		

Code	Description
0	Excisional debridement:
1	Scrub
2	Hydrodebridement
3	Dermabrasion
-1	Not stated/Inadequately described

Reporting guide	The operation notes should detail the type of debridement performed to excise the burn. Different types of debridement include: 1. **Excisional debridement:** Excision of burned tissue using a surgical instrument containing a blade (Braithwaite, Watson, Humby, Goulian, Weck, Dermatome). 2. **Scrub:** Rubbing a burn wound, often with gauze, to remove blisters and loose skin. 3. **Hydro-debridement:** Debridement using high pressure saline jet. 4. **Dermabrasion:** Debridement using a rapidly rotating burr

Purpose	To identify the types of debridement techniques used. The type of debridement performed is also indicative of depth. This information can identify if the debridement types make a difference to patient outcomes to identify best practices.
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16
Definition source	BRANZ
Code set source	BRANZ

7.19 Skin Graft - Date & Time

Definition	To determine the time and date the patient underwent the first skin grafting procedure		
Database Name	DebriGraftDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set			
Reporting guide	Paper or electronic operation reports will contain the details of the timing of surgical procedures performed.		
Purpose	To identify when the patient underwent the first skin grafting procedure		
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners		
Collection start	Jul-10 (see note under BurnMgtYN)		
Definition source	BRANZ		
Code set source	BRANZ		

7.20 Allograft - First Theatre

Definition	Use of allograft (cadaver skin) to temporarily close wounds and associated debridement techniques		
Database Name	DebriAllograftYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Operation report details will be located in the patient's or electronic medical record
Purpose	To better understand burn wound management practices in the region and identify best practices
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16
Definition source	BRANZ
Code set source	BRANZ

7.21 What type of debridement was performed?

Definition	Type of debridement used to prepare the wound bed		
Database Name	DebriAllograftType	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpDebriType		

Code	Description
0	Excisional debridement:
1	Scrub
2	Hydrodebridement
3	Dermabrasion
-1	Not stated/Inadequately described

Reporting guide	The operation notes should detail the type of debridement performed to excise the burn. Different types of debridement include: 5. **Excisional debridement:** Excision of burned tissue using a surgical instrument containing a blade (Braithwaite, Watson, Humby, Goulian, Weck, Dermatome). 6. **Scrub:** Rubbing a burn wound, often with gauze, to remove blisters and loose skin. 7. **Hydro-debridement:** Debridement using high pressure saline jet. 8. **Dermabrasion:** Debridement using a rapidly rotating burr
Purpose	To identify the types of debridement techniques used. The type of debridement performed is also indicative of depth. This information can identify if the debridement types make a difference to patient outcomes to identify best practices.
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16
Definition source	BRANZ
Code set source	BRANZ

7.22 Allograft - Date & Time

Definition	To determine the time and date the patient underwent the first allograft procedure		
Database Name	DebriAllograftDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set			
Reporting guide	Paper or electronic operation reports will contain the details of the timing of surgical procedures performed.		
Purpose	To identify when the patient underwent the first skin grafting procedure		
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners		
Collection start	Jul-16		
Definition source	BRANZ		
Code set source	BRANZ		

7.23 Were there other Burn Wound Management Procedure(s) conducted during the 'First Theatre' episode?

Definition	Other burn wound management procedures performed during the first theatre episode		
Database Name	TheatreProcedureYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpTreatment		

Code	Description
-2	Not Applicable
1	Dressing change only (in theatre)
3	Fasciotomy
5	Amputation
9	Other (Specify)

Reporting guide	Locate first operation report in the Medical Record, identify other burn wound procedures performed during the first theatre episode which have not already been documented.
Purpose	To better understand urgent burn wound management practices and identify best practices
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-10 Jul-16 Note: Drop down list reduced to above. Removed Codes 2, 4, 6 to 8.
Definition source	BRANZ
Code set source	BRANZ

7.23.99 First theatre – Other

Definition	Other surgical procedures performed during the first surgical episode that are not available from the drop down menu selection		
Database Name	TheatreProcOther	**Collection**	Conditional
Data type	AlphaNumeric	**Form**	Text
Field size	100	**Layout**	AAA
Reporting guide	Operation report details will be located in the patient's or electronic medical record		
Purpose	To better understand urgent surgical practices in the region and identify best practices		
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners		
Collection start	Jul-10		
Definition source	BRANZ		
Code set source	BRANZ		

7.24 Date & Time of Procedure

Definition	The time and date of the first theatre procedure		
Database Name	TheatreProcDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set			
Reporting guide	Paper or electronic operation reports will contain the details of the timing of the first burn wound management procedure performed.		
Purpose	To identify which was the first theatre episode in reference to other surgical procedures		
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners		
Collection start	Jul-10		
Definition source	BRANZ		
Code set source	BRANZ		

7.25 Deep Burns Excision Completed?

Definition	Identify if all deep burns were excised.		
Database Name	DebriExcisionYN	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
-2	Not Applicable
0	No
1	Yes

Reporting guide	Complete burn wound excision will be documented in the operation report or Multidisciplinary Plan of Care located in the patient's or electronic medical record. Discuss with local clinical expert regarding where this is located/documented in MR
Purpose	To allow for the analysis of the time to deep burn excision and patient outcomes to identify best practices
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	2016
Definition source	BRANZ
Code set source	BRANZ

7.26 Deep Burns Excision Completed – Date & Time

Definition	The date when all deep burn eschar has been excised		
Database Name	DebriExcisionDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS

Code set	
Reporting guide	The time and date of complete burn wound excision will be documented in the operation report details or MD Plan of Care located in the patient's or electronic medical record. Discuss with clinical expert regarding documentation of this information in MR.
Purpose	This data item will allow for comparison of complete excision time frames with patient outcomes to identify best practices.
Data Users	Researchers, burn surgeons, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16
Definition source	BRANZ
Code set source	BRANZ

8.0 Assessment Quality Indicators

Content	Assessment Quality Indicators
Collected by	Participating Australian and New Zealand burns units
Collected for	All acute admissions
Data source	Hospital Medical Record
Database Location	tblAssessmentQI Table
Reporting Guide	

8.1 For patients with LOS >48 hours, did the patient have a physical functioning assessment by the Physiotherapist/Occupational Therapist in <48 hours of admission?

Definition	A physical functioning assessment includes the assessment and documentation of the patients past and present physical functioning state, by the Physiotherapist/Occupational Therapist within 48 hours of admission		
Database Name	PhyAssess	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNo (reference table)		

Code	Description
0	No
1	Yes
-2	Not applicable
-1	Not stated/Inadequately described

Reporting guide	Conditional: If LOS>48hours SELECT 1 – YES if a complete assessment by the physiotherapist or occupational therapist was documented in the medical record within that time frame. If LOS <=48 hrs, select Not Applicable
Purpose	Rehabilitation following burn injury requires a coordinated early approach from a specialised multi-disciplinary team to minimise complications from burns such as scarring, contractures and loss of function. Dedicated allied health burn clinicians are responsible for assessing burns patients and commencing rehabilitation as close to admission as possible. This quality indicator allows this to be determined.

Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, allied health managers & clinicians, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-10 Jul-16 Note: Prior to this date this data item was conditional to : If **TBSA** > 15% in adults (16 years of age and older) or > 10% in paediatrics (15 years of age and under). This no longer applies.
Definition source	BRANZ
Code set source	-

8.2 Did the Patient have their Nutritional Status screened within 24 hours of Admission?

Definition	To determine if the patients has their nutritional status screened within 24 hours of admission		
Database Name	NutriScreeningYN	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes
-2	Not Applicable

Reporting guide	Speak with clinical expert/dietitian regarding what Nutritional Screening Tool is used and where this documentation is located in the MR. SELECT 1(Yes) when the patient has had a Nutritional Screen completed with 24 hours using one of the validated Nutritional Screening Tools found in Appendix 1
Purpose	A significant proportion of patients admitted to hospital are at risk of malnutrition. Early identification of patients who are nutritionally depleted (or likely to become so) is vital to provide quality care and use resources effectively
Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, dietitians, allied health managers & clinicians, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16
Definition source	BRANZ
Code set source	

8.3 If the Nutritional Screening was positive, did the patient have a complete Nutritional Assessment with 24 hours of the positive screen?

Definition	If the patient screened positive as at risk, to determine that a complete assessment was then completed within the next 24 hours		
Database Name	NutriAssessYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNo		

Code	Description
0	No
1	Yes
-2	Not applicable
-1	Not stated/Inadequately described

Reporting guide	Conditional if 1(YES) to Nutritional Screen completed in <24 Hours Speak with clinical expert/dietitian regarding what Nutritional Screening Tool is used and where this documentation is located in the MR. Review the Nutritional Assessment Score. If score is within at risk groups, then review the relevant medical history to determine when a complete nutritional assessment was completed and documented by the dietitian. SELECT1 (YES) if this Nutrition Assessment occurred in < 24 hours of the positive Nutrition Screen
Purpose	Early nutritional assessment and intervention in at risk patients is considered best quality care
Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, dietitians, allied health managers & clinicians, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16
Definition source	BRANZ
Code set source	

8.4 Did the Patient receive Enteral or Parenteral Feeding?

Definition	To determine if the patients received enteral or parenteral nutrition at any time during admission.		
Database Name	FeedingYN	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	Documentation regarding enteral or parenteral nutrition will be found in the dietitian notes; nursing documentation; multidisciplinary plan of care, fluid balance charts, medical and ICU notes
Purpose	Burn injury increases the body's metabolic requirements and the provision of adequate supply of nutrients as close to the time of the burn injury is considered crucial in reducing the effects of metabolic abnormalities. Enteral nutrition is commonly administered through a nasogastric tube placed via the nose. Enteral nutrition is the preferred route of nutritional supplementation. Parenteral nutrition is administered via a peripheral or central vein. Enteral and parenteral nutritional supports are used to provide nutrients on a temporary or permanent basis to patients who are unable to ingest or tolerate adequate nutrients or to tolerate an oral diet. This quality indicator allows benchmarking against best practice guidelines for nutritional supplementation following burn injury.
Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, dietitians, allied health managers & clinicians, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-16

Definition source	BRANZ
Code set source	-

8.5 If %TBSA >20% TBSA Adults and >15% Children – Was Enteral/Parenteral Nutrition commenced within 24 hours of admission to the Burn Service?

Definition	To determine if patients with severe burns received supplemental nutrition within 24 hours of arrival at the burn unit.		
Database Name	Feeding	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
-2	Not Applicable
0	No
1	Yes

Reporting guide	Paediatric %TBSA burns changed to >15%TBSA burns in Jul-16 (from 10%TBSA burns) Review nursing and dietitian documentation in MR. SELECT 1(YES) if enteral/parenteral nutrition commenced within 24 hours from admission time (arrival time to BRANZ Hospital)
Purpose	Burn injury increases the body's metabolic requirements and the provision of adequate supply of nutrients as close to the time of the burn injury is considered crucial in reducing the effects of metabolic abnormalities. Evidence demonstrates that early enteral feeding has a significant impact on the morbidity and mortality of severe burn injuries. Severe burn injuries are >20%TBSA in adults and >15%TBSA in children. Enteral nutrition is commonly administered through a nasogastric tube placed via the nose. Enteral nutrition is the preferred route of nutritional supplementation. Parenteral nutrition is administered via a peripheral or central vein to patients who for various reasons are unable to ingest or tolerate nutrition via their gastrointestinal tract. This quality indicator allows benchmarking against best practice guidelines for nutritional supplementation following burn injury.
Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, dietitians, allied health managers & clinicians, local burn quality improvement programs, ANZBA BQIP, service planners
Collection start	Jul-09 Jul-16 Note: TBSA range changed from previous version
Definition source	
Code set source	

8.6 For burns >20% TBSA (adults) and >10% TBSA (children): Was there evidence/documentation in the medical record, that an accepted Formula (Parklands or similar) was used to estimate the patients fluid resuscitation requirements in the first 24 hours of admission?

Definition	To determine if a formula was used to guide resuscitation in severe burns		
Database Name	FormulaUsedYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
-2	Not Applicable
0	No
1	Yes

Reporting guide	Documentation of a formula to guide initial fluid resuscitation, will be documented in the initial BRANZ ED notes, Medical notes, ICU notes, Nursing documentation, ICU charts and Fluid Balance Charts within the first 24 hours. The Modified Parkland Formula (4 ml/kg/%TBSA) and Modified Brooke Formula (2 ml/kg/%TBSA) are the two most widely used resuscitation formulas. Discuss with a local clinical expert regarding the documentation of fluid resuscitation calculations.
Purpose	Specialized burn care includes the estimation of fluid resuscitation requirements in severe burns. Fluid resuscitation remains a cornerstone of quality early burn care.
Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, ICU staff, burn clinicians, local burn quality improvement programs, ANZBA BQIP
Collection start	Jul-16
Definition source	BRANZ
Code set source	

8.7 For patients with LOS >48 hours, did they have their psychosocial needs screened during their admission?

Definition	To determine if the patient (with LOS >48 hours) had their psycho social needs screened during their admission.		
Database Name	PsychScreeningYN	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNo		

Code	Description
0	No
1	Yes
-2	Not applicable
-1	Not stated/Inadequately described

Reporting guide	Psychosocial screening can be classified into two broad categories with each having 3 distinct sub categories: • **Social screening** – family/social supports, home and work situation, legal and financial situation • **Psychologica**l – current distress, premorbid diagnoses and reaction at time of injury SELECT 1 (YES) if there is documentation in the MR relating to the screening of at least one sub category from both the social and psychosocial broad categories (listed above, one from each category, two in total) and the need for psychosocial intervention. Documentation of the elements of psychosocial screening will be in the nursing, medical or allied health notes in the MR.
Purpose	Psychosocial care is paramount to quality burn care. The ANZBA Psychosocial Expert Reference Group agreed to the definition of Psychosocial Screening based on the commonly accepted definitions defined previously No psychosocial screening tools have been validated in the burns population, hence no screening tool was recommended.

	There is no evidence regarding the timeliness of screening or assessment of psychosocial needs in burn injuries which is why no time frame has been set around when the initial screening should occur. A time frame was set around patients admitted for more than 48 hours to increase the sensitivity of the QI for those with more complex injuries or needs.
Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, social work departments, psychology departments, psychiatry departments, allied health managers, burn clinicians, local burn quality improvement programs, ANZBA BQIP
Collection start	Jul-16
Definition source	BRANZ, ANZBA Psychosocial Expert Reference Group
Code set source	

8.8 When did Psychosocial Screening OCCUR?

Definition	The date and time when psychosocial screening occurred		
Database Name	PsychScreeningDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set			
Reporting guide	Document the date and time when the elements of psychosocial screening were evident in the MR documentation		
Purpose	To increase knowledge of quality burn care and analyse if there is any relationship between the timeliness of psychosocial screening and patient outcomes.		
Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, social work departments, psychology departments, psychiatry departments, allied health managers, burn clinicians, local burn quality improvement programs, ANZBA BQIP		
Collection start	Jul-16		
Definition source	BRANZ, ANZBA Psychosocial Expert Reference Group		
Code set source			

8.9 For patients who were positive in their psychosocial screen, were they referred to psychosocial services in <24 hours of the positive screen?

Definition	Was the patient referred to Psychosocial Services within 24 hours of the positive screen?		
Database Name	PsychReferYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes
-2	Not Applicable

Reporting guide	Select 1 – YES if the patient was referred to Psychosocial Services within 24 hours of the documentation of the positive psychosocial screen that identified potential risk or issues.

	Referral to Psychosocial Services will be recorded in the hospitals electronic referral Patient Information Systems, or in the medical history. Psychosocial Services include Social Work, Psychology and Psychiatry
Purpose	If the patients screen was positive for having possible psychosocial issues, it is reasonable to expect as good quality care that referral to a psychosocial health care clinicians should be made within 24 hours of documentation of the positive psychosocial screen
Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, social work departments, psychology departments, psychiatry departments, allied health managers, burn clinicians, local burn quality improvement programs, ANZBA BQIP
Collection start	Jul-16
Definition source	BRANZ, ANZBA Psychosocial Expert Reference Group
Code set source	

8.10 When did Psychosocial Assessment occur?

Definition	One referral has made to psychosocial services, a complete psychosocial assessment should be completed. When this is completed should be documented		
Database Name	PsychAssessDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set			
Reporting guide	The date and time that psychosocial assessment (regardless of whether they were referred in <24 hours) of the first documentation entry from either the social work, psychology or psychiatry services.		
Purpose	To understand if there is a relationship between the timeliness of psychosocial assessment and patient outcomes.		
Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, social work departments, psychology departments, psychiatry departments, allied health managers, burn clinicians, local burn quality improvement programs, ANZBA BQIP		
Collection start	Jul-16		
Definition source	BRANZ, ANZBA Psychosocial Expert Reference Group		
Code set source			

8.11 Did the Patient have a Pain Assessment completed (using a validated Pain Scale) within 24 hours of Admission?

Definition	To determine if the patient had a pain assessment within 24 hours of admission.		
Database Name	PainAssessYN	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	SELECT 1 (YES) when the patient has had a pain assessment completed with 24 hours. Pain assessment must be completed using one of the validated Pain Assessment Tools found in Appendix 2

	Discuss with clinical expert/Pain service regarding what Pain Assessment Tool is used at your service and where to locate it in the MR. Validated Pain Assessment Tools will be found on the Graphic Observation Chart, the ICU or ED Graphics Observation Charts.
Purpose	Pain is often the most frequent complaint following burn injury. Early intervention minimises the risk of long term sequelae such as chronic pain. Assessment of pain is vital in determining the most effective management. As a sign of good quality care, it is reasonable to expect that a patient who has been admitted for a burn injury should have an assessment of their pain within 24 hours of admission.
Data Users	BRANZ staff, Reporting, Epidemiologists, Researchers, burn directors, nurse managers, pain services, anaesthetic departments, burn clinicians, local burn quality improvement programs, ANZBA BQIP
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

9.0 Inpatient

Content	ICU, Inpatient quality indicators, Transfer of care
Collected by	Participating Australian and New Zealand burns units
Collected for	All admissions
Data source	Hospital Medical Record
Database Location	tblInpatient Table
Reporting Guide	Readmissions pre-fixed by Readm_ ICU data should be retrieved from the hospital administrative dataset to ensure consistency with data collection.

9.1 ICU Admission

Definition	To determine if the patient was admitted to the BRANZ hospital Intensive Care Unit		
Database Name	ICU	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	An ICU is a designated ward of a hospital that is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems
Purpose	To determine if the patient was admitted to an Intensive Care Unit. Minimising the time ventilated and ICU length of stay is important in avoiding complications following burn injury
Data Users	BRANZ staff, Reporting, Epidemiologists

Collection start	Jul-09
Definition source	BRANZ
Code set source	-

9.2 ICU Admission Date & Time

Definition	Date and Time of first admission to the BRANZ Intensive Care Unit		
Database Name	IcuAdmDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set	-		
Reporting guide	Conditional: If ICU = 1 A valid date greater than or equal to the Admission Date/Time and less than or equal to Discharge Date/Time **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).		
Purpose	To calculate time in ICU		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

9.3 ICU Discharge Date & Time

Definition	Date and Time of first discharge from the BRANZ hospital Intensive Care Unit		
Database Name	IcuDisDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set	-		
Reporting guide	Conditional: If ICU = 1 A valid date greater than or equal to the Admission Date/Time and less than or equal to Discharge Date/Time **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).		
Purpose	To calculate time in ICU		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

9.4 Was Patient Mechanically Ventilated in ICU?

Definition	To determine if patient was mechanically ventilated in the BRANZ hospital Intensive Care Unit		
Database Name	VentHourCalc	**Collection**	Conditional

Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpHoursCalculated (reference table)		

Code	Description	
-1	Yes - Hours not calculated	Patient was mechanically ventilated, however total hours not known so the start/stop times of mechanical ventilation need to be calculated by system (code must enter start/stop times of ventilation)
0	No	Patient not ventilated in ICU
1	Yes - Calculated hours	Patient mechanically ventilated in ICU and the total number of ventilation hours is known (coder does not need to enter the start/stop times of ventilation)

Reporting guide	Conditional: If **ICU = 1** Excludes ventilation hours outside of the BRANZ hospital Intensive Care Unit
Purpose	To determine if the patient was mechanically ventilated in ICU
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	BRANZ

9.5 Mechanical Ventilation – Number of Hours

Definition	Total number of hours patient was mechanically ventilated in the BRANZ hospital Intensive Care Unit (manually entered by coded)		
Database Name	VentHours	**Collection**	Conditional
Data type	Numeric	**Form**	-
Field size	6	**Layout**	NNNN.N
Code set	-		
Reporting guide	Conditional: If **VentHourCalc** =1, Permitted values: 1 and 9999 If the total mechanical ventilation hours are known, the coder is able to enter the value. The start/stop dates and times of mechanical ventilation are not required. Hours are inclusive of first admission and readmission to ICU		
Purpose	To determine if the patient was mechanically ventilated in ICU		
Data Users	Data Collectors, BRANZ staff		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

9.6 Mechanical Ventilation Start Date & Time

Definition	Date and time mechanical ventilation started in the BRANZ hospital Intensive Care Unit		
Database Name	VentStartDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set	-		

Reporting guide	Conditional: If **VentHourCalc** =-1 Date sequence must be 'ICU Admission <= Mechanical Ventilation Start <= Mechanical Ventilation Stop <= ICU Discharge **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).
Purpose	To calculate time mechanically ventilated
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	-

9.7 Mechanical Ventilation Stop Date & Time

Definition	Date and Time mechanical ventilation stopped in the BRANZ hospital Intensive Care Unit		
Database Name	VentStopDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set	-		
Reporting guide	Conditional: If **VentHourCalc** =-1 A valid date greater than or equal to the Admission Date/Time and less than or equal to Discharge Date/Time **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).		
Purpose	To calculate time mechanically ventilated		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-10		
Definition source	BRANZ		
Code set source	-		

9.8 Was This Patient Readmitted to ICU?

Definition	To determine if the patient was readmitted to the BRANZ hospital Intensive Care Unit during the same episode of care		
Database Name	ICURe	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
-1	Not stated/Inadequately described
0	No
1	Yes

Reporting guide	-
Purpose	To determine if the patient was readmitted to ICU

Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Jul-09
Definition source	BRANZ
Code set source	-

9.9 ICU Readmission Date & Time

Definition	Date and Time of readmission to BRANZ hospital Intensive Care Unit		
Database Name	IcuReAdmDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set	-		
Reporting guide	Conditional: If **ICURe** = 1 A valid date greater than or equal to the Admission Date/Time and less than or equal to Discharge Date/Time **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).		
Purpose	To calculate time in ICU		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

9.10 ICU Readmission Discharge Date & Time

Definition	Date and Time of readmission discharge from the BRANZ hospital Intensive Care Unit		
Database Name	IcuReDisDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set	-		
Reporting guide	Conditional: If ICURe = 1 A valid date greater than or equal to the Admission Date/Time and less than or equal to Discharge Date/Time **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).		
Purpose	To calculate time in ICU		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

9.11 Was this ICU Readmission Planned or Unplanned?

Definition	To determine if the readmission to ICU was expected or unexpected

Database Name	ReAdmPlanned	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpReAdmPlanned		

Code	Description
1	Planned
2	Unplanned
-1	Not Stated/Inadequately described

Reporting guide	Refer to the medical documentation related to the ICU Readmission to determine if the ICU Readmission was planned or unplanned. If unclear, clarify with the BQIP Champion or similar expert clinical reference.
Purpose	To better understand the incidence of unplanned ICU readmissions of burn patients
Data Users	BRANZ Staff, ANZBA BQIP, local quality improvement projects, intensive care services.
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

9.11.2 Reason for Unplanned Readmission

Definition	The reason the burn patient had an unplanned readmission to the intensive care as documented in the ICU Readmission medical documentation.		
Database Name	ReAdmPlannedOther	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	500	**Layout**	-
Code set	-		
Reporting guide	Document the reason for unplanned readmission to ICU as documented in the MR		
Purpose	To better understand the causes of unplanned ICU readmissions of burn patients		
Data Users	BRANZ Staff, ANZBA BQIP, local quality improvement projects, intensive care services.		
Collection start	Jul-16		
Definition source	BRANZ, QI Working Party		
Code set source			

9.12 Start Date & Time OF Mechanical Ventilation (ICU Readmit)

Definition	Date and time mechanical ventilation started in the BRANZ hospital Intensive Care Unit		
Database Name	VentStartDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set	-		
Reporting guide	Conditional: If **VentHourCalc** =-1 Date sequence must be 'ICU Admission <= Mechanical Ventilation Start <= Mechanical Ventilation Stop <= ICU Discharge **Midnight**		

	Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).
Purpose	To calculate time mechanically ventilated
Data Users	BRANZ Staff, ANZBA BQIP, local quality improvement projects, intensive care services, Reporting, Epidemiologists
Collection start	Jul-10
Definition source	BRANZ
Code set source	-

9.13 Stop Date & Time of Mechanical Ventilation (ICU Readmit)

Definition	Date and Time mechanical ventilation stopped in the BRANZ hospital Intensive Care Unit		
Database Name	VentStopDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set	-		
Reporting guide	Conditional: If **VentHourCalc** =-1 Date sequence must be 'ICU Admission <= Mechanical Ventilation Start <= Mechanical Ventilation Stop <= ICU Discharge **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).		
Purpose	To calculate time mechanically ventilated		
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, intensive care services.		
Collection start	Jul-10		
Definition source	BRANZ		
Code set source	-		

10.0 Inpatient Quality Indicators

10.1.1 First Serum Creatinine in <24 hours of admission

Definition	The first (<24 hours of admission) Serum Creatinine (SCr)		
Database Name	FirstSerumCr	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	3	**Layout**	N
Code set			
Reporting guide	Sourced from pathology results – usually biochemistry. To provide a baseline of the patients renal function on admission. Enter -1 for unknown		
Purpose	Acute renal failure can develop during the early resuscitation stage in treating a burn injury and is associated with complications and poor outcomes in severe burn injury. This data provides a baseline parameter to assess renal function on admission to allow for comparison of other SCr results in the first 72 hours to identify acute kidney injury		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-16		

Definition source	BRANZ, QI Working Party
Code set source	BRANZ

10.1.2 First eGFR in <24 hours of Admission

Definition	The first(<24 hours of admission) estimated glomerular filtration rate		
Database Name	FirsteGFR	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	3	**Layout**	N
Code set			
Reporting guide	Sourced from pathology results – usually biochemistry. To provide a baseline of the patients renal function on admission. Acute renal failure can develop during the early resuscitation stage in treating a burn injury and is associated with complications and poor outcomes in severe burn injury. Enter -1 for unknown		
Purpose	Acute renal failure can develop during the early resuscitation stage in treating a burn injury and is associated with complications and poor outcomes in severe burn injury. This data provides a baseline parameter to assess renal function on admission to allow for comparison of other eGFR results in the first 72 hours to identify acute kidney injury		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-16		
Definition source	BRANZ		
Code set source	BRANZ		

10.1.3 Highest Serum Creatinine in first 72 hours of Admission

Definition	The highest Serum Creatinine (SCr) in first 72 hours of admission		
Database Name	HighestSerumCr	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	3	**Layout**	N
Code set			
Reporting guide	Sourced from pathology results – usually biochemistry. Acute renal failure can develop during the early resuscitation stage in treating a burn injury and is associated with complications and poor outcomes in severe burn injury. Enter -1 for unknown		
Purpose	The highest SCr in the first 72 hours provides to comparison to the baseline SCr results. The RIFLE criteria will be used to analyse the differences between the numbers to identify acute kidney injury.		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-16		
Definition source	BRANZ, QI Working Party		
Code set source	BRANZ		

10.1.4 Lowest Estimated Glomerular Filtration Rate (eGFR) in first 72 hours of Admission

Definition	Lowest estimated Glomerular Filtration rate (eGFR) in the first 72 hours		
Database Name	LowesteGFR	**Collection**	Conditional
Data type	Numeric	**Form**	Code

Field size	3	**Layout**	N
Code set			
Reporting guide	Sourced from pathology results – usually biochemistry. Enter -1 for unknown		
Purpose	The lowest eGFR in the first 72 hours provides a comparison to the baseline eGFR results. The RIFLE criteria will be used to analyse the eGFR data to identify acute kidney injury. Acute renal failure can develop during the early resuscitation stage in treating a burn injury and is associated with complications and poor outcomes in severe burn injury.		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Jul-16		
Definition source	BRANZ		
Code set source	BRANZ		

10.2 First Positive MRSA Microbiology Results

Definition	Did the patient have any swabs (regardless of location) for MRSA?		
Database Name	SwapMRSA	**Collection**	
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNo (reference table)		

Code	Description
0	No
1	Yes

Reporting guide	Using Pathology Results, identify if MRSA was isolated from any microbiology specimen regardless of location. First isolation only.
Purpose	Culture of resistant microorganisms can be an indicator of hand hygiene practices and over use of antibiotics
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-09
Definition source	BRANZ, QI Working Party
Code set source	-

10.2.1 First Positive MRSA Swab Site

Definition	The location of the first positive swab for MRSA		
Database Name	MRSASite	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	DD/MM/CCYY HH:NN
Code set	tlkpSpecimenSite		

Code	Description
-1	Not Stated/Inadequately described
1	Wound
2	Sputum
3	Urine

4	Blood
5	Tissue
99	Other

Reporting guide	Conditional: If 10.2 SwapMRSA = 1 Use Pathology Results to determine specimen site/type
Purpose	Identify site where MRSA was cultured from
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-16
Definition source	BRANZ
Code set source	-

10.2.2 First Positive MRSA Date & Time

Definition	Date and time of positive swab for MRSA		
Database Name	MRSASiteDt	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	DD/MM/CCYY HH:NN
Code set			
Reporting guide	Conditional: If 10.2 SwapMRSA = 1		
Purpose	Identify the date and time MRSA was cultured (collection date & time)		
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control		
Collection start	Jul-16		
Definition source	BRANZ		
Code set source	-		

10.2.3 If the Patient had positive MRSA swabs during Admission, was it previously isolated on Admission?

Definition	To determine if the MRSA was isolated from swabs on admission		
Database Name	MRSAIsolatedYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpIsolated		

Code	Description
0	No swabs taken in first 24 hours
1	No – swabs on admission taken and not positive for MRSA
2	Yes - swabs on admission taken and positive for MRSA
-1	Not Stated/Inadequately Described

Reporting guide	Refer to any microbiology results taken in the first 24 hours of admission and identify if the patient had any positive results for MRSA organisms
Purpose	If the MRSA organism was isolated on admission, we can determine that it was already present, and not associated with care received in the BRANZ Hospital
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

10.3 Positive VRE Microbiology Results

Definition	Did the patient have any swabs (regardless of location) for VRE?		
Database Name	SwapVRE	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNo (reference table)		

Code	Description
0	No
1	Yes

Reporting guide	Using Pathology Results, identify if VRE was isolated from any microbiology specimen regardless of location. First result only.
Purpose	Culture of resistant microorganisms can be an indicator of hand hygiene practices and over use of antibiotics
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-09
Definition source	BRANZ
Code set source	-

10.3.1 VRE Swab Site

Definition	The location of the first positive swab for VRE		
Database Name	VRESite	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	DD/MM/CCYY HH:NN
Code set	tlkpSpecimenSite		

Code	Description
-1	Not Stated/Inadequately described
1	Wound
2	Sputum
3	Urine
4	Blood
5	Tissue
99	Other

Reporting guide	Conditional: If 10.3 SwapVRE = 1 Use Pathology Results to determine specimen site/type
Purpose	Identify the where VRE was cultured from
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	-

10.3.2 First Positive VRE Date & Time

Definition	Date and time of positive swab for VRE		
Database Name	VRESiteDt	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	DD/MM/CCYY HH:NN
Code set			
Reporting guide	Conditional: If 10.3 SwapVRE = 1		
Purpose	Identify the date and time VRE was cultured		
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control		
Collection start	Jul-16		
Definition source	BRANZ, QI Working Party		
Code set source	-		

10.3.3 If the Patient did have Positive VRE swabs during Admission, was it previously isolated on Admission?

Definition	To determine if the VRE was isolated from swabs on admission		
Database Name	VREIsolatedYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpIsolated		

Code	Description
0	No swabs taken in first 24 hours
1	No – swabs on admission taken and not positive for VRE
2	Yes - swabs on admission taken and positive for VRE
-1	Not Stated/Inadequately Described

Reporting guide	Refer to any microbiology results taken in the first 24 hours of admission and identify if the patient had any positive results for VRE organisms
Purpose	If the VRE organism was isolated on admission, we can determine that it was already present, and not associated with care received in the BRANZ Hospital
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control

Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

10.4 Positive Carbopenum Resistant Pseudomonas MICROBIOLOGY RESULTS?

Definition	Did the patient have any swabs (regardless of location) for Carbopenum resistant pseudomonas (first only)?		
Database Name	SwapMRP	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	**2**	**Layout**	N
Code set	tlkpYesNo (reference table)		

Code	Description
0	No
1	Yes

Reporting guide	Using Pathology Results, identify if Carbopenum resistant pseudomonas was isolated from any microbiology specimen regardless of location. First result only.
Purpose	Identify if Carbopenum resistant pseudomonas was isolated from any microbiology specimen regardless of location. Culture of resistant microorganisms can be an indicator of hand hygiene practices and over use of antibiotics
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	2016
Definition source	BRANZ, QI Working Party
Code set source	

10.4.1 Carbopenum Resistant Pseudomonas Swab Site

Definition	The location of the first positive swab for Carbopenum resistant pseudomonas		
Database Name	PseudomonasSite	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	DD/MM/CCYY HH:NN
Code set	tlkpSpecimenSite		

Code	Description
-1	Not Stated/Inadequately described
1	Wound
2	Sputum
3	Urine
4	Blood
5	Tissue
99	Other

Reporting guide	Conditional: If 10.4 Swap**MRP** = 1 Use Pathology Results to determine specimen site/type
Purpose	Identify where Carbopenum resistant pseudomonas was cultured from
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control

Collection start	Jul-16
Definition source	BRANZ
Code set source	-

10.4.2 First Positive Carbopenum Resistant Pseudomonas DATE & TIME

Definition	Date and time of positive swab for Carbopenum resistant pseudomonas?		
Database Name	PseudomonasSiteDt	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	DD/MM/CCYY HH:NN
Code set			
Reporting guide	Conditional: If 10.4 Swap**MRP** = 1		
Purpose	Identify the date and time Carbopenum resistant pseudomonas was cultured		
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control		
Collection start	Jul-16		
Definition source	BRANZ		
Code set source	-		

10.4.3 If the patient did have positive Carbopenum Resistant Pseudomonas swabs during admission, was it previously isolated on admission?

Definition	To determine if the Carbopenum resistant pseudomonas was isolated from swabs on admission		
Database Name	PseudomonasIsolatedYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpIsolated		

Code	Description
0	No swabs taken in first 24 hours
1	No – swabs on admission taken and not positive for Carbopenum resistant pseudomonas
2	Yes - swabs on admission taken and positive for Carbopenum resistant pseudomonas
-1	Not Stated/Inadequately Described

Reporting guide	Conditional: If 10.4 Swap**MRP** = 1. Refer to any microbiology results taken in the first 24 hours and identify if the patient had any positive results for Carbopenum resistant pseudomonas organisms
Purpose	Identify if Carbopenum resistant pseudomonas was isolated from any microbiology specimen regardless of location. Culture of resistant microorganisms can be an indicator of hand hygiene practices and over use of antibiotics
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

10.5 Positive Carbopenum Resistant Enterobacter MICROBIOLOGY RESULTS

Definition	Did the patient have any swabs (regardless of location) for Carbopenum resistant Enterobacter(first only) ?		
Database Name	Enterobacter	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpYesNo (reference table)		

Code	Description
0	No
1	Yes

Reporting guide	Using Pathology Results, identify if Carbopenum resistant Enterobacter was isolated from any microbiology specimen regardless of location. First result only.
Purpose	Identify if Carbopenum Resistant Enterobacter was isolated from any microbiology specimen regardless of location. Culture of resistant microorganisms can be an indicator of hand hygiene practices and over use of antibiotics
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

10.5.1 Carbopenum Resistant Enterobacter Swab Site

Definition	The location of the first positive swab for Carbopenum resistant Enterobacter		
Database Name	EnterobacterSite	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	DD/MM/CCYY HH:NN
Code set	tlkpSpecimenSite		

Code	Description
-1	Not Stated/Inadequately described
1	Wound
2	Sputum
3	Urine
4	Blood
5	Tissue
99	Other

Reporting guide	Conditional: If 10.5 Enterobacter = 1 Use Pathology Results to determine specimen site/type
Purpose	Identify the where Carbopenum resistant pseudomonas was cultured from
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-16

Definition source	BRANZ
Code set source	-

10.5.2 First Positive Carbopenum Resistant enterobacter DATE & TIME

Definition	Date and time of positive swab for VRE Carbopenum resistant Enterobacter?		
Database Name	EnterobacterDt	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	DD/MM/CCYY HH:NN
Code set			
Reporting guide	Conditional: If 10.5 Enterobacter = 1		
Purpose	Identify the date and time Carbopenum resistant Enterobacter was cultured		
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control		
Collection start	Jul-16		
Definition source	BRANZ		
Code set source	-		

10.5.3 If the Patient did have positive Carbopenum Resistant Enterobacter swabs during Admission, was it previously isolated on Admission?

Definition	To determine if the Carbopenum resistant Enterobacter was isolated from swabs on admission		
Database Name	MREnterobacterAdmIsolatedYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpIsolated		

Code	Description
0	No swabs taken in first 24 hours
1	No – swabs on admission taken and not positive for Carbopenum resistant Enterobacter
2	Yes - swabs on admission taken and positive for Carbopenum resistant Enterobacter
-1	Not Stated/Inadequately Described

Reporting guide	Conditional: If 10.5 Enterobacter = 1.Refer to any microbiology swab results taken in the first 24 hours and identify if the patient had any positive results for Carbopenum resistant Enterobacter organisms
Purpose	Identify if Carbopenum Resistant Enterobacter was isolated from any microbiology specimen regardless of location. Culture of resistant microorganisms can be an indicator of hand hygiene practices and over use of antibiotics
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

10.6 Did the Patient Have Blood Cultures taken during this Admission?

Definition	To determine if the patient had a positive blood culture result during the admission		
Database Name	Blood	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	N
Code set	tlkpBloodCultureYN (reference table)		

Code	Description	
-3	Not collected for this patient	Blood cultures not collected for patient during admission
-1	Not stated/Inadequately described	Data not retrievable
0	Cultures collected - result(s) negative	Blood cultures collected and results negative
1	Cultures collected - result(s) positive	Blood cultures collected and there was at least one positive blood culture during the admission

Reporting guide	Sourced from patient's pathology/microbiology results. Blood culture is a microbiological culture of blood. It is employed to detect infections that are spreading through the bloodstream (such as bacteremia, septicemia amongst others). This is possible because the bloodstream is usually a sterile environment.
Purpose	The aim of this Quality Indicator is to collect data on the number of blood cultures taken, and the blood infection rates within the burns service. Bloodstream infections increase the risk of complications and mortality in burn injured patients. When a patient shows signs or symptoms of a systemic infection, results from a blood culture can verify that an infection is present, and they can identify the type (or types) of microorganism that is responsible for the infection. However, negative growths do not exclude infection
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-09, revised 2016
Definition source	BRANZ, QI Working Party
Code set source	BRANZ

10.6.1 Date and Time of First Positive Result

Definition	To determine the date and time of the first (preliminary) positive result		
Database Name	BloodPositiveDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CC/YY HH:MM
Code set			
Reporting guide	Positive blood culture results and the time they are collected can be found in the Patient Result reporting System. Note: document the time of the FIRST PRELIMINARY positive blood culture result.		
Purpose	To determine the date and time of the first positive result (preliminary). In conjunction with other data items relating to blood culture management, these series of questions seeks to determine the incidence of positive blood cultures and the proactive, pre-emptive management.		
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control		
Collection start	Jul-16		

Definition source	BRANZ, QI Working Party
Code set source	

10.6.2 Microorganism

Definition	What microorganism was identified in the first positive blood culture result		
Database Name	Microorganism	**Collection**	Conditional
Data type	Text	**Form**	Text
Field size	200	**Layout**	-
Code set			
Reporting guide	Positive blood culture results and the micro-organism identified can be found in the Results Patient Information System. Write the free text name of the organism exactly as detailed in the microbiology report, no abbreviations.		
Purpose	To identify any variance in incidence and trends in positive blood cultures results in burn services across the region		
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control		
Collection start	Jul-16 Note: All data related to Blood culture prior to this date is concatenated and mapped to this field.		
Definition source	BRANZ, QI Working Party		
Code set source			

10.7 At the time of the first positive result, was the patient on appropriate antibiotics?

Definition	To determine if the clinical team pre-emptively considered what antibiotics to prescribe the patient before the results was back		
Database Name	AntibioticsYN	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNo		

Code	Description
0	No
1	Yes
-1	Not stated/Inadequately described

Reporting guide	Note the date and time of the preliminary blood culture result. Antibiotic sensitivity will accompany positive microbiological results, and are likely to be available with subsequent final microbiology results. Note the sensitivities. Refer to the BQIP champion, BRANZ staff and/ or appropriate clinical expert for advice on where this information is located as necessary Refer to the Medication Chart of the day of the preliminary positive result - see if the patient was already prescribed the appropriate antibiotics (according to sensitivity results), at the time of the first preliminary positive result. Select 1 = YES if the patient had been proactively prescribed the antibiotic/s identified as “Sensitive” at the time the first preliminary blood culture result was available, and had already been administered.

	SELECT 0 = NO if the patient was not already prescribed SENSITIVE antibiotics (as identified by the microbiology lab) at the time of the first preliminary positive blood culture result
Purpose	For quality burn care, it is reasonable to expect that if and when a clinician takes blood cultures because they suspect the patient has a bloodstream infection - thoughtful consideration regarding antibiotic selection (and perhaps some expert advice) should be given to ensure targeted appropriate management is commenced proactively. It would be unreasonable in the management of positive blood cultures, to start antibiotics once the organism has been isolated.
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-16
Definition source	BRANZ, QI Working party
Code set source	

10.7.1 What time were they put on the Antibiotics?

Definition	To determine when the patient was prescribed and administered appropriate antibiotics following the first preliminary result (if they were not already prescribed them before the first positive result)		
Database Name	AntibioticsDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set			
Reporting guide	For patients who were not already on appropriate antibiotics before the first preliminary blood culture result, identify from the medical record, the date and time they were eventually prescribed and administered appropriate antibiotics (as identified with the antibiotic sensitivity results associated with the positive blood culture). To find this information: 1. Identify antibiotics identified as sensitive from the microbiology results. These maybe available with the final microbiology results. If difficult to locate, discuss with the BQIP champion, appropriate clinical expert, or BRANZ staff for advice. 2. Review the Medication Record, medical notes, Infection Disease service notes for documentation of the prescribing of appropriate antibiotics, as identified by the micro results. Refer to documentation at the time immediately before and following the date and time of the first positive preliminary result. 3. Document the time and date the patient was prescribed and administered the appropriate antibiotic.		
Purpose	To identify when the patient was eventually placed on appropriate antibiotics. Bloodstream infections increase the risk of complications and mortality in burn injured patients. This data item will help to understand if there is an association between the early management of positive blood cultures and patient outcomes. This data will inform future evidence based, best practice guidelines		
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control		
Collection start	Jul-16		
Definition source	BRANZ, QI Working Party		
Code set source			

10.7.2 What Antibiotics were they on at the time of the result?

Definition	To determine what antibiotics the patient was on at the time of the positive blood culture result		
Database Name	Antibiotics	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	NN
Code set	tlkpAntibiotics		

Code	Description
-2	Not Applicable
-1	Not Stated/Inadequately described
0	Amoxycillin+/- Clavulanate
1	Cefepime
2	Ceftazidime
3	Ceftriaxone
4	Cephalexin
5	Cephazolin
6	Ciprofloxacin
7	Flu/dicloxacillin
8	Meropenem
9	Piperacillin/Tazobactam
10	Teicoplanin
11	Tobramycin/Gentamicin
12	Trimethoprim/Sulfamethoxazole
13	Vancomycin
99	Other

Reporting guide	Refer to the Medication Chart in the Medical Record on the date of the first positive blood culture result, identify the antibiotics the patient was prescribed and select from the drop down menu options.
Purpose	To better understand the management of positive blood culture results including trends in antibiotic use.
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

10.7.2.99 Antibiotics -Other

Definition	To identify antibiotics the patient was placed on which were not listed in the drop down menu selection in item 10.17.		
Database Name	AntibioticsOther	**Collection**	Conditional
Data type	Text	**Form**	Text
Field size	200	**Layout**	-
Code set			
Reporting guide	Write the name of the antibiotic/s the patient was prescribed in this field if the antibiotic is not available in the drop down menu selection of 10.17xxx,		
Purpose	Microbiology Departments do not always list all of the antibiotic sensitivities to minimise prescribing variation. Additional antibiotics prescribed will be clarified with an Infectious Diseases expert for appropriateness.		

Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, infectious disease services, researchers, service planners, infection control
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

10.8 If the Patient is ≥16 years old, did they receive Anticoagulation Prophylaxis?

Definition	Did the patient receive anticoagulation prophylaxis?		
Database Name	AnticoagulationYN	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND		

Code	Description
-1	Not stated/Inadequately described
-2	Not applicable
0	No
1	Yes

Reporting guide	Review the patients Medication Chart in the Medical Record. Identify if the patient received anticoagulation prophylaxis during their admission. Prescribed medications used for anticoagulation prophylaxis include: 1. Clexane 2. Heparin 3. Warfarin 4. Apixiban 5. Dabigatran 6. Rivaroxaban Select -2 Not Applicable if < 16 years old; patient receives end of life care on admission
Purpose	Anticoagulation prophylaxis is used in adult burn patients to prevent venous thrombosis and pulmonary embolism. This data item will assist in a better understanding of anticoagulation prophylaxis practices in adults with burn injuries.
Data Users	BRANZ staff, Reporting, Epidemiologists, ANZBA BQIP, local quality improvement projects, haemotology services, researchers, service planners,
Collection start	Jul-16
Definition source	BRANZ, QI Working Party
Code set source	

11.0 Transfer of Care

11.1 Was Patient Discharged from Burns Care prior to Hospital Discharge?

Definition	To determine if the patient was transferred from care of the Burns Service to a different unit (prior to hospital discharge)		
Database Name	Discharge	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	1	**Layout**	N
Code set	tlkpYesNoND (reference table)		

Code	Description
0	No

1	Yes
Reporting guide	To identify if the patient was transferred from the care of the burns service to a different unit during the episode of inpatient care. In this scenario, the patient's burn injury is no longer considered the primary admitting reason and they are discharged from burns care to another unit. For example, the burn wound is healed; however ongoing cardiac problems prevent the patient from being discharged and they are subsequently transferred to the Cardiac unit. The Burns Service may still be involved in the patient's care, but on a reduced level such as for wound management advice. The patient may also be physically moved to a different ward. Transfer of Care data should be readily available in the hospital Patient Information System.
Purpose	To differentiate hospital length of stay and length of stay under the burns unit
Data Users	BRANZ staff, Reporting, Epidemiologists
Collection start	Apr-10
Definition source	BRANZ
Code set source	-

11.2 Date & Time Discharged from Burns Care

Definition	Date and Time the patient was transferred from care of the Burns Service to a different unit (prior to hospital discharge)		
Database Name	DischargeDate	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN
Code set	-		
Reporting guide	Conditional: If **Discharge** = 1 A valid date greater than or equal to the Admission Date/Time and less than or equal to Discharge Date/Time **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).		
Purpose	To differentiate burns unit length of stay from total hospital length of stay.		
Data Users	BRANZ staff, Reporting, Epidemiologists		
Collection start	Apr-10		
Definition source	BRANZ		
Code set source	-		

12.0 Discharge Details

Content	Burns unit Discharge destinations and date
Collected by	Participating Australian and New Zealand burns units
Collected for	All admissions
Data source	Hospital Medical Record
Database Location	tblDischarge Table
Reporting Guide	Readmissions pre-fixed by Readm_

12.1 Disposition

Definition	Patient status and/or destination on departure from the hospital		
Database Name	Disposition	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpDisposition (reference table)		

Code	Description	
-1	Not stated/inadequately described	Data not retrievable
0	Another BRANZ hospital	Hospital campus with a designated Burns Service (BRANZ hospital)
1	Other acute hospital (specify)	Other acute hospital
3	Psychiatric hospital/Unit	Psychiatric hospital or psychiatric unit outside or within the BRANZ hospital campus
4	Other health care accommodation, unless this is usual place of residence (specify)	If the patient is discharged to other health care accommodation (e.g. nursing home and hostel) that is on a temporary basis or has not previously been their usual place of residence (prior to admission).
5	Statistical discharge – acute to subacute care (eg. Rehab. bed)	
6	Left against medical advice/discharge at own risk	Patient absconds or leaves against medical advice, at own risk.
7	Statistical discharge - from leave	Change in Care Type occurs within the same hospital stay when a patient goes on leave (i.e weekend leave) and the hospital discharges and re-admits the patient on their return to hospital.
8	Died	Died in hospital
9	Usual residence/home	
10	Other rehabilitation hospital (specify)	Designated inpatient rehabilitation facility
11	Hospital in the Home	Hospital in the Home services are defined as acute health care services provided to people living in the community, in their own homes or in residential facilities such as nursing homes, hostels or other forms of supported accommodation
99	Other destination (specify)	

Reporting guide	-
Purpose	To determine the outcome status of patients
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Jul-09 Note: migrated data from Jan-5, however not used in BRANZ reporting.
Definition source	NHDD (separation mode)
Code set source	NHDD/BRANZ

12.1.0 Another BRANZ Hospital

Definition	Indicates the BRANZ hospital campus at which the patient was discharged or transferred to		
Database Name	DisHospID	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN

Code set	tlkpHosp (reference table)

Code	Description	State	Abbreviated
1	Alfred Hospital	VIC	ALF
2	Fiona Stanley Hospital	WA	FSH
3	Middlemore Hospital	NZ	MDM
4	Women's and Children's Hospital	SA	WCH
5	Royal Darwin Hospital	NT	RDH
6	Princess Margaret Hospital for Children	WA	PMH
9	Royal Hobart Hospital	TAS	RHH
10	Royal Adelaide Hospital	SA	RAH
11	Concord Hospital	NSW	CCH
12	NSW Unspecified (cases entered pre-Jul 09 only	NSW	NSW
13	Children's Hospital at Westmead	NSW	WMH
14	Lady Cilento Children's Hospital	QLD	LCC
16	Royal Children's Hospital	VIC	RCM
17	Royal North Shore Hospital	NSW	RNS
19	Royal Brisbane & Women's Hospital	QLD	RBW
21	Christchurch Hospital	NZ	CHC
22	Waikato Hospital	NZ	WKT
23	Hutt Hospital	NZ	HUT

Reporting guide	Conditional: If **Disposition**=0
Purpose	To allow the other BRANZ hospital to view data already entered for the patient.
Data Users	Data Collectors, BRANZ Staff
Collection start	Jul-09
Definition source	BRANZ
Code set source	BRANZ

12.1.8 Cause of Death

Definition	The cause of death as documented in the medical history.		
Database Name	DeathCause	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpDeathCause (reference table)		

Code	Description
-1	Not stated/inadequately described
2	Burns shock
3	Cardiac (AMI)
5	Cerebrovascular (stroke)
6	Haematological (DIC)
7	Haemorrhage (blood loss/exsanguinations)
8	Multi-system organ failure
9	Pulmonary (PE, pneumonia, ARDS)
10	Renal (Acute Renal Failure)
11	Sepsis
12	Other

Reporting guide	Conditional: If **Disposition**= Died (8)
Purpose	To ascertain the cause of death, as documented in the medical history.
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists

Collection start	Jul-09
Definition source	BRANZ
Code set source	BRANZ

12.1.8.12 Cause of Death - Other

Definition	Text description of the discharge destination if rehabilitation, hospital for convalescence or Other.		
Database Name	DisOther	**Collection**	Conditional
Data type	Alphanumeric	**Form**	Text
Field size	50	**Layout**	AAAAAAAAAAAAAA
Code set	-		
Reporting guide	Conditional: If **Disposition**= 1,4,10, 99		
Purpose	To provide further detail on the discharge destination		
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

12.2 Disposition Date/Time (or Death Date/Time)

Definition	Date and Time the patient departed from hospital (i.e. discharge time)		
Database Name	DOD	**Collection**	Mandatory
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set	-		
Reporting guide	A valid date greater than or equal to the Admission Date/Time and less than or equal to the Disposition Date/Time **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted).		
Purpose	To determine the length of stay during the episode of inpatient care		
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists		
Collection start	2005		
Definition source	NHDD (separation date, separation time)		
Code set source	-		

12.3 Treatment Decision

Definition	If the patient died, to identify if the medical decision was to withdraw or withhold medical treatment.		
Database Name	Decision	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpDecision (reference table)		

Code	Item	Description
-1	Not stated/inadequately described	Data not retrievable
-2	Not Applicable	
1	Palliative management	Burn was assessed as non-survivable, the patient was made palliative and received end of life care.
2	Initial treatment subsequently changed to palliative	Active treatment initiated but subsequently changed to palliative management as further treatment considered non-survivable
3	Active treatment until the time of death	Patient was receiving active treatment at the time of death

Reporting guide	Conditional: If **Disposition** = Died (8)
Purpose	To ascertain if the patient was able to be actively treated or their condition was irredeemable.
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Jul-09 Jul-16 Note: Code 1 is renamed to 'Palliative management' and Code 2 to' Initial treatment subsequently changed to palliative'
Definition source	BRANZ
Code set source	BRANZ

12.4 Date/Time of Treatment Decision

Definition	The documented date and time of the clinician's decision to withhold treatment or withdraw treatment		
Database Name	DecisionDt	**Collection**	Conditional
Data type	Numeric	**Form**	Date
Field size	8	**Layout**	DD/MM/CCYY HH:NN:SS
Code set	-		
Reporting guide	Conditional: If **Disposition** = Died (8) and **Decision =** Palliative Management (0) or Subsequent Palliative Management (1) A valid date greater than or equal to the Admission Date/Time and less than or equal to Discharge Date/Time. If the date is unknown, 09/09/9999 is recorded. **Midnight** Following international convention, midnight is either 23:59 of preceding date or 00:01 of following date (00:00 and 24:00 are not accepted). If the time is unknown, 00:00 is recorded.		
Purpose	To determine when active treatment ceased (if the patient died during the episode of admitted patient care and treatment was withdrawn or withheld)		
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

13.0 Weight Quality Indicators

13.1 Was the Patient's Weight Measured and Recorded within 3-5 days of Admission?

Definition	To identify if the patient's weight was measured and recorded between Day 3 and Day 5 of admission (if length of stay > 14 days)		
Database Name	WeightDay5	**Collection**	When LOS > 14 days
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpYesNoColl (reference table)		

Code	Description	
-2	Not collected at site	Patients are not routinely weighed at the facility
-1	Not stated/Inadequately described	Data not retrievable
0	No	Patient's weight was not measured and recorded between Day 3 and Day 5 of admission
1	Yes	Patient's weight was measured and recorded between Day 3 and Day 5 of admission.

Reporting guide	Conditional: Length of Stay in hospital is greater than 2 weeks The patient's weight must be a measured weight (i.e. on weigh scales), not estimated or based on a self-reported weigh. There is an assumption the patient is admitted to the BRANZ hospital very soon after the time of injury (within 24 hours). For this reason measuring weight between Day 3 and Day 5 of admission is indicated as the patients weight can significantly fluctuate by fluid resuscitation within the initial 72 hours of injury.
Purpose	The aim of this Quality Indicator is to determine what the current practice is for weighing a patient on admission. Given the implications of weight on initial management (and fluid resuscitation); estimating (vs. measuring) weight is not considered best practice.
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Jul-09
Definition source	BRANZ
Code set source	BRANZ

13.2 Did the Patient Lose Weight during the Episode of Care i.e. Discharge Weight is less than Admission Weight?

Definition	To identify if the patient losses weight loss during the episode of admitted patient care (i.e. discharge weight is less than admission weight)		
Database Name	WeightLoss	**Collection**	Conditional
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpYesNoND (reference table)		

Code	Description	
-1	Not stated/Inadequately described	Data not retrievable
0	No	Patient's discharge weight is *not* less than the admission weight (i.e. patient has gained weight during admission)
1	Yes	Patient's discharge weight is less than admission weight

Reporting guide	Conditional: If **WeightDay5**=1. The patient's weight was measured and recorded between Day 3 and Day 5 of admission AND the patient's weight was measured and recorded weekly during their episode of care.
Purpose	Weight loss is a complication following burn injury that can affect patient outcomes in terms of healing potential. Patients with an extended length of stay are more at risk of weight loss and therefore poorer outcomes. The aim of this Quality Indicator is to better understand the incidence of weight loss in the burns patient (during the acute admission) and how this can affect patient outcomes.
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Jul-09
Definition source	BRANZ
Code set source	BRANZ

13.3 Weight Loss

Definition	The measurement of weight loss (in kilograms) during the episode of admitted patient care		
Database Name	WeightLossKg	**Collection**	Conditional
Data type	Numeric	**Form**	Decimal
Field size	5	**Layout**	NNN.N
Code set	-		
Reporting guide	Conditional: If **Weight Loss** = Yes (1)		
Purpose	Weight loss is a complication following burn injury that can affect patient outcomes in terms of healing potential. The aim of this Quality Indicator is to better understand the measurement of weight loss in the burns patient (during the acute admission) and how this can affect patient outcomes		
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

13.4 Was the Patient's Weight Measured and Recorded Weekly during their Episode of Care?

Definition	To identify if the patient's weight was measured and recorded weekly during the episode of inpatient care (if length of stay > 14 days)		
Database Name	WeightWeekly	**Collection**	When LOS > 14 days
Data type	Numeric	**Form**	Code
Field size	2	**Layout**	NN
Code set	tlkpYesNoColl (reference table)		

Code	Description	
-2	Not collected at site	Patients are not routinely weighed at the facility
-1	Not stated/Inadequately described	Data not retrievable
0	No	
1	Yes	The patient's weight was measured and recorded weekly during the episode of inpatient care

Reporting guide	Conditional: Length of Stay in hospital is greater than 14 days

	The patient's weight must be a measured weight (i.e. on weigh scales), not estimated or based on a self-reported weigh.
Purpose	It is considered best practice to weigh the patient weekly during the acute burn admission. This data item will provide information on whether this practice is occurring or not.
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Jul-09
Definition source	BRANZ
Code set source	BRANZ

14.0 Comments

14.1 Any Further Comments about Episode of Care

Definition	Any further comments about the episode of admitted patient care		
Database Name	Comments	**Collection**	Optional
Data type	Alphanumeric	**Form**	Text
Field size	500	**Layout**	AAAAAAAAAAAAAA
Code set	-		
Reporting guide	Coder to enter any additional information they weren't able to enter elsewhere. For example, if the patient had more than one readmission to ICU.		
Purpose	To provide further detail on the inpatient stay		
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	BRANZ		
Code set source	-		

15.0 ICD-10 Diagnosis

Content	ICD10-AM diagnosis codes and prefixes
Collected by	Participating Australian and New Zealand burns units
Collected for	All admissions
Data source	Hospital Medical Record
Database Location	tblICDDiag Table
Reporting Guide	The International Classification of Diseases, 10th Revision, Australian Modification is based on the official version of the World Health Organisation's 10th Revision. ICD-10 is designed for classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations, for data storage and retrieval. When the patient is discharged from hospital, Health Information Services assign ICD 10 codes to the episode of care. Information about a patient's diagnosis, recorded in their notes by the clinician treating them, is translated into ICD-10 codes by a clinical coder. This means it is possible to select and compare conditions consistently, not only in HES but also across the world wherever ICD-10 is used. ICD-10 codes consist of a single letter followed by three or more digits, with a decimal point between the second and third. As there are many thousands of variations at the 4-character level (where all three digits are used) it is common practice to summarise at the 3-character level.

15.1 Have ICD10 Diagnoses been Coded for this Admission?

Definition	The ICD10-AM diagnosis is the decision reached, after assessment, of the nature and identity of the disease, morbid condition or injuries of a patient.		
Database Name	ICDDiag	**Collection**	Mandatory
Data type	Alphanumeric	**Form**	Code
Field size	5	**Layout**	ANNNN
Code set	tlkpICDDiag (reference table – See ICD10-AM Manual)		
Reporting guide	The ICD-10 codes are submitted to the registry on a quarterly basis. Sites have the option to manually enter the codes into the registry or submit a data extraction of codes (from their hospital Health Information Service) to be electronically uploaded to the registry. Each episode of admitted patient care has a principal diagnosis and may have additional diagnoses. The primary diagnosis is the reason for clinical visit and is determined in accordance with the Australian Coding Standards. The diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status.		
Purpose	Diagnostic		
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists		
Collection start	Jul-09		
Definition source	AIHW, WHO		
Code set source	ICD-10, WHO (1992)		

16.0 ICD-10 Procedures

Content	ICD10-AM procedure codes
Collected by	Participating Australian and New Zealand burns units
Collected for	All episodes of acute care
Data source	Hospital Medical Record
Database Location	icdProc Table
Reporting Guide	The International Classification of Diseases, 10th Revision, Australian Modification is based on the official version of the World Health Organisation's 10th Revision. All procedures undertaken during the episode of care are coded. Procedures are derived from and must be substantiated by clinical documentation. .A procedure code is a clinical intervention represented by a code that: • is surgical in nature, and/or • carries a procedural risk, and/or • carries an anaesthetic risk, and/or • requires specialised training, and/or • requires special facilities or equipment only available in an acute care setting.

16.1 Have ICD10 Procedures been Coded for this Admission?

Definition	The ICD10-AM procedures performed on the patient.		
Database Name	ICDProc	**Collection**	Mandatory
Data type	Numeric	**Form**	Code
Field size	7	**Layout**	NNNNNNN
Code set	tlkpICDProc (reference table – See ICD10-AM Manual)		

Reporting guide	The ICD-10 codes are submitted to the registry on a quarterly basis. Sites have the option to manually enter the codes into the registry or submit a data extraction of codes (from their hospital Health Information Service) to be electronically uploaded to the registry.
Purpose	To monitor and compare outcomes of patients with particular procedures
Data Users	Data Collectors, BRANZ Staff, Reporting, Epidemiologists
Collection start	Jul-09
Definition source	AIHW, WHO
Code set source	ICD-10, WHO (1992)

17.0 Additional calculation queries

Age at time of burn

TimeToAdmission_Hours

TimeToGraft_Hoursgraft

Appendix 1. Nutritional Screening Tools

Poor nutrition status in burn patients has negative impacts on wound healing, metabolism and best patient outcomes. It is essential to identify patients at nutrition risk so that timely and appropriate nutrition intervention and treatment plans may be implemented and nutrition deterioration prevented to improve health outcomes. Identification of patients at risk of malnutrition can be identified using one of the validated nutrition risk screening tools.

One of the BRANZ Quality Indicators looks at the timeliness of nutrition screening (<24 hours of admission). Select YES if the patients nutrition risk was assessed using one of the following validated nutrition screening tools:

	Adult	**Paediatric**
1	Malnutrition Screening Tool (MST)	Subjective Global Nutrition Assessment (SGNA)
2	Mini Nutritional Assessment – Short Form (MNA-SF)	Paediatric Nutrition Screening Tool (PNST)
3	Malnutrition Universal Screening Tool (MUST)	Paediatric Nutrition Risk Score
4	Nutrition Risk Screening (NRS-2002)	Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP)
5	Subjective Global Assessment (SGA)	Paediatric Yorkhill Malnutrition Score (PYMS)
6	Patent Generated Subjective Global Assessment (PG-SGA)	Screening Tool Risk on Nutritional status and Growth (STRONGkids)
7	Mini-Nutritional Assessment (MNA)	

Appendix 2. Validated Pain Assessment Tools

Effective identification, assessment and management of burn pain are critical to reduce suffering, prevent functional decline and improve the quality of life. Pain assessment should be conducted as early as possible in the patient's admission. Self-report is the most reliable source of information on pain.

Validated Multidimensional Pain Assessment Tools include:

1. Short-form McGill questionnaire
2. Brief pain inventory – short form
3. Brief pain inventory – long form
4. Pain disability index.

Validated Unidimensional Pain Assessment Tools are used for ongoing evaluation of pain intensity and response to treatment. They evaluate only the sensory component of pain. Examples include:

1. Numeric Rating Scale (NRS)
2. Verbal Descriptor Scale (VDS)
3. Pain thermometer
4. Visual Analogue Scale (VAS)
5. A pictorial pain scale (FACES pain scale).