



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

Emergency Department Patient Activity Data Business Rules

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Links to:	Information Management Policy Framework https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Information-Management

Contents

Abbreviations	1
1. Purpose	2
2. Background	2
3. Contact details.....	2
4. Scope.....	2
4.1 COVID-19	3
5. Documentation	4
5.1 Medical record	4
5.2 Requirements.....	4
6. Definitions.....	5
6.1 Emergency department.....	5
6.2 Emergency patient	5
6.3 Emergency attendance	5
6.4 Emergency department episode of care	6
6.5 Emergency department activity.....	6
7. ED Episode of care.....	7
7.1 Identification and registration	7
7.2 Arrival date and time	7
7.3 Triage date and time	7
7.4 Triage.....	7
7.4.1 Emergency Virtual Care and (tele-) virtual triage	8
7.5 Arrival mode.....	9
7.5.1 Ambulance Case number.....	9
7.6 Visit type	9
7.6.1 Planned / Unplanned re-attendances.....	9
7.6.2 Planned re-attendance.....	10
7.7 Presenting complaint / diagnosis	10
7.8 Commencement of clinical care.....	10
8. Departure from ED	11
8.1 Referred from triage.....	11
8.2 Did not wait	11
8.3 Left at own risk.....	11
8.4 Transfer to another health service	12
8.5 Deceased in ED	12
8.6 Admission from ED	12
8.6.1 ED short stay unit admissions	13
8.6.2 Mental Health Observation Area	14
8.6.3 Virtual bed / Virtual ward admissions	14
9. Classification of ED activity	15
9.1 Australian Emergency Care Classification	15
10. Rules for recording activity	15
11. WA Emergency Access Target.....	16
12. High-cost, highly specialised therapies	16
13. Wearable Technology	16
14. Compliance and audits	17

14.1 Audit of the Business Rules17

14.2 Validation and compliance monitoring17

15. Glossary 18

16. References 19

Appendix A – Summary of revisions 20

Abbreviations

ABF	Activity Based Funding
AECC	Australian Emergency Care Classification
ATS	Australasian Triage Score
CHE	Contracted Health Entity
ED	Emergency Department
EDDC	Emergency Department Data Collection
EDIS	Emergency Department Information System
EVC	Emergency Virtual Care
HITH	Hospital In The Home
HSP	Health Service Provider
HST	Highly Specialised Therapy
ID	Identifier
IHACPA	Independent Health and Aged Care Pricing Authority
MRN	Medical Record Number
PAS	Patient Administration System
SSU	Short Stay Unit
UDG	Urgency Disposition Group
UMRN	Unit Medical Record Number
URN	Unique Record Number
WA	Western Australia

1. Purpose

The purpose of the *Emergency Department Patient Activity Data Business Rules* (the Business Rules) is to outline criteria to correctly record, count and classify Emergency Department (ED) patient activity data within the Western Australian health system.

The *Emergency Department Patient Activity Data Business Rules* is a related document mandated under [MP 0164/21 Patient Activity Data Policy](#).

The Business Rules are to be read in conjunction with this policy and other related documents and supporting information as follows:

- [Emergency Department Data Collection Data Specifications](#)
- [Emergency Department Data Collection Data Dictionary](#)
- [Patient Activity Data Policy Information Compendium](#).

2. Background

ED activity is defined as services provided either in dedicated specialist multidisciplinary units that are purposely designed and equipped to provide 24 hour emergency care or in a designated virtual ED. A physical ED has designated assessment, treatment and resuscitation areas with the availability of medical and nursing staff as well as a nursing unit manager 24 hours a day, 7 days a week.

The Business Rules ensure that the collection of ED activity is standardised across the WA health system and that Health Service Providers (HSPs) and Contracted Health Entities (CHEs) record, count and classify activity correctly for the services they provide. High quality information is required to inform the planning, monitoring, evaluation and funding of health services.

The Business Rules are reviewed annually, with reference to national policy and legislation, to ensure relevance and currency. Any revisions are made following extensive consultation with stakeholders.

3. Contact details

Queries and feedback on the Business Rules can be submitted to the Department of Health via DataRequests.EDDC@health.wa.gov.au.

4. Scope

The ED services provided in all public hospitals and CHEs are in scope for the *Emergency Department Patient Activity Data Business Rules*.

The scope includes physical attendances at EDs, Emergency Virtual Care (EVC), and virtual triage:

- EVC uses a direct video and telephone link to allow patients to receive clinical care which may be completed virtually, or occur before ED arrival or diversion to another service. It may also be used to provide specialist emergency medicine remotely another hospital and care team.
- Virtual models of care which provide only triage and diversion to a suitable service may be referred to as virtual triage or tele-triage.

- Advice received by telehealth may form part of care provided to patients physically receiving care in an ED.
- Patients who were dead on arrival are in scope if an ED clinician examined and certified the death of the patient.
- Patients who attend an ED and leave after being triaged and advised of alternative treatment options at another health service/urgent care facility are in scope.
- Patients who are directly admitted to the hospital without triage or care in an ED or by EVC are out of scope.

For the purposes of the Business Rules:

- An approved information system for WA public hospital Emergency Departments refers to the Emergency Department Information System (EDIS), ED webPAS and Midland webPAS.
- Recorded refers to recorded in an approved information system and documented refers to documented in the medical record (paper-based, digital or electronic or a combination of all or some).
- Virtual care patient level activity, that cannot be recorded in an approved information system due to structural limitations (for example the system is not able to classify an episode as having received EVC or virtual triage), must be recorded in another secure system. The Data Custodian for the secure system must collaborate with the Emergency Department Data Collection (EDDC) Custodian for progress towards an approved information system and incorporation of EVC and virtual triage activity into the EDDC.
- Until incorporation into an approved information system, all WA health system entities must provide patient level activity recording of patients who have received EVC or virtual triage to the Department of Health on a monthly basis through secure feed or MyFT link to DataRequests.EDDC@health.wa.gov.au. This must be a patient level activity submission (extract/export) from the secure information system used to record virtual care data that cannot be recorded in an approved information system. As EVC is an evolving data collection, activity requirements are subject to change.

4.1 COVID-19

In order to implement the measures under the [National Partnership on COVID-19 Response](#) agreement, and to accurately capture COVID-19 episodes of care and COVID-19 related hospital activity for other purposes, the Independent Health and Aged Care Pricing Authority (IHACPA) has issued national classification and reporting rules to ensure this activity is captured on a nationally consistent basis.

IHACPA has updated the Emergency Department ICD-10-AM Principal Diagnosis Short List (EPD Short List) in 2022 with additional codes to classify COVID-19 testing and adverse reactions to the COVID-19 vaccine in Australian public hospitals for ED care that all HSPs and CHEs must comply with.

[How to classify COVID-19](#) guidance released by IHACPA, and [COVID-19 Activity Data Recording Guidelines](#) developed and published by the Department of Health brings together all advice related to the classification of COVID-19. These documents provide guidance and frequently asked questions (FAQs) to assist in the recording and coding of COVID-19. All WA health system entities must comply with the business rules and requirements in the [COVID-19 Activity Data Recording Guidelines](#).

5. Documentation

5.1 Medical record

Medical records are formal collections of information regarding an individual's healthcare plan, medical history, assessments and other health related documentation.

Medical records can exist in a physical, digital and/or electronic form. It is typically a record created when a patient first presents to a healthcare facility and is used to document care in all subsequent care and/or admissions. Where an electronic record is made as a substitute for a physical record, it is to be viewed and treated in a similar manner to the physical record.

While the medical record primarily serves the patient as a documented history by documenting patient care interactions, for the purposes of patient activity data reporting, it is a necessary evidentiary record for mandatory audit purposes and to meet legislated funding agreements and record keeping requirements.

5.2 Requirements

All admissions must be supported by documentation and a record of treatment and/or care that includes:

- administrative documentation (e.g. registration on the Patient Administration System (PAS) and financial election forms)
- documentation in the medical record by a medical practitioner or authorised clinician to evident compliance with the definition of [admitted activity](#), including:
 - the decision to admit and time made
 - the reason for admission
 - the intended clinical treatment plan for admitted activity
 - factors/exceptional patient circumstances contributing to the admission
 - conditions identified and treated/care provided
 - the date and time of discharge from the hospital
 - specific documentation requirements of the admission category and care type.

Information not written or recorded within a conventional paper-based or digital medical record but captured electronically via a supporting administrative and/or clinical application (e.g. EDIS, EBM, iCM) may, by definition, be considered an extended part of the medical record. Where such an application is used to document any decision in relation to the admission (e.g. a decision to admit and/or decision time to admit), local procedures must evidence this as standard practice and the information must be documented consistently. Documentation must be clearly delineated, with information recorded according to the type of activity being undertaken.

6. Definitions

For the purposes of the Business Rules, the key terms below have the following meanings.

6.1 Emergency department

EDs are dedicated specialist multidisciplinary units specifically designed and staffed to provide 24-hour emergency care. The role of the ED is to treat urgent or life-threatening illnesses and injuries. The aim of the treatment is to assist in the restoration of health either during the emergency visit or the admission to hospital which may follow emergency care.

An ED must meet all of the following criteria:

- be a purposely designed and equipped area with designated assessment, treatment and resuscitation areas
- have the ability to provide resuscitation, stabilisation and initial management of all emergencies
- have medical staff in the hospital 24 hours a day including designated ED staff and unit manager.

A facility providing emergency type services must be formally designated by the Department of Health as an ED in order to qualify for ED activity data recording, counting and funding recognition.

6.2 Emergency patient

A patient who receives treatment in a designated ED.

6.3 Emergency attendance

Occurs where a patient attends an ED and is registered in an approved information system or triaged by ED staff.

An ED attendance includes, but is not limited to, the following:

- Patients who receive treatment in the designated ED and are subsequently discharged from ED, including cases where the patient is admitted to hospital from ED.
- Patients who are triaged and/or registered in an approved information system but choose to leave the hospital before receiving treatment.
- Patients who are triaged and/or registered in an approved information system but choose to leave the hospital before the completion of assessment or treatment.
- Patients who leave the ED after being registered to receive care and then advised of alternative treatment options.
- A patient is dead on arrival and an ED clinician certifies death. Refer to [Section 8.5 Deceased in ED](#) for more information.

An ED attendance excludes the following:

- A patient attends a physical ED but is not triaged or clerically registered.
- Where only a clerical service is provided to people supporting pre-arranged admission.

- The patient is physically present while waiting transit to another facility. The patient receives no clinical care from the ED team and is not recorded as an emergency attendance.

Definitions in the Australian Institute of Health and Welfare (AIHW) Metadata Online Registry (METEOR) may refer to an ED attendance as an ED presentation.

6.4 Emergency department episode of care

The period between when a patient attends the ED, and when that person is recorded as having physically departed the ED.

6.5 Emergency department activity

Includes all treatment and care provided in an ED.

For this activity to be included in reporting (counted and funded), all of the following criteria for an ED attendance must be met:

- a triage category must be recorded and documented (where applicable)
- the patient must be registered and recorded in an approved Patient Administration System
- treatment is provided by a medical practitioner or other authorised clinician
- at least one valid discharge diagnosis must be recorded for this activity, except where the departure status is 'Did Not Wait'.

For details on data elements required for recording ED activity, refer to the [Emergency Department Data Collection Data Specifications](#).

7. ED Episode of care

7.1 Identification and registration

When a patient attends a designated ED for treatment, the patient must be correctly identified and registered in an approved information system.

When patient identification cannot be obtained due to the patient's presenting state or condition (for example when the patient is unconscious, intoxicated, mentally impaired or experiencing language difficulties) they must be registered as an 'Unknown Patient' by:

- using 'Unknown Male' or 'Unknown Female' in the patient name fields
- allocating a patient identifier UMRN
- entering an estimated date of birth, according to the data dictionary this must be entered as 01/07/YYYY.

Once the patient's identity has been confirmed and the patient has an existing UMRN, the 'Unknown Patient' registered UMRN must be merged with the existing UMRN for the patient. If there is no previous existing UMRN, the UMRN used for the 'Unknown Patient' registration must have the patient demographics updated with the correct patient information.

7.2 Arrival date and time

Reflect the date and time that the patient first attends the ED. For patients that arrive via St John WA Ambulance Services, this time is recorded and documented as the time the patient enters the ED or when the Triage and/or ED clinician first receives the patient.

7.3 Triage date and time

Reflect the date and time the triage commenced for the patient. This must not be retrospectively changed except under exceptional circumstances, for example, if an error was made.

If the patient's condition deteriorates during the course of their episode of care, a second triage assessment may be conducted, and triage category updated to reflect this.

7.4 Triage

A patient must have a triage assessment completed as soon as possible on arrival, to enable them to be prioritised on the basis of illness or injury severity and their need for medical and nursing care.

The patient must be assigned a triage category based on the Australasian Triage Scale (ATS) (Table 1). The triage category cannot be retrospectively changed to another category except under exceptional circumstances, for example, if the patient's condition deteriorates during the course of their episode of care and a second triage assessment was conducted.

Table 1: Australasian Triage Scale Description¹

Australasian Triage Scale		
ATS Category	Broad Definition of Category	Treatment Time Target
Resuscitation ATS 1	Definitely life threatening, requiring immediate medical care	Less than or equal to 2 minutes
Emergency ATS 2	Probable threat to life or limb	Less than or equal to 10 minutes
Urgent ATS 3	Possible threat to life or limb	Less than or equal to 30 minutes
Semi-urgent ATS 4	No threat to life or limb but some incapacity or injury	Less than or equal to 60 minutes
Non-urgent ATS 5	No incapacity or threat to life or limb	Less than or equal to 120 minutes

Some hospitals use triage to record additional patient information including classifying patients who are dead on arrival, directly admitted or current inpatients (Table 2). These codes enable more detailed recording of the episode of care so that the activity can be included or excluded from ED activity reporting, depending on requirements.

Table 2: Optional Administrative Triage Categories

Australasian Triage Scale Additional Optional Codes used in WA		
ATS Category	Description	Treatment Time Target
DOA	Dead on arrival	N/A
Direct Admission	Planned admission	N/A
Inpatient	Current inpatient	N/A

7.4.1 Emergency Virtual Care and (tele-) virtual triage

HSPs utilise EVC with the aim of streamlining emergency medicine pathways. EVC uses direct video and telephone to link a command or operations centre, based at a hospital or HSP, with ambulance services and other settings. EVC allows patients to receive clinical care before they physically arrive at an ED or are diverted to another suitable service. EVC may also be used to provide specialist emergency medicine remotely to another hospital and care team.

According to the national definition, EVC must follow all of the criteria below to be considered in-scope:

- care must be equivalent to a face to face consultation
- the patient and emergency clinician must interact in a mutually responsive manner
- interactions must be via an audio-visual link
- the patient’s presenting condition/injury must be visible to the remote emergency clinician

¹ Adapted from <https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Triage>

- the virtual care must be provided by an emergency clinician as part of a hospital department/emergency service.

If a virtual model of care provides only triage and diversion to a suitable service, it may be referred to as virtual triage. This model is subject to the same recording and reporting requirements as more complex EVC models of care.

In order to identify this activity for reporting, analysis and patient safety, all HSPs and CHEs must provide patient level activity recording of patients who have received EVC or virtual triage to the Department of Health through an approved information system or on a monthly basis through DataRequests.EDDC@health.wa.gov.au. Specific fields may be required for local and national requirements and sites must contact DataRequests.EDDC@health.wa.gov.au to ensure they capture the required information.

7.5 Arrival mode

The mode of transport to the ED must be recorded in an approved information system. If the patient arrives at the ED via ambulance, the ambulance handover and case number details are also required to be recorded.

7.5.1 Ambulance Case number

Ambulance case number is a unique identifier issued by St John WA Ambulance Services for each transport. This number must be recorded as soon as possible when patients arrive and are triaged.

7.6 Visit type

7.6.1 Planned / Unplanned re-attendances

When a patient re-attends the same ED within 24 hours (after a previous ED attendance), the following circumstances must be considered to determine if a new ED episode is to be recorded or if the preceding ED episode is to be recommenced:

- If a patient returns to the same ED after receiving part of their care outside of the ED, the preceding episode must be recommenced. For example, admitted for management of toxic effects of drugs and alcohol, and then returned to the ED for continuation of treatment. As the ED episode had been temporarily interrupted (on leave) the patient must not have two ED episodes recorded as it is a continuation of care.
- If a patient is assumed to have left at their own risk and re-attends within 24 hours, for example, left temporarily without advising staff, the preceding episode must be recommenced and continued.
- If a patient is discharged home from the ED or to a SSU, and then subsequently re-attends the ED within 24 hours, a new episode must be recorded in this circumstance. In this circumstance, there may be no care provided between discharge and re-attendance. This may be a planned return visit, see [Section 6.6.2 – Planned re-attendance](#).

7.6.2 Planned re-attendance

A planned re-attendance is a planned return to the ED following a previous ED episode. A new episode (with a planned return Visit Type) must be recorded in this circumstance. This return visit may be for planned follow-up treatment, as a consequence of test results becoming available indicating the need for further treatment, or as a result of a care-plan initiated at discharge.

7.7 Presenting complaint / diagnosis

A presenting complaint/diagnosis must be recorded in an approved information system. Observations related to the presenting complaint/diagnosis must also be recorded and documented in the medical record.

7.8 Commencement of clinical care

Treatment in the ED is deemed to commence at the time that a medical practitioner or other authorised clinician (earliest of doctor/nurse for regional sites and doctor/nurse practitioner for metropolitan sites) first assesses or treats a patient.

Note: The triage process and/or the placement of a patient in a cubicle and observations being taken to monitor a patient pending a decision regarding clinical care does not constitute a commencement of clinical care.

The commencement of clinical care time must be recorded in an approved information system as it is used to calculate the waiting time for ED care. This is nationally defined as the time elapsed for each patient from arrival in the ED to the commencement of ED non-admitted clinical care. Assessment and treatment may include the time the patient had temporarily left for diagnostic tests and returned to the ED.

8. Departure from ED

Departure from ED is where the patient's ED episode of care is completed. Status, date, time and destination must reflect the actual departure time and be recorded in the approved information system and documented in the medical record.

Examples:

- a patient is admitted to an inpatient ward/unit, or to a SSU which is physically separate from ED acute assessment area
- a patient is discharged or transferred to another hospital/institution (aged care facility or prison)
- a patient is discharged to their home or other residence
- a patient may choose to leave before the emergency care treatment has commenced or is completed.

8.1 Referred from triage

If a patient is triaged and registered but then referred to another service, for example an ambulatory care unit for assessment, the date and time the patient left the ED must be recorded in the approved information system, together with an ED departure status of 'Referred at Triage to other Health Care Service'. This may display as 'Referred from Triage' in EDIS.

8.2 Did not wait

If a patient is triaged and registered but leaves the ED without clinical care commencing, it must be recorded that they did not wait. For example, a triaged and registered patient leaves due to long wait times. This includes where the patient intends to attend another health service/urgent care facility but was not referred to the health service/urgent care facility as part of the triage process.

As the patient has left before the commencement of clinical care, a commencement of clinical care date and time and diagnosis are not to be recorded.

The date and time the patient leaves the ED, or if unknown, an approximation based on when the patient was observed to be absent, must be recorded as the discharge date and time. Every endeavor must be made to ensure the patient has in fact left the ED before the departure status is recorded as 'Did Not Wait'.

8.3 Left at own risk

If a patient chooses to leave the hospital:

- after clinical assessment and/or treatment has commenced
- before the completion of treatment (if commenced), and/or
- against the advice of the treating medical practitioner.

It must be recorded in an approved information system and documented in the medical record that they 'Left at Own Risk'. If the patient has been admitted to the hospital for observation or treatment, refer to *Section 13.3 Patient Initiated Discharge* in the [Admitted Patient Activity Data Business Rules](#).

The date and time a patient left ED, or if unknown, an approximation based on when the patient was observed to be absent, must be recorded in the approved information

system as the discharge date and time. A valid principal diagnosis short list code must also be recorded.

When the patient leaves the hospital and it remains unclear whether they intend to return, it is a clinical decision whether to delay the discharge of the patient from the ED until this is confirmed. Every endeavor must be made to ensure the patient has in fact left the ED before being recorded as 'Left at Own Risk'. If the patient is located and returns to resume their care, a new ED episode must not be recorded, and the patient is to continue their current episode of care.

8.4 Transfer to another health service

If a patient is transferred to another hospital without first being admitted, the ED departure status and time must be recorded in the approved information system as 'transferred to another hospital' and the time the patient was transferred.

For patients who are admitted from ED, the episode of care is complete for ED and as such the appropriate departure status should be applied to the ED episode e.g. admitted to hospital ward/ SSU/ hospital in the home. Any subsequent transfer of an admitted patient to another hospital must be recorded as described by the [Admitted Patient Activity Data Business Rules](#).

The destination health service must be recorded with a valid establishment code from the [Establishment Code List](#).

8.5 Deceased in ED

If a patient that was being treated in the ED dies:

- the death must be recorded in the 'departure status' as '6 - Died in ED'
- the time of death must be recorded as the patient's 'departure time'

If a patient is pronounced 'dead on arrival' to the ED and is assessed by an ED clinician, including where no treatment or care is provided, an ED attendance must be recorded:

- the triage category is recorded as '6 - Dead on arrival'
- the departure status is entered as '7 - Dead on arrival, not treated in ED'
- the visit type is entered as '10 - Dead on arrival'
- the discharge datetime is the date and time the patient was certified dead.

If patient is 'dead on arrival' and does not receive an assessment, care, treatment or death certification by an ED clinician, they are not to be recorded as an ED attendance.

8.6 Admission from ED

When a patient requires admission from the ED, the admission date and time to be recorded must be the date and time the patient physically left the ED to go to a designated SSU, inpatient ward or operating theatre/procedure room at the same hospital.

The decision to admit the patient must be documented in the patient's medical record by a medical practitioner or authorised clinician to evidence compliance with the definition of admitted activity, including:

- the date and time of the decision to admit;

- the reason for admission;
- the intended clinical treatment plan for admitted activity; and
- factors/exceptional patient circumstances contributing to the admission.

8.6.1 ED short stay unit admissions

An ED SSU may also be known as a Clinical Decision Unit, Emergency Observation Unit or another term appropriate for the specific unit in question. An SSU is a designated inpatient unit with all of the following characteristics.²

- are designated and designed for the short-term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the ED
- have specific admission and discharge criteria and procedures
- are designed for short term stays no longer than 24 hours
- are physically separate from the ED acute assessment area
- have a static number of available treatment spaces with oxygen, suction and patient ablution facilities
- are not a temporary ED overflow area, nor used to keep patients solely awaiting an inpatient bed, nor awaiting treatment in the ED.

Note: The SSU must not be used to avoid breaching a measured performance threshold.

Admissions to the SSU must meet the requirements for admission and specific admission criteria for ED Short Stay admissions. For further information on ED short stay admissions, refer to the [Admitted Patient Activity Data Business Rules](#).

If an ED patient is relocated to, but not admitted to an SSU, or the intended SSU admission is cancelled/reversed, the ED episode of care must continue and include the ED non-admitted care provided in the SSU. In this scenario:

- the ED departure status must be corrected from 'Admitted' to record the actual outcome of the ED episode, and
- the ED episode end date and time must be corrected to record the time the patient actually leaves the ED either from the SSU or ED, whichever is the later.

Activity for patients admitted directly to the SSU from Triage or another source, without receiving clinical assessment and treatment in the ED must not have an ED attendance recorded.

Specific information relevant to the EDIS:

- Admission of a patient to ED SSU using the EDIS Short Stay Module ends the ED episode and records this as the departure date and time.
- When admitting a patient using the EDIS Short Stay Module the patient must physically leave the ED and be admitted to the SSU and recorded in EDIS at the date and time of actual departure from ED.

² [National Health Information Standard - ED SSU](#)

- The admit date and time field in the EDIS must match the actual date and time of admission to the SSU or inpatient ward recorded in the Patient Administration System (PAS). Where the functionality is available this is to be automatically populated from the PAS and not manually overwritten or disabled.

8.6.2 Mental Health Observation Area

A Mental Health Observation Area may also be known as a Mental Health Observation Unit or Mental Health Emergency Centre, and are co-located with the ED. The purpose of the Mental Health Observation Area is to provide mental health treatment in acute situations, and it is designed for 24 to 72 hour stays. The Mental Health Observation Area is not in scope for ED activity. For further information, refer to *Section 7.8.4 Mental Health Observation Area* in the [Admitted Patient Activity Data Business Rules](#).

8.6.3 Virtual bed / Virtual ward admissions

A virtual bed is a term used to denote a nominal location which the patient is held against in the hospital's information system.

Patients still being cared for in the ED and waiting to be allocated/transferred to an inpatient bed must not be admitted to a virtual ward.

Admitted patients who deteriorate and require transfer for care within the location of an ED, can be transferred to an ED virtual ward for bed movement tracking purposes.

For further information, refer to Section 10.2 Virtual Beds/Wards in the [Admitted Patient Activity Data Business Rules](#).

9. Classification of ED activity

ED activity is classified using the following classification system. ED activity includes all treatment and care provided in an ED and in a designated virtual ED. Data elements used to calculate the Australian Emergency Care Classification (AECC) end class must be recorded in an approved information system.

For details on data elements required for recording ED activity, refer to the [Emergency department activity](#) definition and the [Emergency Department Data Collection Data Specifications](#).

9.1 Australian Emergency Care Classification

All public hospital ED activity is classified using the AECC which was introduced in July 2021. The AECC has three hierarchical levels that categorise ED activity into end classes reflecting different complexity levels.

The complexity levels are based on a score assigned to each attendance which is calculated using the patient's diagnosis, age group, visit type, episode end status, triage category and transport mode.

End class calculations validate reported activity data. If a patient Did Not Wait yet a diagnosis is reported, an error class will be allocated as no diagnosis can be assigned when no care was provided. Similarly, an error class will be allocated if no valid diagnosis is reported for a completed emergency attendance where a patient received ED care and was admitted to the hospital.

The IHACPA Emergency Care ICD-10-AM Principal Diagnosis Short List (also known as the EPD Short List) is a set of medical terms and codes used for reporting emergency care principal diagnoses to national activity datasets. It is also used to calculate AECC end classes. The EPD Short List is a subset of the ICD-10-AM classification and aims to provide a nationally consistent approach to classifying principal diagnosis reporting for emergency departments and emergency services. The Department will only accept valid ED principal diagnoses with descriptors and codes which are mapped to the EPD Short List as specified by the ICD-10-AM 12th edition.

The EPD Short List is reviewed regularly. The current 12th edition was published May 2023. Further information on the AECC is available from the IHACPA website: [Australian Emergency Care Classification](#).

10. Rules for recording activity

HSPs and CHEs are responsible for ensuring that data is entered correctly and in a timely manner in an approved information system so that up to date data can be provided for reporting purposes.

Data must be retrospectively entered or corrected where required for data quality purposes. However, data entry and corrections for the previous quarter's activity must be completed by the second month of the current quarter (for example corrections to ED activity data for July – September activity can be made through to 30 November). This timeframe ensures all activity is included in national data submissions required for activity based funding.

11. WA Emergency Access Target

The WA Emergency Access Target, sometimes referred to as the Four-Hour Rule, is a monitored performance indicator measuring the percentage of ED episodes of care with a length of episode less than or equal to four hours. This indicator is reliant on the accurate recording of ED activity data as outlined within the Business Rules. Refer to the [MP 0111/19 Performance Management Policy](#) for further information.

12. High-cost, highly specialised therapies

Access to new high cost, highly specialised, and potentially curative therapy treatments are an emerging option for patients in WA. A small number of patients are expected to benefit from access to highly specialised therapies (HST) each year. This includes, but is not limited to, the provision of Chimeric Antigen Receptor Therapies (CAR-T) such as Yescarta[®], Kymriah[®], and Tecartus[™], and other specialised therapies including Luxturna[™] and Qarziba[®].

IHACPA has developed guidelines for the costing, counting and reconciliation of funding. In order to comply, all HSPs must provide patient level activity recording of HST to the Department of Health on a quarterly basis through DataRequests.EDDC@health.wa.gov.au.

In scope activity includes services relating to the delivery of HST, including patient referral processes, consultations, treatments, and monitoring. To be considered in scope, costs must be incurred by the HSP. This may include costs incurred by EDs due to attendances relating to HST treatment.

The specifications are available on the IHACPA website, under [alternative funding source](#); however, the Department of Health requires HSPs and CHEs to provide the patient UMRN, activity type, type of treatment, and date of event to identify activity within central records. This will enable the required reporting to IHACPA and will ensure that HST can be identified and reported for a range of purposes, including patient safety, research and funding.

13. Wearable Technology

HSPs are utilising wearable technologies in the ED, with the aim of detecting early signs of clinical deterioration and facilitating rapid delivery of care. Post-triage, patients waiting in EDs may be given wearable devices which measure vital parameters including heart and respiratory rates, blood pressure, oxygen saturation levels, and skin temperature. These parameters are continuously monitored, and data is streamed live to hospital command centers and ED teams.

Data generated from wearable devices that cannot be stored in an approved information system should be recorded in another secure system. As this is an emerging method of data collection, activity relating to wearable devices should be provided on a best endeavours basis where requested by the Department of Health.

14. Compliance and audits

14.1 Audit of the Business Rules

The System Manager, through the Purchasing and System Performance Division, will carry out audits to ascertain the level of compliance with the Business Rules contained in this document. The purpose of the audit program is to add value, improve performance and support the business objectives of the Department of Health.

Audit findings will be communicated to the HSPs, CHEs, Information Stewards, HSP Chief Executives, the Director General and other relevant persons regarding the findings of compliance monitoring activities.

HSPs are required to facilitate these audits by providing the required information and resources to the audit team.

Further information regarding audits conducted by the Health Information Audit Team is contained in the [Health Information Audit Practice Statement](#).

14.2 Validation and compliance monitoring

Data quality validation is an essential tool used to ensure the accuracy and appropriateness of data submitted to the EDDC. Validations are applied to individual data elements and reflect national reporting obligations, best practice and policy, as well as the five data quality principles of relevance, accuracy, timeliness, coherence and interpretability.

Validations are reliably used to support:

- key performance indicators
- Activity Based Funding (ABF)
- clinical indicators developed by the Office of Patient Safety and Clinical Quality
- health service monitoring, evaluation and planning
- reporting to the Federal Government
- research
- response to Parliamentary requests/questions.

Further information on data quality and validation processes and timeframes, refer to the [Patient Activity Data Policy Information Compendium](#).

15. Glossary

The following definition(s) are relevant to this document:

Term	Definition
Approved Information System	An information system approved for use to record patient activity data in compliance with the Information Management Policy Framework. For WA public hospital Emergency Departments this refers to the Emergency Department Information System (EDIS), ED webPAS and Midland webPAS.
Contracted Health Entity	As per section 6 of the <i>Health Services Act 2016</i> , a non-government entity that provides health services under a contract or other agreement entered into with the Department Chief Executive Officer on behalf of the State, a Health Service Provider or the Minister.
Data Collection	Refer to Information Asset.
Health Service Provider	As per section 6 of the <i>Health Services Act 2016</i> , a Health Service Provider established by an order made under section 32(1)(b).
Information asset	A collection of information that is recognised as having value for the purpose of enabling the WA health system to perform its clinical and business functions, which include supporting processes, information flows, reporting and analytics.
Information Management Policy Framework	The Information Management Policy Framework specifies the information management requirements that all Health Service Providers must comply with in order to ensure effective and consistent management of health, personal and business information across the WA health system.
Medical record	A documented account, in any format, of a client's/patient's health, illness and treatment during each visit or stay at a health service.
Non-admitted patient	A person who does not meet the admission criteria and does not undergo a hospital's formal admission process.
Patient Activity Data Business Rules	Patient Activity Data Business Rules mandate the rules, scope and criteria to be used when recording health service patient activity data and reporting to the Department of Health.
Steward	A Steward's role is to implement the strategic direction of information management governance as recommended by the Information Management Governance Advisory Group, and manage the information asset(s) under their control to ensure compliance in line with legislation, policies and standards.
WA health system	Pursuant to section 19(1) of the <i>Health Services Act 2016</i> , means the Department of Health, Health Service

Term	Definition
	Providers, and to the extent that Contracted Health Entities provide health services to the State, the Contracted Health Entities.

16. References

1. Definition of emergency services for ABF purposes
<https://www.ihacpa.gov.au/resources/definitions-emergency-services>
2. Australian Institute of Health and Welfare – Glossary
<https://www.aihw.gov.au/reports-data/myhospitals/content/glossary>
3. Australian Institute of Health and Welfare – Emergency department stay – waiting time
<https://meteor.aihw.gov.au/content/746117>
<https://meteor.aihw.gov.au/content/index.phtml/itemId/472951>

Appendix A – Summary of revisions

Date Released	Author	Approval	Amendment
1 July 2021	Shani Shiham	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document created.
1 July 2022	Gwynedd Spicer- Wensley	Rob Anderson, Assistant Director General, Purchasing and System Performance	<p>Dates updated</p> <p>Replaced “EDIS and/WebPAS” and with approved information system for consistency.</p> <p>Added Virtual Emergency Medicine and Tele-Triage to scope and on recording in an information system.</p> <p>Amended content on COVID-19 to include updated information.</p> <p>Separated “Arrival date and time and Triage date and time” into two different sections.</p> <p>Removed ICD-10-AM diagnosis code Z53.9 as it can no longer be mapped to IHPA Short List.</p> <p>Updated High Cost Therapy section.</p> <p>Added Virtual Emergency Medicine and Tele-Triage sections.</p> <p>Added the definition for Medical Record.</p>
1 July 2023	Gwynedd Spicer- Wensley & Francesca McGrath	Rob Anderson, Assistant Director General, Purchasing and System Performance	<p>Dates updated</p> <p>Updated references to the Independent Health and Aged Care Pricing Authority (IHACPA).</p> <p>Throughout the document references to “presentation” have been removed and replaced with “attendance”</p> <p>Amended content to comply with style guide.</p> <p>Content updated for:</p> <ul style="list-style-type: none"> - Abbreviations - Background - Scope - Emergency Attendance

			<ul style="list-style-type: none"> - Emergency department episode of care - Emergency department activity - Identification and registration - Emergency Virtual Care and (tele-) virtual triage (formerly Virtual Emergency Medicine and tele-triage) - Transfer to another health service - Deceased in ED - ED Short stay unit admissions - Virtual bed/virtual ward admissions - Australian Emergency Care Classification - High-cost therapies - Validation and compliance monitoring - Glossary <p>Removed sections:</p> <ul style="list-style-type: none"> - Emergency presentation - Emergency activity <p>New sections:</p> <ul style="list-style-type: none"> - - Referred from triage - Mental Health Observation Area - Wearable Technology
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Purchasing and System Performance Division
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