Government of **Western Australia**
Department of **Health**

Emergency Department and Emergency Services Patient Level Data Collection and Reporting Manual

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Contents

Acronyms

ATS	Australasian Triage Scale
DVA	Department of Veteran Affairs
ED	Emergency Department
EDDC	Emergency Department Data Collection
EDIS	Emergency Department Information System
GP	General Practictioner
ISPD	Information and System Performance Directorate
WA	Western Australia
webPAS	Web-based Patient Administration System

1 Introduction

The *Emergency Department and Emergency Services Patient Level Data Collection and Reporting Manual* is a related document to the *Emergency Department Data Collection and Reporting Policy* in the *Information Management Policy Framework*.

The information in this manual facilitates Health Services Providers compliance with the requirements of the Policy.

2 Purpose

The purpose of this manual is to describe the data collection and reporting rules for services provided to patients in designated hospital Emergency Departments (ED) and Emergency Services in smaller hospitals, to meet the requirements for:

- Local reporting by the Western Australian Department of Health
- National reporting to the Australian Government Department of Health and the Australian Institute of Health and Welfare pursuant to the National Agreements
- Classification of activity to inform activity based funding
- System performance management, health service planning, clinical governance, clinical research and other functions of the Department of State, the System Manager and Health Service Providers.

3 Background

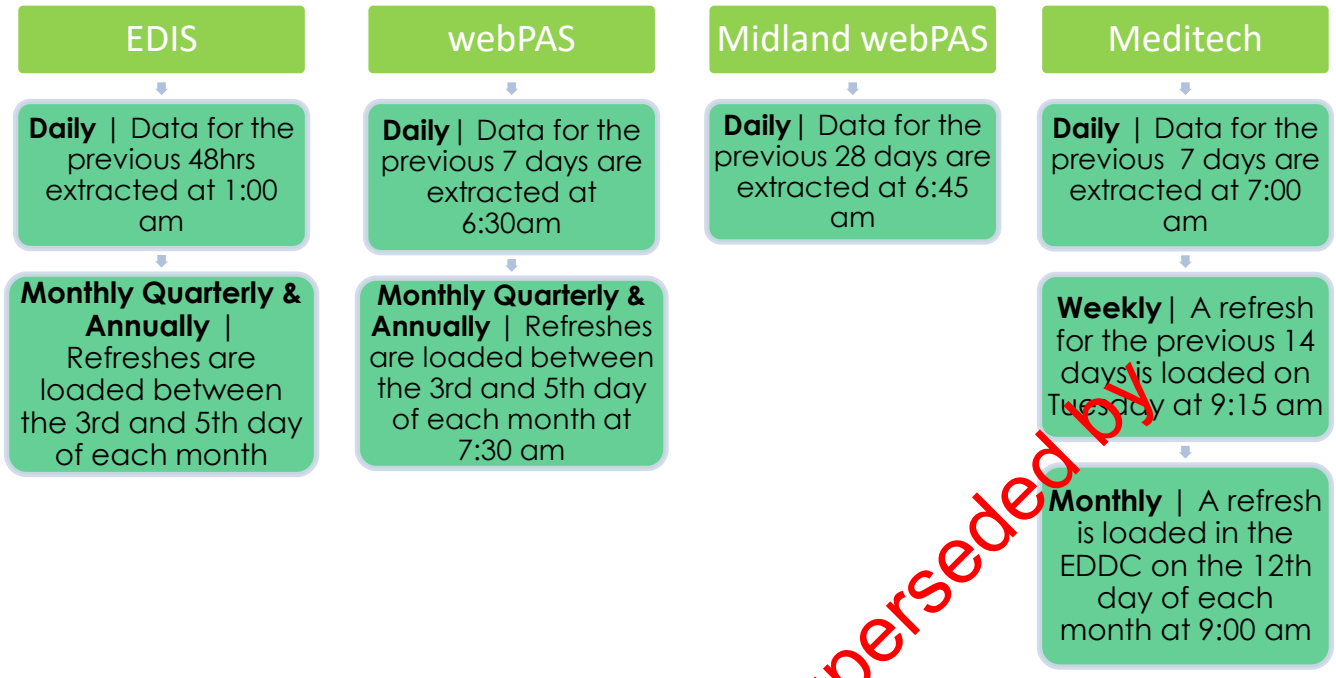
Data relating to activity in EDs has been collected in a centralised statewide collection, the Emergency Department Data Collection (EDDC) since 2002-2003. Incomplete data is available from 2000-01.

4 Responsibility for data collection and provision

4.1 Data Collection in the Health Services

Health Service Providers are responsible for ensuring that reporting timeframes are met, and for providing high quality ED activity information via their ED data collection systems (EDIS, webPAS, Meditech and Midland webPAS), to enable data to be extracted to the EDDC.

4.2 Data Capture by Information and System Performance Directorate



4.3 Changes to Data Collected

Systems Application Managers and Health Service Providers are responsible for ensuring that early notification is provided to Information and System Performance Directorate (ISPD) of any changes required to be made to data elements and/or value domains in the collection of ED data, e.g. adding a new value to a value domain. Common data elements must be defined and used consistently by stakeholders. Additional data elements should not be implemented until agreement has been reached between Systems Application Managers, Health Service Providers and ISPD.

5 Scope of patient-level reporting required for services provided in Emergency Departments/Services

The scope of patient-level reporting for emergency activity is limited to services provided to emergency patients at hospitals. These services may be provided through designated EDs or through emergency services at smaller hospitals.

Data relating to activity in emergency departments/services are collected in the EDDC for all patients attending, even if they are subsequently admitted.

A patient who has been admitted and returns from a ward or Hospital in the Home (HITH) to the ED for a procedure (e.g. to have intravenous cannula re-sited) is within scope, and this activity is to be captured in the ED electronic system.

6 Data Reporting Requirements

Appendix 1 lists the mandatory data items collected for ED patients for the EDDC. The data items include all those required to meet State reporting needs and required by the Commonwealth for the Non-Admitted Patient Emergency Care Department National Minimum Data Set (NAPEDC NMDS) reporting.

All patients who attend an ED are to have the relevant data entered as timely as possible.

7 Definitions

This section presents information about concepts related to EDs.

7.1 Emergency Department / Services

An ED is a set area in a hospital that provides triage, assessment, care and/or treatment for patients suffering from medical condition/s and/or injury. Emergency Services are also provided in smaller hospitals; however, this activity is not necessarily within a defined ED.

7.2 Non-admitted Patient

A non-admitted patient is a patient who receives care at a hospital or health service but has not undergone the hospital's formal admission process. There are several categories of non-admitted patients, one of which is an emergency patient.

7.3 Emergency Patient

Patients who require unplanned services, including those who have contacted a general practitioner and have been directed to the hospital by them, are emergency patients. This type of care is unplanned in that the illness or injury was sudden and the services unplanned.

A service does not have to be provided in person for remotely located patients. A telephone service conducted as a substitute for face-to-face contact with the patient or the use of a Telehealth service may be counted as an occasion of service. The location of the provider and patient is not relevant. For this activity to be included in reporting, the usual criteria for an attendance must be met, that is, the service must have been provided by a clinician, a triage category must be recorded, and the patient must be clerically registered.

7.4 Occasion of Service[a]

Patients meeting the criteria for a non-admission may receive treatment in a designated department or clinic within a hospital. The unit of measure for recording these visits is an "occasion of service".

An occasion of service is defined as any examination, consultation, treatment or other service provided to a patient, or a group of patients, in each functional unit of a health service or hospital on each occasion such a service was provided.

In Western Australia, occasions of service for emergency patients are categorised as attendances or presentations. Attendance figures are used for all local reporting. Presentations are used for national reporting.

[a] The definitions of occasion of service, as per the NMDS definitions, are described in more detail in further guidelines available at: http://meteor.aihw.gov.au/content/index.phtml/itemId/336947

7.5 Presentation

An emergency presentation is an occasion of service where a patient is registered clerically, has a Unit Medical Record Number (UMRN), and has been triaged, indicated by a code on the Australasian Triage Scale. The total presentation count is a subset of the total attendance count.

7.6 Australasian Triage Scale (ATS)

Emergency patients are triaged on arrival to assess the urgency of the required treatment.

A triage category is assigned to each patient based on the triage assessment, with triage 1 being the most urgent and triage 5 being the least urgent. This allows patients to be seen in order of clinical priority and ensures that the patients with the most urgent requirements for medical care are seen first. Each triage category has a maximum waiting time for medical assessment and treatment. Ideally, patients should be seen within the maximum waiting times.

The ATS must be used to report the urgency category of the patient from the values listed below.

Australasian Triage Scale (ATS)		
Triage Category	**Treatment Urgency**	**Maximum waiting time**
1.	Resuscitation	Immediate (within 2 minutes)
2.	Emergency	10 minutes
3.	Urgent	30 minutes
4.	Semi-urgent	60 minutes
5.	Non-urgent	120 minutes

Source: Health Service Performance Report (HSPR)

8 Data quality

This section presents information about the quality of data collected by emergency departments.

8.1 Data consistency - examples

To ensure reporting consistency for other critical items such as length of episode, transfer to other hospitals and unplanned re-attendances, data should be recorded as in the examples outlined in the following table:

If Patient Episode Detail is:	Triage should be:	And Visit Type should be:	And Episode End Status should be:	And Admit date/time should be:
Admission (to ED or hospital ward)	*	*	Admission	Entered
ED service event completed; departed under own care	*	*	ED service event completed; departed under own care	Not entered
Transferred (to another hospital)	*	*	Transferred	Not entered

Unplanned reattendance	*	Unplanned Return Visit	*	*
Referred to After Hours GP Clinics	*	*	Referred to After Hours GP Clinic	Not entered
Note: * Use the appropriate recording from the value domain.				

NOTE: Additional codes are not to be created without consultation and agreement between ISPD, Health Support Services and the Health Service Providers, including ratification by the appropriate user groups.

9 Assistance

Should you have any queries, please contact the Principal Data Management Officer, Emergency Department Data Collection, ISPD.
Phone: 08 9222 0281
Email: datarequests.eddc@health.wa.gov.au

Appendix 1: Data Element Definitions for Recording Emergency Activity

Data Element Title	Data Element Description
Account Number *	A unique identifier of a hospital episode of care.
Admission Date (Date Admitted as Inpatient) #*	The date on which the patient was formally or statistically admitted to a hospital and commenced an inpatient episode of care.
Admission Time (Time Admitted as Inpatient) #*	The time at which the patient was formally or statistically admitted to a hospital and commenced an inpatient episode of care.
Admitting Doctor Code *	The code used to indicate that a doctor has admitting rights.
Admitting Doctor Type *	The type that indicates that a doctor has admitting rights to the ED e.g. Observation area.
Arrival Date #*	The date on which the patient/client presents for the delivery of a service.
Arrival Time #*	The time at which the patient/client presents for the delivery of a service.
Bed Request Date *	The date a request for an inpatient bed is made.
Bed Request Time *	The time a request for an inpatient bed is made.
Consultation Code *	The specialty of the consultation provider, to whom a patient has been referred, as represented by a code, e.g. ANAE – Anaesthetics, CARD – Cardiology, PSYCL – Psychiatric Liaison Nurse.
Clinical Comments *	The description of a patient's clinical comments made by the clinician.
Date Seen by Doctor/Senior Doctor/Nurse Practitioner #*	The date on which a patient is seen by a clinician and the non admitted patient ED/Service event commences.
Date Seen by Nurse #*	The date on which a patient is seen by a nurse and the non admitted patient ED/Service event commences.
Departure Destination on Discharge from Emergency Department *	The place to where the patient was discharged or transferred when they left the ED/Service, as represented by a code.
Departure Ready Date *	The date on which the patient is ready to leave the ED but may be waiting on a final procedure or to be collected.
Departure Ready Time *	The time at which the patient is ready to leave the ED but may be waiting on a final procedure or to be collected.

Data Element Title	Data Element Description
Diagnosis Code *	The diagnosis established after study to be chiefly responsible for occasioning an episode of patient care, as represented by a code.
DVA Authorisation Date *	The date on which a hospital receives the authorisation of treatment eligibility from the Department of Veteran Affairs (DVA).
DVA Authorisation Number *	The DVA Authorisation Number refers to the confirmation of eligibility of the patient to receive treatment that will be funded by the DVA. This applies to White cardholders only.
DVA Card Colour #*	An eligible Veteran beneficiary is a patient who holds a current DVA Repatriation Health entitlement card: • Gold (Treatment entitlement card for all conditions). • White (Treatment entitlement card for specific conditions).
DVA File Number *	The Number located below the person's name on the Repatriation Health Card that is issued by the DVA to eligible Veteran beneficiaries.
Employment Status *	The self-reported employment status of a person, immediately prior to admission.
Episode End Status (Departure Status) #*	The status of the patient at the end of the non admitted patient ED/Service episode, as represented by a code. Locally known as departure status, disposition or treatment outcome.
Episode Number *	An identifier in the source system that distinguishes related non-admitted services.
Establishment Identifier #*	The identifier for the establishment in which the episode or event occurred.
External Cause of Injury *	The environmental event, circumstance or other condition that caused an injury, poisoning or adverse effect (e.g. Falls).
First Name(s) *	The person's identifying name within the family group or by which the person is socially identified, as represented by text.
Funding Source for Hospital Patient #*	An indicator of the source of payment for the hospital account.
Home Phone *	The home telephone number recorded for a person, as represented by a code.
Human Intent Code *	The clinician's assessment identifying the most likely role of human intent in the occurrence of the injury or poisoning (e.g. Self Harm).
Interpreter Required *	The need for use of an interpreter service by the patient.

Data Element Title	Data Element Description
Investigation Code *	The type of investigation as represented by a code, e.g. ECG – electrocardiogram.
Major Diagnostic Category *	The category into which the patient's diagnosis and the associated Australian Refined Diagnosis Related Group (ARDRG) falls, as represented by a two-digit code (HCARe/CMS only).
Meth Flag At Triage	Describes whether the the triage nurse thought the patient may be under the influence of methamphetamine.
Meth Flag At Diagnosis	Describes whether the doctor thought the patient may be under the influence of methamphetamine during discharge.
Meth Manual Flag	If at anytime during the ED episode, a clinician thought the patient may have been under the influence of methethamphetamine.
Meth Manual Date	The Date that the manual entry took place for the meth manual flag.
Meth Manual Time	The Time that the manual entry rook place for the meth manual flag.
Marital Status *	A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.
Person Identifier #*	Person identifier unique within an establishment or agency. A logical combination of valid alphanumeric characters that identify an entity.
Physical Departure Date (Discharge Date) #*	The date on which a patient physically departs an ED/Service after a stay.
Physical Departure Time (Discharge Time) #*	The time at which a patient physically departs an ED/Service after a stay.
Postcode #*	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person.
Presenting Problem Code *	The clinical interpretation of the problem or concern that is the person's main reason for seeking health care from the ED/Service, as represented by a code.
Presenting Problem Description *	The description of the clinical interpretation of the problem or concern that is the person's main reason for seeking health care from the ED/Service.
Procedure Category Code *	A clinical intervention category represented by a code.
Procedure Code *	A clinical intervention represented by a code.
Referred to on departure *	The place to where the patient was referred when they left the ED/Service, as represented by a code.

Data Element Title	Data Element Description
Sex #*	The biological distinction between male and female, as represented by a code.
Source of Referral *	The person or agency responsible for the referral of a client to a service provider agency, as represented by a code.
Street Address *	The concatenation of a person's street type and street suffix resulting in a name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality, as represented by text.
Stream *	Pathway for patient care (includes COVID-19 pathway).
Suburb #*	The full name of the locality contained within the specific address of a person, as represented by text.
Surname *	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.
Time Seen by Doctor/Senior Doctor/Nurse Practitioner #*	The time at which a patient is seen by a clinician and the non admitted patient ED/Service event commences.
Time Seen by Nurse #*	The time at which a patient is seen by a nurse and the non admitted patient ED/Service event commences.
Transport Mode (Arrival) #*	The mode of transport by which the person arrives at the ED/Service, as represented by a code.
Triage Category #*	The urgency of the patient's need for medical and nursing care, as represented by a code.
Triage Date #*	The date on which the patient is triaged.
Triage Time #*	The time at which the patient is triaged.
Type of Visit #*	The reason the patient presents to an ED/Service, as represented by a code.
Work Phone *	The work telephone number recorded for a person, as represented by a code.

Item required for NMDS reporting
* Item required for WA reporting

This document can be made available in alternative formats on request for a person with a disability.