

Project Details	
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Name	hoaap_dictionary
Organisation(s)	

Versioning	
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Version	v0.1 (DRAFT)
Version Notes	359215 cohort size, 2017-2025

Cohort	
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Inclusion Criteria	* all patients admitted between 01/01/2017 and 31/07/2025 * over 18 at the time of admission
Exclusion Criteria	* under 18 at the time of admission

Metadata	
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Template Version	v1.0
Tables	24
Columns	124
Issues	None

Table	Description	CHECKS
HOAAP_BASE	Base cohort table following inclusion and exclusion criteria	OK
HOAAP_ED	ED encounters for the cohort	OK
HOAAP_DEMOGRAPHICS	Demographics	OK
HOAAP_DEMOGRAPHICS_DECODE	Demographics Decode table	OK
HOAAP_COMORBIDITIES	ICD-10 comorbidities	OK
HOAAP_COMORBIDITIES_DECODE	ICD-10 code descriptions	OK
HOAAP_AUDIT_C_SUMMARY	AUDIT-C scores	OK
HOAAP_AUDIT_C_DETAIL	AUDIT-C scores for individual questions	OK
HOAAP_AUDIT_C_DECODE	HOAAP_AUDIT_C_DETAIL Decode	OK
HOAAP_ALCWEEK	Weekly Alcohol Consumption	OK
HOAAP_SMOKING_STATUS	Admission level smoking status	OK
HOAAP_LAB_RESULTS	Lab results	OK
HOAAP_LAB_RESULTS_DECODE	HOAAP_LAB_RESULTS Decode	OK
HOAAP_VITALS	Metavision measurements + NEWS2 score	OK
HOAAP_WARD_MOVEMENTS	Patient ward movements	OK
HOAAP_ITU_DAYS	Days spent in ITU	OK
HOAAP_CSRS	eQuest referrals (clinical support requests)	OK
HOAAP_DAMA	Discharge against medical advice	OK
HOAAP_DAMA_DECODE	HOAAP_DAMA decode	OK
HOAAP_DRUGS_LIST	List of required JAC prescriptions	OK
HOAAP_DRUGS	Inpatient prescriptions following drugs from HOAAP_DRUGS_LIST	OK
HOAAP_READMISSIONS	Readmissions	OK
HOAAP_MORTALITY	1-year mortality	OK
HOAAP_SEEN_BY_ACT	Seen by Alcohol Care Team? Manually imported from excel sheets	OK

Table	Column	Order	Data Type	Length	Vocabularies	Enumerations	Primary Key	Foreign Key Target	Column Description	CHECKS
HOAAP_BASE	PATIENT_ID		1 Integer					1	Unique pseudonymised patient identifier for the cohort.	OK
HOAAP_BASE	SPELL_ID		2 Integer					2	Unique hospital spell identifier for the admission episode.	OK
HOAAP_BASE	ADMISSION_DATE		3 Timestamp						Date and time of admission for the hospital spell.	OK
HOAAP_BASE	DISCHARGE_DATE		4 Timestamp						Date and time of discharge for the hospital spell.	OK
HOAAP_BASE	LOS		5 Float						Length of Stay	OK
HOAAP_BASE	AGE_AT_ADMISSION		6 Integer						Patient age at the time of admission.	OK
HOAAP_ED	PATIENT_ID		1 Integer					1	Unique pseudonymised patient identifier for the ED encounter.	OK
HOAAP_ED	SPELL_ID		2 Integer					2	Hospital spell identifier linked to the ED encounter.	OK
HOAAP_ED	DATE_OF_ARRIVAL		3 Timestamp						Date and time the patient arrived in the ED department.	OK
HOAAP_ED	LEFT_DEPARTMENT_DATETIME		4 Timestamp						This is the time the patient actually Left the ED department - this measure includes the time patients spent in CDU and PSSU. AKA clock stop time. The Clock stop Timestamp (Also called ADT Timestamp) is a calculation that uses when the patient is discharged, transferred, or admitted. In this case a clock is stopped when a patient enters CDU or PSSU. SDEC is considered a location outside of ED so is an admission. (Further details below)	OK
HOAAP_ED	DEPARTURE_DATETIME		5 Timestamp						SDEC Inclusion (NHS Definition): Any patients that undergo further assessment/treatment in the A&E but are then transferred to SDEC (where it is appropriate to do so) should be counted as an A&E attendance with the clock stop being defined as the point at which the patient leaves the A&E department and ceases to be under the care of the A&E consultant. In cases where SDEC is located within the A&E and the patient does not leave the department, it is when the responsibility of care is passed from the A&E consultant to the SDEC consultant.	OK
HOAAP_ED	ED_IN_SPELL_LINKAGE_FLAG		6 Integer						Indicates how we linked ED admission to hospital admission. Flag '0' indicates LEFT_DEPARTMENT_DATETIME = DEPARTURE_DATETIME. Flag '1' indicates patient admitted up to 4 hours after LEFT_DEPARTMENT_DATETIME. Flag '2' indicates patient admitted up to 4 hours after DEPARTURE_DATETIME.	OK
HOAAP_DEMOGRAPHICS	PATIENT_ID		1 Integer					1	Unique pseudonymised patient identifier for demographics.	OK
HOAAP_DEMOGRAPHICS	SEEN_BY_ACT		2 Integer						Patient seen by alcohol care team?	OK
HOAAP_DEMOGRAPHICS	SEX		3 Text	1					Patient sex code.	OK
HOAAP_DEMOGRAPHICS	ETHNICITY		4 Text	1					Patient ethnicity code; decode using HOAAP_DEMOGRAPHICS_DECODE where DOMAIN	OK
HOAAP_DEMOGRAPHICS	POSTCODE		5 Text	7					Patient postcode recorded for geographical linkage.	OK
HOAAP_DEMOGRAPHICS	LSOA_CODE		6 Text	9					Lower Layer Super Output Area code derived from postcode.	OK
HOAAP_DEMOGRAPHICS	LA_DISTRICT_CODE		7 Text	9					Local authority district code derived from postcode.	OK
HOAAP_DEMOGRAPHICS	IMD_DECILE		8 Integer						Index of Multiple Deprivation decile for the patient area.	OK
HOAAP_DEMOGRAPHICS_DECODE	DOMAIN		1 Text	12				1	Decode domain identifying the type of demographic code.	OK
HOAAP_DEMOGRAPHICS_DECODE	CODE		2 Text	9				2	Demographic code value within the decode domain.	OK
HOAAP_DEMOGRAPHICS_DECODE	DESCRIPTION		3 Text	35					Description for the demographic code.	OK
HOAAP_COMORBIDITIES	PATIENT_ID		1 Integer					1	Unique pseudonymised patient identifier for the comorbidity record.	OK
HOAAP_COMORBIDITIES	SPELL_ID		2 Integer					2	Hospital spell identifier for the comorbidity record.	OK
HOAAP_COMORBIDITIES	DIAGNOSIS_CODE		3 Text	5				3	ICD-10 diagnosis code recorded for the spell.	OK
HOAAP_COMORBIDITIES	CODING_METHOD		4 Integer						Coding method used for the diagnosis code.	OK
HOAAP_COMORBIDITIES	PRIMARY_DIAG		5 Integer					4	Is primary diagnosis?	OK
HOAAP_COMORBIDITIES_DECODE	DIAGNOSIS_CODE		1 Text	5				1	ICD-10 diagnosis code.	OK
HOAAP_COMORBIDITIES_DECODE	CODING_METHOD		2 Integer					2	Coding method associated with the diagnosis code.	OK
HOAAP_COMORBIDITIES_DECODE	DIAGNOSIS_DESCRIPTION		3 Text	60					Text description for the ICD-10 diagnosis code.	OK
HOAAP_AUDIT_C_SUMMARY	PATIENT_ID		1 Integer					1	Unique pseudonymised patient identifier for the AUDIT-C summary.	OK
HOAAP_AUDIT_C_SUMMARY	SPELL_ID		2 Integer					2	Hospital spell identifier linked to the AUDIT-C summary.	OK
HOAAP_AUDIT_C_SUMMARY	ID_HASH		3 Text	64				3	Unique hashed identifier for the AUDIT-C assessment; links to	OK
HOAAP_AUDIT_C_SUMMARY	DATE_ENTERED		4 Timestamp						Date and time the AUDIT-C assessment was entered.	OK
HOAAP_AUDIT_C_SUMMARY	ASSESSMENT_DATE		5 Timestamp						Date and time the AUDIT-C assessment was completed.	OK
HOAAP_AUDIT_C_SUMMARY	AUDIT_C_SCORE		6 Integer						Total AUDIT-C score for the assessment.	OK
HOAAP_AUDIT_C_SUMMARY	SCREENING_DONE		7 Integer						Code indicating whether or how AUDIT-C screening was completed.	OK

						Indicates how SPELL_ID was derived from admission_date and discharge_date recorded in the excel sheet. Flag '0' indicates ADMISSION_DATE and DISCHARGE_DATE match exactly with EPR database. Flag '1' indicates ADMISSION_DATE matches the ADMISSION_DATE in EPR database within one day.	
HOAAP_AUDIT_C_SUMMARY	MATCH_FLAG	8					OK
HOAAP_AUDIT_C_DETAIL	ID_HASH	1	64		1	Can be joined with HOAAP_AUDIT_C_SUMMARY.ID_HASH	OK
HOAAP_AUDIT_C_DETAIL	QUES_ID	2			2	Join with HOAAP_AUDIT_C_DECODE.QuestionCode to get description	OK
HOAAP_AUDIT_C_DETAIL	ANS_ID	3				Join with HOAAP_AUDIT_C_DECODE.AnswerCode to get the answer description	OK
HOAAP_AUDIT_C_DECODE	QUESTIONCODE	1			1	Can be joined with HOAAP_AUDIT_C_DETAIL.QUESTION_ID	OK
HOAAP_AUDIT_C_DECODE	QUESTION	2	110			AUDIT-C question text.	OK
HOAAP_AUDIT_C_DECODE	ANSWERCODE	3			2	Can be joined with HOAAP_AUDIT_C_DETAIL.ANS_ID	OK
HOAAP_AUDIT_C_DECODE	ANSWER	4	21			AUDIT-C answer text.	OK
HOAAP_AUDIT_C_DECODE	SCORE	5				Score assigned to the AUDIT-C answer.	OK
HOAAP_ALCWEEK	PATIENT_ID	1			1	Unique pseudonymised patient identifier for weekly alcohol consumption.	OK
HOAAP_ALCWEEK	SPELL_ID	2			2	Hospital spell identifier linked to the weekly alcohol consumption record.	OK
HOAAP_ALCWEEK	UNIQUE_ID_HASH	3	64		3	Unique hashed identifier for the weekly alcohol consumption result.	OK
HOAAP_ALCWEEK	RESULT_NUMERIC	4				Numeric weekly alcohol consumption result.	OK
HOAAP_SMOKING_STATUS	PATIENT_ID	1			1	Unique pseudonymised patient identifier for smoking status.	OK
HOAAP_SMOKING_STATUS	SPELL_ID	2			2	Hospital spell identifier linked to the smoking status record.	OK
HOAAP_SMOKING_STATUS	UNIQUE_ID_HASH	3	64		3	Unique hashed identifier for the smoking status record.	OK
HOAAP_SMOKING_STATUS	MEASURE_DATE	4				Date and time the smoking status was measured or recorded.	OK
HOAAP_SMOKING_STATUS	SCREENING_DONE	5				Code indicating whether or how smoking screening was completed.	OK
HOAAP_SMOKING_STATUS	SCREENINGDESCRIPTION	6	29			Description of the smoking screening completion status.	OK
HOAAP_SMOKING_STATUS	STATUSCODE	7				Smoking status code.	OK
HOAAP_SMOKING_STATUS	STATUSDESCRIPTION	8	36			Text description of the smoking status.	OK
HOAAP_LAB_RESULTS	PATIENT_ID	1			1	Unique pseudonymised patient identifier for the lab result.	OK
HOAAP_LAB_RESULTS	SPELL_ID	2			2	Hospital spell identifier linked to the lab result.	OK
HOAAP_LAB_RESULTS	SPECIMEN_ID	3			3	Specimen identifier for the laboratory sample.	OK
HOAAP_LAB_RESULTS	SYSTEM_ID	4	1			Laboratory system identifier; joins to HOAAP_LAB_RESULTS_DECODE.SYSTEM_ID.	OK
HOAAP_LAB_RESULTS	REQUEST_TYPE	5	2			Laboratory request type; joins to HOAAP_LAB_RESULTS_DECODE.REQUEST_TYPE.	OK
HOAAP_LAB_RESULTS	TEST_CODE	6	4			Laboratory test code; joins to HOAAP_LAB_RESULTS_DECODE.TEST_CODE.	OK
HOAAP_LAB_RESULTS	SAMPLE_DATE	7				Date and time the laboratory sample was taken.	OK
HOAAP_LAB_RESULTS	REPORT_DATE	8				Date and time the laboratory result was reported.	OK
HOAAP_LAB_RESULTS	RESULT_PROCESSED	9				Processed numeric laboratory result value.	OK
HOAAP_LAB_RESULTS_DECODE	SYSTEM_ID	1	1		1	Laboratory system identifier used in the lab results decode table.	OK
HOAAP_LAB_RESULTS_DECODE	REQUEST_TYPE	2	2		2	Laboratory request type used in the lab results decode table.	OK
HOAAP_LAB_RESULTS_DECODE	TEST_CODE	3	4		3	Laboratory test code used in the lab results decode table.	OK
HOAAP_LAB_RESULTS_DECODE	TEST_NAME	4	28			Name of the laboratory test.	OK
HOAAP_LAB_RESULTS_DECODE	RANGE_LOW	5				Lower reference range for the laboratory test.	OK
HOAAP_LAB_RESULTS_DECODE	RANGE_HIGH	6				Upper reference range for the laboratory test.	OK
HOAAP_LAB_RESULTS_DECODE	UNITS	7	13			Units for the laboratory result.	OK
HOAAP_LAB_RESULTS_DECODE	UCUM_UNIT_CODE	8	21			UCUM unit code for the laboratory result unit.	OK
HOAAP_LAB_RESULTS_DECODE	LOINC_CODE	9	7			LOINC code for the laboratory test.	OK
HOAAP_VITALS	PATIENT_ID	1			1	Unique pseudonymised patient identifier for the vital sign or Metavision measurement.	OK
HOAAP_VITALS	SPELL_ID	2			2	Hospital spell identifier linked to the vital sign or Metavision measurement.	OK
HOAAP_VITALS	PARAMETER_ID	3			3	Identifier for the vital sign or Metavision measurement parameter.	OK
HOAAP_VITALS	PARAMETER_NAME	4	38			Name of the vital sign or Metavision measurement parameter.	OK
HOAAP_VITALS	VALUE	5				Recorded numeric value for the vital sign or Metavision measurement.	OK
HOAAP_WARD_MOVEMENTS	PATIENT_ID	1			1	Unique pseudonymised patient identifier for ward movements.	OK
HOAAP_WARD_MOVEMENTS	SPELL_ID	2			2	Hospital spell identifier linked to the ward movement record.	OK
HOAAP_WARD_MOVEMENTS	WARD_SEQUENCE	3			3	Sequence number for the ward episode within the spell.	OK
HOAAP_WARD_MOVEMENTS	WARD_CODE	4	10			Ward code for the ward episode.	OK
HOAAP_WARD_MOVEMENTS	WARD_BAY	5	10			Ward bay recorded for the ward episode.	OK
HOAAP_WARD_MOVEMENTS	IWE_START_DATE	6				Ward episode start date	OK
HOAAP_WARD_MOVEMENTS	IWE_END_DATE	7				Ward episode end date	OK
HOAAP_WARD_MOVEMENTS	BED_SEQUENCE	8			4	Sequence number for the bed episode within the ward movement record.	OK
HOAAP_WARD_MOVEMENTS	BED_CODE	9				Bed code recorded for the bed episode.	OK
HOAAP_WARD_MOVEMENTS	IBE_START_DATE	10				Bed episode start date	OK

HOAAP_WARD_MOVEMENTS	IBE_END_DATE	11	Timestamp		Bed episode end date	OK	
HOAAP_WARD_MOVEMENTS	IWP_CAREINTENS	12	Integer		Intended clinical care intensity	OK	
HOAAP_WARD_MOVEMENTS	HDU_OR_ICU	13	Text	1	Stay in HDU/ICU?	OK	
HOAAP_ITU_DAYS	PATIENT_ID	1	Integer		1	Unique pseudonymised patient identifier for ITU days.	OK
HOAAP_ITU_DAYS	SPELL_ID	2	Integer		2	Hospital spell identifier linked to ITU days.	OK
HOAAP_ITU_DAYS	DAYS_IN_ITU	3	Float			Number of days spent in ITU during the spell.	OK
HOAAP_CSRS	PATIENT_ID	1	Integer		1	Unique pseudonymised patient identifier for the clinical support request.	OK
HOAAP_CSRS	SPELL_ID	2	Integer		2	Hospital spell identifier linked to the clinical support request.	OK
HOAAP_CSRS	REQUEST_HASH	3	Text	64	3	Unique hashed identifier for the clinical support request.	OK
HOAAP_CSRS	REQUEST_DATE	4	Timestamp			Date and time the clinical support request was made.	OK
HOAAP_CSRS	LOCATION_WARD	5	Text	6		Ward or location associated with the clinical support request.	OK
HOAAP_CSRS	STATUS	6	Text	1		Status code for the clinical support request.	OK
HOAAP_CSRS	CREATION_DATE	7	Timestamp			Date and time the clinical support request record was created.	OK
HOAAP_CSRS	PATIENT_CATEGORY	8	Integer			Patient category code for the clinical support request.	OK
HOAAP_CSRS	REQUEST_TYPE	9	Text	2		Request type code for the clinical support request.	OK
HOAAP_CSRS	REQUEST_CODE	10	Text	3	4	Request code for the clinical support request.	OK
HOAAP_CSRS	DISPLAY_NAME	11	Text	38		Display name for the clinical support request.	OK
HOAAP_DAMA	PATIENT_ID	1	Integer		1	Unique pseudonymised patient identifier for discharge against medical advice.	OK
HOAAP_DAMA	SPELL_ID	2	Integer		2	Hospital spell identifier linked to discharge against medical advice.	OK
HOAAP_DAMA	IPE_DISCHARGEMETHD	3	Integer			Can be decoded with HOAAP_DAMA_DECODE.IPE_DISCHARGEMETHD	OK
HOAAP_DAMA_DECODE	IPE_DISCHARGEMETHD	1	Integer		1	Discharge method code used to decode discharge against medical advice.	OK
HOAAP_DAMA_DECODE	NAME	2	Text	40		Description/name of the discharge method.	OK
HOAAP_DAMA_DECODE	STATUS	3	Text	1		Status code for the discharge method decode record.	OK
HOAAP_DRUGS_LIST	DRUGID	1	Text	6	1	Drug identifier for a required JAC prescription.	OK
HOAAP_DRUGS_LIST	DRUGNAME	2	Text	60		Drug name for a required JAC prescription.	OK
HOAAP_DRUGS_LIST	DRUGFORMDESCRIPTION	3	Text	26		Description of the drug form.	OK
HOAAP_DRUGS_LIST	DMDID	4	Integer			Dictionary of Medicines and Devices identifier for the drug.	OK
HOAAP_DRUGS_LIST	DMDNAME	5	Text	127		Dictionary of Medicines and Devices name for the drug.	OK
HOAAP_DRUGS_LIST	FINANCIALCODE	6	Text	11		Financial code associated with the drug.	OK
HOAAP_DRUGS	PATIENT_ID	1	Integer		1	Unique pseudonymised patient identifier for the inpatient prescription.	OK
HOAAP_DRUGS	SPELL_ID	2	Integer		2	Hospital spell identifier linked to the inpatient prescription.	OK
HOAAP_DRUGS	HASH_KEY	3	Text	64	3	SDE specific key	OK
HOAAP_DRUGS	LNKORDID	4	Integer			Linked order identifier for the inpatient prescription.	OK
HOAAP_DRUGS	LNKINTSPL	5	Integer			Linked internal spell/order identifier for the inpatient prescription.	OK
HOAAP_DRUGS	PRESCRIBING_DRUG_ID	6	Text	6		Prescribing drug identifier; can be linked to HOAAP_DRUGS_LIST.DRUGID.	OK
HOAAP_DRUGS	ORDER_TYPE	7	Text	9		Prescription order type.	OK
HOAAP_DRUGS	ROUTE	8	Text	35		Route of administration for the prescription.	OK
HOAAP_DRUGS	START_DATE	9	Date			Prescription start date.	OK
HOAAP_DRUGS	STOP_DATE	10	Date			Prescription stop date.	OK
HOAAP_DRUGS	ADMIN_DATE	11	Date			Prescription administration date.	OK
HOAAP_DRUGS	CHARTED_DATE	12	Date			Date the prescription was charted.	OK
HOAAP_READMISSIONS	PATIENT_ID	1	Integer		1	Unique pseudonymised patient identifier for the readmission record.	OK
HOAAP_READMISSIONS	SPELL_ID	2	Integer		2	Hospital spell identifier for the readmission record.	OK
HOAAP_READMISSIONS	ADMISSION_DATE	3	Timestamp			Date and time of the readmission.	OK
HOAAP_READMISSIONS	DISCHARGE_DATE	4	Timestamp			Date and time of discharge from the readmission.	OK
HOAAP_READMISSIONS	DAYS_TO_READMISSION	5	Float			Number of days between discharge and readmission.	OK
HOAAP_MORTALITY	PATIENT_ID	1	Integer		1	Unique pseudonymised patient identifier for mortality follow-up.	OK
HOAAP_MORTALITY	SPELL_ID	2	Integer		2	Hospital spell identifier linked to mortality follow-up.	OK
HOAAP_MORTALITY	DISCHARGE_DATE	3	Timestamp			Date and time of discharge used as the start point for mortality follow-up.	OK
HOAAP_MORTALITY	X_DAY_MORTALITY	4	Integer			Integer days to death (up to 1 year), allowing filters such as <=30 for 30-day mortality.	OK
HOAAP_SEEN_BY_ACT	PATIENT_ID	1	Integer		1	Unique pseudonymised patient identifier for Alcohol Care Team data.	OK
HOAAP_SEEN_BY_ACT	SPELL_ID	2	Integer		2	Hospital spell identifier linked to Alcohol Care Team data.	OK
HOAAP_SEEN_BY_ACT	HASH_KEY	3	Text	64	3	Unique hashed identifier for the Alcohol Care Team record.	OK
HOAAP_SEEN_BY_ACT	MATCH_FLAG	4	Integer			Flag indicating how the Alcohol Care Team record was matched to the hospital spell.	OK
HOAAP_SEEN_BY_ACT	ADMISSION_DATE	5	Date			Admission date recorded for the Alcohol Care Team episode.	OK
HOAAP_SEEN_BY_ACT	DISCHARGE_DATE	6	Date			Discharge date recorded for the Alcohol Care Team episode.	OK
HOAAP_SEEN_BY_ACT	NUMBER_OF_EPISODES	7	Integer			Number of hospital episodes recorded for the Alcohol Care Team spell.	OK
HOAAP_SEEN_BY_ACT	NO_OF_BED_DAYS	8	Integer			Number of bed days recorded for the Alcohol Care Team spell.	OK

HOAAP_SEEN_BY_ACT	REFERRAL_SOURCE	9 Text	23	Referral source to the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	PRESENTING_COMPLAINT	10 Text	73	Presenting complaint recorded for the Alcohol Care Team episode.	OK
HOAAP_SEEN_BY_ACT	PRIMARY_DIAGNOSIS_ON_HMR	11 Text	117	Primary diagnosis recorded on HMR for the Alcohol Care Team episode.	OK
HOAAP_SEEN_BY_ACT	SPECIALITY	12 Text	19	Clinical speciality associated with the Alcohol Care Team episode.	OK
HOAAP_SEEN_BY_ACT	ASSESSMENT_DATE	13 Date		Date of Alcohol Care Team assessment.	OK
HOAAP_SEEN_BY_ACT	DAILY_UNIT_CONSUMPTION	14 Float		Daily alcohol unit consumption recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	WEEKLY_UNIT_CONSUMPTION	15 Float		Weekly alcohol unit consumption recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	AUDIT_C_SCORE	16 Integer		AUDIT-C score recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	DRINKING_LEVEL_RISK	17 Text	23	Drinking risk level recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	NUMBER_OF_DRINKING_DAYS	18 Integer		Number of drinking days recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	HIGH_IMPACT_USER	19 Text	3	High impact user status recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	DETOX_STARTED	20 Text	12	Whether detox was started during the Alcohol Care Team episode.	OK
HOAAP_SEEN_BY_ACT	DETOX_OUTCOME	21 Text	31	Outcome of detox recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	PABRINEX_RECOMMENDATIONS	22 Text	42	Pabrinex recommendations recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	PARENT_CARER	23 Text	3	Parent or carer status recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	ADDITIONAL_LIAISON_1	24 Text	14	First additional liaison category recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	ADDITIONAL_LIAISON_2	25 Text	13	Second additional liaison category recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	ADDITIONAL_VULNERABILITY	26 Text	22	Additional vulnerability recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	ADDITIONAL_VULNERABILITY_2	27 Text	22	Second additional vulnerability recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	CO_MORBIDITIES	28 Text	13	First comorbidity category recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	CO_MORBIDITIES_2	29 Text	13	Second comorbidity category recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	CO_MORBIDITIES_3	30 Text	13	Third comorbidity category recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	ANY_OTHER_DRUGS	31 Text	30	First other drug use entry recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	ANY_OTHER_DRUGS_2	32 Text	30	Second other drug use entry recorded by the Alcohol Care Team.	OK
HOAAP_SEEN_BY_ACT	ANY_OTHER_DRUGS_3	33 Text	30	Third other drug use entry recorded by the Alcohol Care Team.	OK

Table	Column	Code	Name	Description	CHECKS