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

Emergency Department Data Collection

Data Dictionary

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Contents

Abbreviations

DNW	Did Not Wait
DVA	Department of Veterans Affairs
ED	Emergency Department
EDDC	Emergency Department Data Collection
EDIS	Emergency Department Information System
GP	General Practitioner
HCARe	Health Care Related Client Management System
HITH	Hospital In The Home
HMDS	Hospital Morbidity Data System
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
ISPD	Information and System Performance Directorate
MDC	Major Diagnostic Category
NFPA	No Fixed Permanent Address
PAS	Patient Administration System
SJOGM	St John of God Midland
SSU	Short Stay Unit
UMRN	Unit Medical Record Number
WA	Western Australia
webPAS	Web-based Patient Administration System

1. Purpose

The purpose of the *Emergency Department Data Collection Data Dictionary* is to detail the data elements captured in the Emergency Department Data Collection (EDDC).

The *Emergency Department Data Collection Data Dictionary* is a related document under the *MP 0164/21* *Patient Activity Data Policy*.

This data dictionary is to be read in conjunction with this policy and other Related Documents and Supporting Information as follows:

- *Emergency Department Patient Activity Data Business Rules*
- *Emergency Department Data Collection Data Specifications*
- *Patient Activity Data Policy Information Compendium*.

2. Background

The use of emergency department patient data by the Department of Health is dependent on high quality data that are valid, accurate and consistent.

3. Recording of data

Data that is submitted to the EDDC must be recorded in accordance with the data definitions (Section 4).

4. Data definitions

The following section provides specific information about data elements captured in the EDDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the EDDC and caution should be taken if these data elements are compared with those of other data collections. Where relevant, related national definitions have been referenced.

Aboriginal Status

Field name:	ethnicity
Source Data Element(s):	[Ethnicity] - EDIS, webPAS, Midland webPAS
Definition:	The patient's Aboriginal status.
Requirement status:	Mandatory
Data type:	String
Format:	N
Permitted values:	1 Aboriginal but not Torres Strait Islander origin 2 Torres Strait Islander but not Aboriginal origin 3 Both Aboriginal and Torres Strait Islander origin 4 Not Aboriginal or Torres Strait Islander origin 9 Unknown

Guide for use

Aboriginal but not Torres Strait Islander origin – refers to patients who are of Aboriginal descent and who identify as an Australian Aboriginal.

Torres Strait Islander but not Aboriginal origin– refers to patients who are of Torres Strait Island descent and who identify as Torres Strait Islander.

Both Aboriginal and Torres Strait Islander origin – refers to patients who descent from and identify as both Australian Aboriginal and Torres Strait Islander.

Not Aboriginal or Torres Strait Islander origin – refers to patients who do not identify as an Australian Aboriginal, Torres Strait Islander or both.

Examples

A person who identifies as Aboriginal attends the Royal Perth Hospital ED, select Option 1 Aboriginal but not Torres Strait Islander origin.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/602543

Account Number

Field name:	account_number
Source Data Element(s):	[Account Number] - EDIS, webPAS, Midland webPAS
Definition:	An identifier of an episode of care.
Requirement status:	Mandatory
Data type:	String
Format:	X(12)
Permitted values:	The account number can be alphanumeric or numeric and has a maximum of 12 characters.

Guide for use

The account number is assigned through the webPAS system for all hospitals excluding Joondalup Health Campus and Peel Health Campus where the account number is assigned by Meditech.

EDIS sites interface with webPAS (and Meditech for Joondalup) through Health Level Seven International (HL7) data transmission messaging to receive the account number.

Additional Diagnosis

Field name:	additional_diagnosis
Source Data Element(s):	[Additional Diagnosis] - EDIS, webPAS, Midland webPAS
Definition:	A condition either coexisting with the principal diagnosis or arising during the episode of care, as represented by a code.
Requirement status:	Conditional
Data type:	String
Format:	ANN{.N[N]}
Permitted values:	ICD10-AM Code.

Guide for use

The collection of additional diagnosis is conditional – this data element can be recorded where applicable to the treatment of the client.

Additional diagnosis codes give information on the conditions that are significant in terms of treatment required during the episode of care.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/699588

Additional Diagnosis System Code EDIS

Field name:	di_code2
Source Data Element(s):	[Additional Diagnosis] - EDIS
Definition:	Secondary diagnosis information system identifier to designate ICD-10-AM version, as represented by a code.
Requirement status:	Optional
Data type:	String
Format:	X(8)
Permitted values:	ICD-10-AM Code.

Guide for use

The collection of Additional Diagnosis System Code EDIS is optional.

Admission Datetime

Field name:	admission_datetime
Source Data Element(s):	[Admission DateTime] - EDIS, webPAS, Midland webPAS
Definition:	The date/time that the patient is admitted to a legitimate Short Stay Unit (SSU) or inpatient ward at the same hospital as the ED presentation. This will be blank if the patient was not admitted.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The collection of Admission Date/Time is Mandatory for admitted patients only, when the ED patient was formally admitted to a hospital and commenced an inpatient episode of care.

See *Emergency Department Patient Activity Data Business Rules* and the Admitted Patient Activity Data Business Rules for more information on admissions from ED.

Admission Number

Field name:	episode_number
Source Data Element(s):	[Account Number] - webPAS
Definition:	Account Number that links the Emergency Department Data to Inpatient Data.
Requirement status:	Conditional
Data type:	String
Format:	X(12)
Permitted values:	N/A

Guide for use

The collection of Admission Number is Mandatory for admitted patients only and a value must be entered if the patient is admitted.

It is the Account Admission Number for every episode of care in the Hospital Morbidity Data System (HMDS) that links to emergency department data.

Admitting Doctor Code

Field name:	admit_dr_code
Source Data Element(s):	N/A
Definition:	The code used to indicate that a doctor has admitting rights.
Requirement status:	Conditional
Data type:	String
Format:	X(10)
Permitted values:	N/A

Guide for use

Only used for historical data prior to 01/04/2008.

Admitting Doctor Type

Field name:	admit_dr_type
Source Data Element(s):	N/A
Definition:	The type of medical practitioner that has admitting rights to the ED.
Requirement status:	Conditional
Data type:	String
Format:	X(10)
Permitted values:	ADM Admitting Doctor ADMDR Admitting Doctor CN Charge Nurse CONS Consultant EDADMED Doctor (only ED physicians have admitting rights to CSU) EDCONED Consultant EDJMO ED Junior Medical Officer EDMO ED Medical Officer EDREG ED Registrar EDSMO ED Senior Medical Officer EDSNR ED Senior Registrar INT Intern OTHER Other REG Registrar SREG Senior Registrar Unknown Unknown

Guide for use

This refers to the type of hospital medical practitioner who authorises the patient to be admitted to hospital.

Ambulance Number

Field name:	ambulance_no
Source Data Element(s):	N/A
Definition:	The case number of the ambulance.
Requirement status:	Conditional
Data type:	String
Format:	[X(8)]
Permitted values:	N/A

Guide for use

This field is mandatory if the patient arrived to the ED via Ambulance.

Note this is currently only available in EDIS (Metropolitan and Bunbury hospitals), and this is the identifier for the ambulance case number.

Arrival Datetime

Field name:	arrival_datetime
Source Data Element(s):	[Arrival Datetime] – EDIS, webPAS, Midland webPAS
Definition:	The Date and Time that the patient arrives at the ED.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The arrival date and time is the system default datetime, it is recorded when the triage nurse assesses the patient into the EDIS/webPAS systems.

It is mandatory.

The earlier of the Arrival Datetime and the Triage Datetime is used to derive Presentation Datetime, which is the datetime used as for reporting.

Australian Postcode

Field name:	postcode
Source Data Element(s):	[Postcode] - EDIS, webPAS, Midland webPAS
Definition:	The Australian numeric descriptor for a postal delivery area for an address. The postcode relates to the patient's area of usual residence.
Requirement status:	Mandatory
Data type:	String
Format:	NNNN
Permitted values:	N/A

Guide for use

A postcode list is maintained with entries that are valid on the current list of postcodes from Australia Post. See Australia Post (http://www.auspost.com.au/) for current listings.

Where the address is unknown or there is no fixed permanent address, the following postcodes must be used depending on the patient's State/Territory of residence:

Postcode	Suburb	State/Territory Code	State/Territory Description
0899	Unknown	7	Northern Territory
2999	Unknown		New South Wales
2999	Unknown	8	ACT
3999	Unknown	2	Victoria
4999	Unknown	3	Queensland
5999	Unknown	4	South Australia
6999	Unknown	5	WA
7999	Unknown	6	Tasmania
9999	Unknown	0	Not Applicable

When the patient has no fixed permanent address (NFPA) (e.g. homeless) but the State/Territory they live in is known, enter NFPA in the Residential Address field then enter the Suburb and Postcode combination as listed above.

When both the address and State/Territory are unknown you must assign the 9999 Postcode. Interstate visitors must have the postcode of their usual place of residence recorded. Overseas visitors must have their Country in the Suburb field and the postcode of 8888.

Do not submit Post Office box postcodes with residential addresses.

Related national definition

http://meteor.aihw.gov.au/content/index.phtml/itemId/611398

Australian State or Country of Birth

Field name:	rfc_cob_code
Source Data Element(s):	[Country of Birth] - EDIS, webPAS, Midland webPAS
Definition:	The Australian state or country in which a patient was born, as represented by a code.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(4)
Permitted values:	Refer to the Australian State or Country of Birth Code List

Guide for use

The collection of Australian State or Country of Birth is mandatory.

The country of birth code embodies an important concept in the study of disease patterns between different population groups in Australia.

It also allows health care authorities to monitor the health status of migrants and assists in the provision of health services for diverse population groups.

Rules

This data element is aligned with the Standard Australian Classification of Countries, 2016.

Only where all this information is not available, should the code (0003) Not Stated be entered.

'Australia' should only be used when the Australian state of birth is not known for Australian citizens.

If the patient is born overseas indicate country of birth, e.g. Italy, France, England, Scotland, or Wales.

If the patient is born in an Australian Territory other than the Australian Capital Territory or the Northern Territory (e.g. Christmas Island, Cocos (Keeling) Islands, please enter code (1199) Australian External Territories, etc.

If the patient is born on a ship or aircraft, indicate country of citizenship.

Examples

1. Person born in Western Australia or in Australia (not otherwise specified) the country of Birth Code entered as 1101.
2. Person born in Tokyo the country of Birth code entered as 6201.
3. Person born on Christmas Island the country of Birth code entered as 1199.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/659454

Bed Request Datetime

Field name:	bed_req_date_time
Source Data Element(s):	[Bed Request Datetime] - EDIS
Definition:	Date and time that an inpatient bed is requested for a patient.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The collection of the Bed request date and time is optional. It is expected for all patients who are admitted.

Claim Type

Field name:	claim_type
Source Data Element(s):	[Claim Type] - webPAS
Definition:	Field used to identify funding source.
Requirement status:	Mandatory
Data type:	String
Format:	AAA
Permitted values:	ADF Australian Defence BBD Bulk Billed COM Compensable Other EMV Other States MVIT FOD Foreign Defence OVS Overseas Student OVV Overseas Visitor PUB Public PVT Private Insured SHI Shipping UNI Private Uninsured UNK Unknown VET Veteran Affairs WAM WA MVIT WCC Workers Compensation

Guide for use

The collection of the claim type is mandatory in webPAS.

Refer to the webPAS System Supplementary Information Pack Claim Types – September 2014.

Clinical Comments

Field name:	clinical_comments
Source Data Element(s):	[Clinical Comments] - EDIS
Definition:	The description of a patient's clinical comments made by the clinician.
Requirement status:	Optional
Data type:	String
Format:	[X(2000)]
Permitted values:	N/A

Guide for use

The collection of Clinical Comments is optional.

Date of Birth

Field name:	date_of_birth
Source Data Element(s):	[Date of Birth] - EDIS, webPAS, Midland webPAS
Definition:	Date on which a patient was born.
Requirement status:	Mandatory
Data type:	Date
Format:	DD/MM/YYYY
Permitted values:	N/A

Guide for use

Date of Birth is used to derive the age of the patient for use in demographic analysis. It also assists in the unique identification of patients if other identifying information is missing or in question and may be required for the derivation of other metadata items.

Age is not to be sent on electronic files as it is a calculated field and that is performed by the EDDC.

It is important to be as accurate as possible when completing the birth date. It is recognised that some patients do not know the exact date of their birth. When the exact date of birth is unknown, please estimate the person's age and record the date of birth as appropriate.

Examples

1. If patient with an unknown date of birth presents in ED on July 2020:

   The estimated age is 78 years old, DATE OF BIRTH 01/07/1942

2. If patient with an unknown date of birth presents in ED on January 2021:

   The estimated age is 33 years old, DATE OF BIRTH 01/07/1987

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/287007

Department of Veteran Affairs Authorisation Date

Field name:	dva_auth_date
Source Data Element(s):	[Department of Veteran Affairs Authorisation Date] - EDIS, webPAS, Midland webPAS
Definition:	The Department of Veteran Affairs (DVA) authorisation date. This is the date at which hospital receives the authorisation of treatment eligibility from the DVA
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD
Permitted values:	N/A

Guide for use

Mandatory for DVA patients only. Only applies to treatment that are not listed on the Medicare Benefits Schedule and those occasionally nominated in writing by the DVA such as cosmetic surgery or in vitro fertilisation.

Department of Veteran Affairs Authorisation Number

Field name:	dva_auth_no
Source Data Element(s):	[Department of Veteran Affairs Authorisation Number] - EDIS, webPAS, Midland webPAS
Definition:	The Department of Veteran Affairs (DVA) authorisation number. This number confirms the patients eligibility for treatment to be funded by the DVA.
Requirement status:	Conditional
Data type:	String
Format:	[X(12)]
Permitted values:	N/A

Guide for use

Mandatory for DVA Patients only. Only applies to treatment that are not listed on the Medicare Benefits Schedule and those occasionally nominated in writing by the DVA such as cosmetic surgery or in vitro fertilisation.

Department of Veterans' Affairs Card Colour

Field name:	dva_card_colour
Source Data Element(s):	[Department of Veterans' Affairs Card Colour] - webPAS, Midland webPAS
Definition:	The Department of Veterans' Affairs (DVA) card colour indicates the level of entitlement to additional health cover.
Requirement status:	Conditional
Data type:	Numeric
Format:	[N]
Permitted values:	1 Gold 2 White

Guide for use

Mandatory for DVA patients only.

The DVA card colour must be recorded for those patients whose treatment is being funded by the DVA.

For all DVA patients, a DVA authorisation number and date must be obtained from the DVA for treatments that are not listed on the Medicare Benefits Schedule as well as those treatments occasionally nominated in writing by the DVA (such as cosmetic surgery or in vitro fertilisation).

Examples

1. A patient who is a veteran arrives at the Rockingham General Hospital ED. The level of cover he is entitled to as shown on his DVA card is Gold, select option 1 Gold.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/563420

Department of Veterans' Affairs File Number

Field name:	dva_file_number
Source Data Element(s):	[Department of Veterans' Affairs File Number] - EDIS, webPAS, Midland webPAS
Definition:	The Department of Veterans' Affairs (DVA) file number. Required to identify those patients entitled to DVA funding for their medical care at the point of service.
Requirement status:	Conditional
Data type:	String
Format:	[N(12)]
Permitted values:	N/A

Guide for use

Mandatory for DVA patients only.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/339127

Departure Ready Datetime

Field name:	departure_ready_datetime
Source Data Element(s):	[Departure Ready Datetime] – EDIS, webPAS, Midland webPAS
Definition:	The date and time when the patient is deemed ready for departure and/or discharge from the ED.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

This is mandatory for patients where an assessment is made and a patient is deemed ready for departure and/or discharge from the ED.

If a patient did not wait for treatment and/or assessment this field may be blank.

Examples

A patient is ready for departure on the 21st of May 2018 at 11:00am, enter 2018-05-21 11:00:00.

Departure Status

Field name:	departure_status
Source Data Element(s):	[Departure Status] - EDIS, webPAS, Midland webPAS
Definition:	The outcome of a patient's ED attendance. Also known as Episode End Status, Disposition or Emergency Discharge Status.
Requirement status:	Mandatory
Data type:	String
Format:	N[N(1)]
Permitted values:	1 Admitted to ward/other admitted patient unit 2 ED service event completed; departed under own care 3 Transferred to another hospital for admission 4 Did not wait to be attended by medical officer 5 Left at own risk 6 Died in ED 7 Dead on arrival, not treated in ED 8 Referred to After Hours General Practitioner 9 Unknown 10 Admitted to ED Observation Ward 11 Admitted to Hospital in the Home 12 Admitted from Hospital in the Home 13 Nursing Home 14 Returned to Hospital in the Home 15 Returned to Rehabilitation in the Home 16 Returned to Hospital at the Home 17 Transferred from Hospital in the Home 18 Transferred from Rehabilitation in the Home 19 Discharged after admission 20 Reversal

Guide for use

Departure Status is Mandatory. Further details about the permitted values and use are detailed below:

1. If the patient was admitted to ward or other patient unit.

2. If the patients service event is complete and the leaves ED under their own care.

3. If transfer to (an) other acute hospital – refers to patients separated to another acute care facility. This includes designated psychiatric units that are part of an acute hospital.

4. If the patient did not wait to be treated.

5. Left against medical advice/discharge at own risk – refers to patients separated against

medical advice, or without advising staff of their intentions (i.e. absconding).

6. Refers to patients separated due to their death while at ED.

7. If the patient was deceased when arrived at ED.

8. If the patient got referred from ED to an afterhours GP for treatment.

9. Unknown.

10. When the patient is admitted to ED observation ward as a result of triage.

11. Admitted to Hospital in the Home.

12. If the patient was admitted from the Hospital in the Home.

13. If the patient was transferred to a residential aged care service – refers to patients separated to a recognised Residential Aged Care Service (i.e. nursing home or aged care hostel), even if this is considered to be their current residential address.

14. Returned to Hospital in the Home.

15. Returned to Rehabilitation in the Home.

16. When the patient is returned to Hospital at the Home.

17. Transferred from Hospital in the Home.

18. Transferred from Rehabilitation in the Home.

19. Discharged after admission.

20. Reversal.

Examples

1. A patient who attended the King Edward Memorial Hospital ED is sent home after being treated by an ED doctor, select Option 19 Discharged after admission.
2. A patient who attended Albany Hospital ED is admitted as they require further medical care, select Option 1 Admitted to ward/other admitted patient unit.
3. A patient who attended Peel Health Campus ED decided that they did not want to wait be seen by medical staff after having been triaged (note, DNW is someone who did not get seen by a doctor at all, Left at Own Risk is someone who is seen by a doctor, but then they leave before the doctor assesses or admits them), select Option 4 Did not wait to be attended by medical officer.

Destination on Departure

Field name:	destination_on_departure
Source Data Element(s):	[Destination on Departure] - EDIS, webPAS, Midland webPAS
Definition:	Where the patient went after treatment.
Requirement status:	Mandatory
Data type:	String
Format:	N[N(1)]
Permitted values:	1 Did not wait 2 Left at own risk 3 Nursing Home/Hostel 4 Transferred 5 Mortuary 6 Admitted 7 Other hospital 8 Home 9 Unknown 10 Other 11 Admitted to ED Observation Ward 12 Mental Health/Psychiatric Facility

Guide for use

For EDIS, the element currently captures the ward that the patient goes to once a patient has been admitted. If a patient is being transferred, some EDIS sites will specify which hospital the patient is going to, some do not.

For webPAS hospitals, this field is only completed when a patient is transferred to another hospital. On transfer, the establishment code of the hospital will be populated in this field.

Discharge Datetime

Field name:	discharge_datetime
Source Data Element(s):	[Discharge Datetime] - EDIS, webPAS, Midland webPAS
Definition:	The Date and time that the patient is discharged from the ED.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The date that the patient is physically discharged from ED. Discharge date and time are mandatory.

If the patient is subsequently admitted to this hospital (including those who are admitted and subsequently die before leaving the emergency department), then record the date the patient's emergency department non-admitted clinical care is completed.

If the service episode is completed without the patient being admitted, then record the date the patient's emergency department non-admitted clinical care is completed.

If the service episode is completed and the patient is referred to another hospital for admission, then record the date the patient's emergency department non-admitted clinical care is completed.

If the patient did not wait, then record the date the patient leaves the emergency department or was first noticed as having left.

If the patient left at their own risk, then record the date the patient leaves the emergency department or was first noticed as having left.

If the patient died in the emergency department as a non-admitted patient, then record the date the patient was certified dead.

If the patient was dead on arrival, then record the date the patient was certified dead.

If the patient was registered, advised of another health-care service, and left the emergency department without being attended by a health-care professional, then record the date the patient leaves the emergency department.

Records that are missing a discharge date are excluded from National reporting and will not receive funding from the Commonwealth. It is therefore imperative that all records including patients that did not wait have a discharge date.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/684489

Doctor Seen Datetime

Field name:	doctor_seen_datetime
Source Data Element(s):	[Doctor Seen Datetime] - EDIS, webPAS, Midland webPAS
Definition:	The earliest time that the treating or senior doctor commenced treatment of the patient in the ED.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The Doctor Seen Datetime is derived as the earlier of Treating Doctor Seen Datetime and Senior Doctor Seen Datetime. This is the date and time that a doctor first saw the patient and commenced clinical care. It will be missing if the patient is not seen by a doctor.

Emergency Department Information System COVID-19 Flag

Field name:	emergency_department_information_system_Covid19_Flag
Source Data Element(s):	[Emergency Department Information System Covid19 Flag] - EDIS
Definition:	Flag that is used if a patient may be infected with COVID-19.
Requirement status:	Optional
Data type:	String
Format:	[N]
Permitted values:	0 False 1 True

Guide for use

The collection of EDIS COVID-19 Flag is optional.

The EDIS COVID-19 Flag has been implemented in the Triage Screen Check box since the COVID-19 outbreak from March 2020. It is used for local reporting to capture the patient is suspected to have COVID-19.

Employment status

Field name:	employment_status
Source Data Element(s):	[Employment status] - EDIS, webPAS, Midland webPAS
Definition:	The self-reported employment status of a patient at the time of the service event.
Requirement status:	Optional
Data type:	String
Format:	[N(10)]
Permitted values:	1 Child not at School 2 Student 3 Employed 4 Unemployed 5 Home Duties 6 Retired 7 Pensioner 8 Other 9 Unknown

Guide for use

The collection of Employment Status is optional.

Child not at School – refers to children attending kindergarten, playgroup, pre-primary and less than 4 years old or have their 5th birthday in the second half of the year (i.e. birth date is after 1 July).

Student – refers to children attending school or individuals with study commitments equivalent to 20 hours per week or more. If the study commitments are less than 20 hours per week and the individual does not fit into any other category, then record the Employment Status as '8-Other'.

Employed – refers to individuals who have full-time or part-time employment either as an employee, employer, self-employed or volunteer.

Unemployed – refers to individuals who are unemployed regardless of whether they are actively seeking employment or receiving unemployment benefits.

Home Duties – refers to individuals whose sole role is performing home duties (i.e. they do not have any other occupation).

Retired – refers to individuals who are retired from work but not receiving an aged pension (i.e. self-funded retiree).

Pensioner – refers to individuals who are retired from work and receiving an aged pension or a person who is unable to work and receives another type of pension (i.e. invalid pension).

Other – refers to individuals with a disability aged between 6 and 15 who are not attending school. Once the individual reaches 16 years of age, they must be entered as employed, unemployed or pensioner (invalid pensioner).

Examples

1. A 3 year old patient arrives at the Perth Children's Hospital ED, select Option 1 Child not at School.
2. A patient arrives at the ED. They are currently unemployed, select Option 3 Unemployed.
3. A patient arrives at the ED. They are retired, select Option 6 Retired.

Related national definition

http://meteor.aihw.gov.au/content/index.phtml/itemId/269955

Establishment Code

Field name:	est_code
Source Data Element(s):	[Establishment Code] - EDIS, webPAS, Midland webPAS
Definition:	A unique four-digit number that is assigned by Department of Health (WA) to hospitals and other health related locations or establishments.
Requirement status:	Mandatory
Data type:	Numeric
Format:	NNNN
Permitted values:	Refer to the Establishment Code List

Guide for use

The Establishment Code List contains hospitals or health services that must report their Emergency Department activity to the EDDC.

Rules

Each organisation must only have one establishment code assigned.

Examples

1. A patient attended the Royal Perth Hospital ED, select Establishment Code for 0101 Royal Perth Hospital.
2. A patient attended the Morawa Hospital ED, select Establishment Code for 0418 Morawa Hospital.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/493975

External Cause of Injury

Field name:	external_cause_of_injury
Source Data Element(s):	[External Cause of Injury] - EDIS
Definition:	Patient's injury major causal factor. The environmental event, circumstance or condition that caused the injury, as represented by a code.
Requirement status:	Optional
Data type:	String
Format:	N[N(1)]
Permitted values:	1 Transport Event 2 Pedestrian 3 Fall 4 Fall on Same Level 5 Fall < 1 Metre 6 Fall ≥ 1 Metre 7 Bite or Sting 8 Contact Burn 9 Blunt Force 10 Cut, Pierced or Stabbed 11 Shot by Weapon 12 Contact with Machinery 13 Contact with Fire or Flame 14 Drowning/ Near Drowning 15 Exposure or Poisoning by Chemicals 16 Other Cause 17 Electrocution 99 Unknown

Guide for use

The collection of external cause of injury code is optional.

Data is only collected from hospitals that use EDIS (all metropolitan public hospitals, Joondalup Health Campus, Peel Health Campus and Bunbury Health Campus).

Family Name

Field name:	Family_name
Source Data Element(s):	[Surname] - EDIS, webPAS, Midland webPAS
Definition:	The part of a name a person usually has in common with other members of their family, as distinguished from their given names.
Requirement status:	Mandatory
Data type:	String
Format:	X(50)
Permitted values:	N/A

Guide for use

The collection of Family Name is mandatory.

Alias or assumed names should not be included if the legal Family Name is known.

Do not use brackets ( ) for alias names in the Family Name.

Where hospitals have the facility to record an alias, this field must be used for alias names.

Where the Family Name is unknown or there is no Family Name, the name the person is identified by should be recorded in the Family Name field and the First Given Name field recorded as 'No Name Given'.

Numeric values are not permitted.

To minimise discrepancies in the recording and reporting of name information, establishments should ask the person for their 'Given name' (First Given Name) and 'Family name'. These may be different from the name that the person may prefer the establishment to use.

Examples

1. A patient presented to ED in a coma and her name was not known. Family Name = UNKNOWN
2. John Smith presented to ED, Family Name = SMITH
3. A patient is identified by a first given name of Anastasia and has no surname. Family Name = ANASTASIA

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/286953

Feeder System

Field name:	fsy_code
Source Data Element(s):	N/A
Definition:	Code identifying the information feeder system for data that is provided to the EDDC.
Requirement status:	Mandatory
Data type:	String
Format:	A
Permitted values:	T TOPAS E EDIS H HCARe P ePAS / Meditech W webPAS M Midland webPAS

Guide for use

This contains information feeder system code to identify source systems.

EDIS is used by Peel Health Campus (8/9/2020 onwards), Bunbury Hospital and all metropolitan hospitals excluding St John of God Midland Public Hospital (SJOGM). All rural hospitals except for Bunbury Hospital currently use webPAS and SJOGM uses a private version of webPAS, referred to as Midland webPAS.

From November 2012 until September 2017, rural hospitals progressively migrated from the Health Care and Related Information System (HCARe) to webPAS. HCARe is no longer used in the EDDC, however historical data was sourced from this system.

ED staff do not directly enter data into webPAS, however data which is not collected by EDIS (e.g. funding source, eligibility for Department of Veterans' Affairs funding, Medicare number) is extracted from webPAS and provided to the EDDC.

Feeder System Update Datetime

Field name:	Updatedate
Source Data Element(s):	N/A
Definition:	The date and time the record was last updated in the hospital system.
Requirement status:	Optional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The date and time the records were last updated in the hospital system. Currently this data is only received from the webPAS system at St John of God Midland.

First Given Name

Field name:	first_given_name
Source Data Element(s):	[First Forename] - EDIS, webPAS, Midland webPAS
Definition:	The first given name of the patient.
Requirement status:	Mandatory
Data type:	String
Format:	X(30)
Permitted values:	N/A

Guide for use

First Given Name is mandatory, except where person is only identified by a single name.

Some patients only have one name by which they are known. Record this name in the Family Name field and enter “No Name Given” in the First Given Name field.

When the First Given Name of a baby aged less than 29 days is unknown, ‘Baby’ is valid.

Babies of multiple births should be reported in the sequence of their birth (i.e. Baby One of Jane, Baby Two of Jane, etc).

If the First Given Name of a person over 28 days old is unknown, ‘Unknown’ is valid.

Alias names should be recorded in the Alias field in the hospital’s Central Patient Index (CPI) or Patient Master Index (PMI). The use of brackets () for alias names is not accepted.

Do not report any characters other than alphabetical letters in the First Given Name field (i.e. dots or commas).

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/453734

Funding Source

Field name:	compensable
Source Data Element(s):	[Payment Classification] - EDIS, webPAS, Midland webPAS
Definition:	Patient's principal funding or payment source for the service event.
Requirement status:	Mandatory
Data type:	String
Format:	N[N(1)]
Permitted values:	21 Australian Health Care Agreements 22 Private Health Insurance 23 Self-Funded 24 Workers Compensation 25 Motor Vehicle Third Party Personal Claim 26 Other Compensation 27 Department of Veterans' Affairs 28 Department of Defence 29 Correctional Facility 30 Reciprocal Health Care Agreements 31 Ineligible 32 Other 33 Ambulatory Surgery Initiative 34 Detainees 99 Not stated/inadequately described

Guide for use

The collection of Funding Source is Mandatory.

Not all of the above may be represented in the establishment's Patient Administration System.

Funding Source is independent of the patient's Insurance Status (i.e. a patient with private health insurance can have a Funding Source election of either public or private).

All qualified and unqualified newborns must have the same Funding Source as their mother.

Further details on permitted values are below:

Australian Health Care Agreements – refers to Medicare eligible patients who are ED patients, admitted public patients, presenting to a public hospital outpatient department for whom there is no third-party arrangement or public patients admitted to a private hospital funded by state or territory health authorities. This excludes inter-hospital contracted patients and overseas visitors who are covered by Reciprocal Health Care Agreements but elect to be treated as public admitted patients and Medicare eligible patients who choose not to register with Medicare and self-fund the admission episode.

Private Health Insurance – refers to patients who are eligible for treatment under the Australian Health Care Agreement but elect to receive hospital care under a private health insurance fund. This excludes overseas visitors for whom travel insurance is the major funding source.

Self-Funded – refers to patients who are eligible for treatment under the Australian Health Care Agreement but elect to be admitted as a private patient and undertake responsibility for paying all hospital charges during the admission episode.

Worker's Compensation – refers to patients injured at their place of work where their employer's workers compensation insurance will pay for hospital and medical charges incurred during the admission episode.

Motor Vehicle Third Party Personal Claim – refers to patients involved in a motor vehicle accident and whose personal injury claims for hospital and medical charges are covered by Motor Vehicle Third Party Insurance.

Other Compensation – refers to patients who are entitled to claim compensation under public liability, common law or medical negligence. Includes compensation from a sporting club / association or other party where the latter are responsible for payment of the admission episode. Foreign shipping company employees have their hospital and medical charges covered by the employing shipping company. Other Compensation excludes patients covered under Workers Compensation, Motor Vehicle Third Party Personal claims, Department of Defence, DVA or Travel Insurance claims.

DVA – refers to patients eligible for Veterans' Affairs beneficiary and whose hospital and medical charges are covered by the DVA. These include payment by DVA for public hospital treatment of DVA gold cardholders for all conditions or payment of public hospital treatment of DVA white cardholders for specific war/conflict related conditions.

Department of Defence – refers to patients who are a member of the Australian Defence Forces and injured at work. Patients who are also members of overseas defence forces should be coded to 31 – Ineligible, unless they are involved in joint armed forces exercises and are covered under a special health cover agreement with the Department of Defence.

Correctional Facility – refers to prisoners and other patients admitted to a hospital where the Department of Justice is responsible for the payment of the admission episode. These patients are treated as a public patient although the funding source is Correctional Facility. Illegal immigrants do not come under this funding source; they should be assigned to category 34 Detainee.

Reciprocal Health Care Agreement – Australia has Reciprocal Health Care Agreements (RHCA) with a number of countries. Please refer to Services Australia's Reciprocal Health Care Agreements for more information.

Other – refers to patients who do not satisfy the requirements of any other funding source.

Ambulatory Surgery Initiative – refers to patients who are admitted to the Ambulatory Surgery Initiative which has been undertaken at some public hospitals to cater for day surgery cases that can be done as ambulatory care.

Detainee – refers to patients who are deemed as ineligible immigrants detained in an Immigration Detention Centre. Please note this value is no longer used and is included for historical purposes only.

Ineligible – refers to patients who are not eligible for the Australian Health Care Agreement, patients from countries who do not have Reciprocal Health Care Agreements

with Australia (these patients may be covered by private travel insurance), Foreign Defence Force personnel (unless injured during a joint exercise), or any other ineligible patient not covered by a funding source listed above.

Related national definition

http://meteor.aihw.gov.au/content/index.phtml/itemId/679815

Examples

Example 1:

A patient is admitted with a work-related injury, where the company is responsible for payment.

Funding Source for Hospital Patient = 2 4 (Worker's Compensation)

Example 2:

A patient is admitted for treatment of an injury sustained in a motor vehicle accident, where the Insurance Commission of WA is responsible for payment.

Funding Source for Hospital Patient = 2 5 (Motor Vehicle Third Party Personal Claim)

Example 3:

A patient is admitted after falling and injuring her back in the local supermarket. She is making a public liability insurance claim.

Funding Source for Hospital Patient = 2 6 (Other Compensation)

Home Phone Number

Field name:	home_ph
Source Data Element(s):	[Home Phone Number] - EDIS, webPAS, Midland webPAS
Definition:	Patient's residential home phone number at the time of the ED presentation.
Requirement status:	Optional
Data type:	Numeric
Format:	N(12)
Permitted values:	N/A

Guide for use

The collection of Home Phone Number is Optional.

Human Intent of Injury

Field name:	human_intent_of_injury
Source Data Element(s):	N/A
Definition:	The injury intentionally inflicted by oneself, or was it unintentional, or was it as a result of an assault.
Requirement status:	Mandatory
Data type:	String
Format:	N
Permitted values:	1 Unintentional 2 Intentional Self-Harm 3 Alleged Assault 4 Alleged Legal or Military Action 5 Undetermined or Other 9 Unknown

Guide for use

Select the code which best represents the injury (on the basis of the information available at the time it is recorded).

This enables categorisation of injury and poisoning according to whether it was due to self-harm or was accidental.

Interpreter Required

Field name:	rfc_int_code
Source Data Element(s):	[Interpreter Required] - EDIS, webPAS, Midland webPAS
Definition:	Whether an interpreter service is required by or for the patient.
Requirement status:	Optional
Data type:	String
Format:	[N(1)]
Permitted values:	1 Interpreter required 2 Interpreter not required 9 Not specified/Unknown

Guide for use

Interpreter required may be missing as it is only recorded in the EDIS feeder information system.

An interpreter service may be required by the patient to be able to effectively communicate with ED staff. This includes any language, including sign language. This information is useful to establish the use of interpreter services resources in the health sector.

This data element must only have a value of "Interpreter required" if an official paid interpreter service is used. Family members or friends interpreting for the patient are not considered to be an interpreter service for the purposes of completing this data element.

If an interpreter service is required for a patient's relative because the patient is unable to communicate, this field must be completed as "Interpreter required" on the patient's record. This may apply to patients who are unconscious or newborn babies/small children whose relatives are not fluent in English and thus require an interpreter to communicate on the patient's behalf.

Examples

1. A patient presents to the ED for treatment of a urinary tract infection and does not speak English.
   - YES, an interpreter service is required.
2. A patient presents to xyz Hospital ED. Their primary language is not English but they are able to speak English.
   - NO, an interpreter service is not required.
3. An unconscious patient arrives at xyz ED accompanied by her partner who only speaks French.
   - YES, an interpreter service is required.

Related national definition

http://meteor.aihw.gov.au/content/index.phtml/itemId/304292

Major Diagnostic Block

Field name:	mdb_code
Source Data Element(s):	N/A
Definition:	Major diagnostic block as represented by a code. Not required for all hospitals.
Requirement status:	Conditional
Data type:	String
Format:	X(2)
Permitted values:	N/A

Guide for use

Mandatory for Peel Health Campus prior to migration to EDIS APAC 21 on 8 September 2020.

Major Diagnostic Category

Field name:	major_diagnostic_category
Source Data Element(s):	N/A
Definition:	Patient's Major Diagnostic Category (MDC) upon completion of the ED service event.
Requirement status:	Mandatory
Data type:	String
Format:	N[N(1)]
Permitted values:	1 Diseases and disorders of the nervous system 2 Diseases and disorders of the eye 3 Diseases and disorders of the ear, nose and throat 4 Diseases and disorders of the respiratory system 5 Diseases and disorders of the circulatory system 6 Diseases and disorders of the digestive system 7 Diseases and disorders of the hepatobiliary system and pancreas 8 Diseases and disorders of musculoskeletal system and connective tissue 9 Diseases and disorders of the skin, subcutaneous tissue and breast 10 Endocrine, nutritional and metabolic diseases and disorders 11 Diseases and disorders of the kidney and urinary tract 12 Diseases and disorders of the male reproductive system 13 Diseases and disorders of the female reproductive system 14 Pregnancy, childbirth and the puerperium 15 Newborns and other neonates with conditions originating in the perinatal period 16 Diseases and disorders of blood & blood forming organs & immunological disorders 17 Myeloproliferative diseases and disorders, and poorly differentiated neoplasms 18 Infectious and parasitic diseases 19 Mental diseases and disorders 20 Substance use and substance induced organic mental disorders 21 Injuries, poisonings and toxic effects of drugs 22 Burns 23 Factors influencing health status and other contacts with health services

	24	Ungrouped
	99	Unknown

Guide for use

This data element is not available for all EDDC records. Data are only collected at Peel Health Campus and HCare sites for historical reporting.

Marital Status

Field name:	marital_status
Source Data Element(s):	[Marital Status] - EDIS, webPAS, Midland webPAS
Definition:	The patient'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.
Requirement status:	Mandatory
Data type:	String
Format:	N
Permitted values:	1 Never Married 2 Widowed 3 Divorced 4 Separated 5 Married (registered and de facto) 6 Not stated / inadequately described

Guide for use

Marital status is mandatory.

Marital status is a core variable used in a wide range of social statistics. Its main purpose is to establish the living arrangements of individuals in general and is used to gauge the need for care of patients who live alone. This field must reflect the current marital status of the patient, including same sex couples. The category "5-Married" applies to registered unions and de facto relationships.

Where a patient's marital status has not been specified and the patient is a minor (16 years of age or less), assign "1-Never Married" as a default.

Examples

1. Marital Status = 5
   - A status of de-facto is assigned to ED.
   - A 17 year old pregnant woman in a de facto relationship presents to the King Edward Memorial Hospital ED to have her baby.

2. Marital Status = 1
   - Never married is assigned to the record.
   - A five-year-old child presents to the Perth Children's Hospital ED.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/291045

Medicare Card Number

Field name:	medicare_no
Source Data Element(s):	[Medicare Number] - EDIS, webPAS, Midland webPAS
Definition:	Identifying number that appears on a Medicare card.
Requirement status:	Conditional
Data type:	Numeric
Format:	N(10)
Permitted values:	N/A

Guide for use

Must be a valid current Medicare Number issued by Services Australia.

Must be entered for patients using a funding source of Australian Health Care Agreement.

Full Medicare Card details are used to define eligibility for specific services and not as a patient identifier.

As persons can be listed on more than one Medicare Card, the full Medicare number is not a unique identifier and should not be used for this purpose.

Examples

Child X appears on two different Medicare Cards held in the names of both their mother and father who are living apart. Each Medicare Card has a separate Medicare Card Number and thus the child will have two valid Medicare Numbers.

The card presented by the parent attending with the child is recorded for that attendance. NB: For this reason, it is good practice to request the physical sighting of the Medicare Card at each attendance.

Medicare Number = 6 0 1 3 0 0 0 0 0 0

Medicare Person Number = 2

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/270101

Methamphetamine Flag at Diagnosis

Field name:	Methd
Source Data Element(s):	[Methamphetamine Flag At Diagnosis] - EDIS
Definition:	Describes whether the doctor believed the patient may be under the influence of methamphetamine during diagnosis.
Requirement status:	Conditional
Data type:	String
Format:	X(5)
Permitted values:	1 Likely Yes 2 Likely No 3 Unsure

Guide for use

The collection of Methamphetamine Flag at Diagnosis is conditional.

Determination of Meth-Related ED Attendance at Clinical Diagnosis: If a patient presents to an ED with a pre-determined set of primary diagnoses, which may be indicative of being Meth affected, the "Meth-related" pop-up will be triggered once the matched presenting complaint is entered into the clinical screen.

The intent of this pop-up is to prompt the ED doctor (and/or specialist) to exercise judgement (if possible) to identify whether or not a patient is likely under the influence of Meth, or their ED attendance has resulted from taking Meth. If a patient has a known history of Meth use but is not under the influence of Meth in the current ED episode, the current ED episode must not be flagged as a Meth-related ED attendance at the time of clinical diagnosis.

Examples

The following are common scenarios that an ED doctor (and/or specialist) may encounter and the information presented is intended to serve as a guide to identify and record a Meth-related ED attendance at the time of clinical diagnosis in EDIS.

1. Patient presents to an ED with chest pain on breathing. The ED doctor enters the primary diagnosis code of R07.1 into the clinical screen. As R07.1 does not match the primary diagnosis codes in Table 1, the Meth-related pop-up at clinical diagnosis is not triggered. ED doctor does not suspect the ED attendance is Meth-related and no further action is required.
2. Patient presents to an ED accompanied by family members due to paranoid schizophrenia however ED doctor does not suspect the ED attendance is Meth-related. The ED doctor enters the primary diagnosis code of F20.0 into the clinical screen. As F20.0 matches the primary diagnosis codes in Table 1, the Meth-related pop-up at clinical diagnosis is triggered. The ED doctor completes the pop-up response indicating "Likely No".
3. Patient presents to an ED with chest pain on breathing and admits to having used Meth within the last two hours. The ED doctor enters the primary diagnosis code of R07.1 into the clinical screen. As R07.1 does not match the primary diagnosis

codes in Table 1, the Meth-related pop-up at clinical diagnosis is not triggered. To record the patient's ED attendance as Meth-related, the ED doctor will need to manually initiate the Meth-related pop-up (see Information on EDIS Methamphetamine Special Projects Manual Pop-Up) using the projects button on the triage screen. The ED doctor selects the correct project code of "METHM" before going through the manual Meth-related pop-up and completing the pop-up response indicating "Likely Yes".

4. Patient presents to an ED with a suspected drug overdose and information from a family member indicated they recently consumed Meth. The ED doctor enters the primary diagnosis code of T43.62 into the clinical screen. As T43.62 matches the primary diagnosis codes in Table 1, the Meth-related pop-up at clinical diagnosis is triggered. The ED doctor completes the Meth-related pop-up response at clinical diagnosis indicating "Likely Yes".

Table 1: Pre-determined ICD10-AM principal diagnosis code set that will trigger the "Meth-related" pop up

Primary Diagnosis
(F00-F09) Organic, including symptomatic, mental disorders
(F10-F19) Mental and behavioural disorders due to psychoactive substance use
(F20-F29) Schizophrenia, schizotypal and delusional disorders
(F30-F39) Mood [affective] disorders
(F40-F48) Neurotic, stress-related and somatoform disorders
(F60-F69) Disorders of adult personality and behaviour
(F90-F98) Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
(R40-R46) Symptoms and signs involving cognition, perception, emotional state and behaviour
(T36-T50) Poisoning by drugs, medicaments and biological substances
(T51-T65) Toxic effects of substances chiefly nonmedicinal as to source
(T80-T88) Complications of surgical and medical care, not elsewhere classified
(Z00-Z13) Persons encountering health services for examination and investigation
(Z40-Z54) Persons encountering health services for specific procedures and health care
(Z55-Z65) Persons with potential health hazards related to socioeconomic and psychosocial circumstances
(Z80-Z99) Persons with potential health hazards related to family and personal history and certain conditions influencing health status

Methamphetamine Flag at Triage

Field name:	Metht
Source Data Element(s):	[Methamphetamine Flag At Triage] - EDIS
Definition:	Describes whether the triage nurse believed the patient may be under the influence of methamphetamine.
Requirement status:	Conditional
Data type:	String
Format:	X(5)
Permitted values:	1 Likely Yes 2 Likely No 3 Unsure

Guide for use

The collection of Methamphetamine Flag at Triage is conditional.

Determination of Meth-Related ED Attendance at Triage: If a patient presents to an ED with a pre-determined set of presenting complaints, which may be indicative of being Meth affected, the "Meth-related" pop-up will be triggered once the matched presenting complaint is entered into the triage screen.

The intent of this pop-up is to prompt the triage nurse (and/or staff) to exercise judgement (if possible) to identify whether or not a patient is likely under the influence of Meth, or their ED attendance has resulted from taking Meth. If a patient has a known history of Meth use but is not under the influence of Meth in the current ED episode, the current ED episode must not be flagged as a Meth-related ED attendance at the time of triage assessment.

Examples

The following are common scenarios that a triage nurse (and/or staff) may encounter and the information presented is intended to serve as a guide to identify and record a Meth-related ED attendance at the time of triage assessment in EDIS.

1. Patient presents to an ED with chest pain. The triage nurse enters the presenting complaint code of BEA00 into the triage screen. As BEA00 does not match the presenting complaint codes in Table 1, the Meth-related pop-up at triage is not triggered. Triage nurse does not suspect the ED attendance is Meth-related and no further action is required.
2. Patient presents to an ED accompanied by family members due to excessive alcohol consumption however triage nurse does not suspect the ED attendance is Meth-related. The triage nurse enters the presenting complaint code of E0000 into the triage screen. As E0000 matches the presenting complaint codes in Table 1, the Meth-related pop-up at triage is triggered. The triage nurse completes the pop-up response indicating "Likely No".
3. Patient presents to an ED with chest pain and admits to having used Meth within the last two hours. The triage nurse enters the presenting complaint code of BEA00 into the triage screen. As BEA00 does not match the presenting complaint

codes in Table 1, the Meth-related pop-up at triage is not triggered. To record the patient's ED attendance as Meth-related, the triage nurse will need to manually initiate the Meth-related pop-up (see Information on EDIS Methamphetamine Special Projects Manual Pop-Up) using the projects button on the triage screen. The triage nurse selects the correct project code of "METHM" before going through the manual Meth-related pop-up and completing the pop-up response indicating "Likely Yes".

4. Patient presents to an ED with a suspected drug overdose and information from a family member indicated they recently consumed Meth. The triage nurse enters the presenting complaint code of EKB00 into the triage screen. As EKB00 matches the presenting complaint codes in Table 1, the Meth-related pop-up at triage is triggered. The triage nurse completes the Meth-related pop-up response at triage indicating "Likely Yes".

Table 1: Pre-determined presenting complaint code set that will trigger the "Meth-related" pop up

Code	Presenting Complaint Description
E0000	DRUG / ALCOHOL USE
EFA00	DRUG / ALCOHOL USE; ALCOHOL; INTOXICATION
EHBH4	DRUG / ALCOHOL USE; ALCOHOL; WITHDRAWAL; SELF HARM
EK000	DRUG / ALCOHOL USE; DRUG
EKA00	DRUG / ALCOHOL USE; DRUG; TOXICITY
EKB00	DRUG / ALCOHOL USE; DRUG; OVERDOSE
EKBA0	DRUG / ALCOHOL USE -> DRUG -> OVERDOSE -> ? & ALCOHOL
EKBAA	DRUG / ALCOHOL USE -> DRUG -> OVERDOSE -> ? & ALCOHOL -> ? ACCIDENTAL
EKBAB	DRUG / ALCOHOL USE; DRUG; OVERDOSE; & ALCOHOL; SELF HARM
EKBBB	DRUG / ALCOHOL USE; DRUG; OVERDOSE; BENZODIAZEPINE; SELF HARM
EKBD0	DRUG / ALCOHOL USE; DRUG; OVERDOSE; HEROIN
EKBDA	DRUG / ALCOHOL USE; DRUG; OVERDOSE; HEROIN; ACCIDENTAL
EKBF0	DRUG / ALCOHOL USE; DRUG; OVERDOSE; MULTIPLE DRUGS
EKBFA	DRUG / ALCOHOL USE -> DRUG -> OVERDOSE -> ? MULTIPLE DRUGS -> ? ACCIDENTAL
EKBFB	DRUG / ALCOHOL USE; DRUG; OVERDOSE; MULTIPLE DRUGS; SELF HARM
EKBGB	DRUG / ALCOHOL USE; DRUG; OVERDOSE; PARACETAMOL; SELF HARM
EKBH0	DRUG / ALCOHOL USE; DRUG; OVERDOSE; SINGLE DRUG
EKBH1	DRUG / ALCOHOL USE -> DRUG -> OVERDOSE -> ? SINGLE DRUG -> NON - PRESCRIPTION -> ? ACCIDENTAL
EKBH2	DRUG / ALCOHOL USE -> DRUG -> OVERDOSE -> ? SINGLE DRUG -> NON - PRESCRIPTION -> ? SELF HARM
EKBH4	DRUG / ALCOHOL USE; DRUG; OVERDOSE; SINGLE DRUG; SELF HARM
EKBHA	DRUG / ALCOHOL USE -> DRUG -> OVERDOSE -> ? SINGLE DRUG -> NON - PRESCRIPTION
KB000	NEUROLOGICAL; ALTERED CONSCIOUS STATE
R0000	POISON / CHEMICAL EXPOSURE

RD000	POISON / CHEMICAL EXPOSURE; POISON INGESTION
RDA00	POISON / CHEMICAL EXPOSURE; POISON INGESTION; ACCIDENTAL
RDB00	POISON / CHEMICAL EXPOSURE; POISON INGESTION; SELF HARM
RHA00	POISON / CHEMICAL EXPOSURE; OTHER; ACCIDENTAL
T0000	SOCIAL / BEHAVIOURAL
TD000	SOCIAL / BEHAVIOURAL; DELIBERATE SELF HARM
TG000	SOCIAL / BEHAVIOURAL -> HALLUCINATIONS
TGA00	SOCIAL / BEHAVIOURAL -> HALLUCINATIONS -> AUDITORY
TGB00	SOCIAL / BEHAVIOURAL -> HALLUCINATIONS -> VISUAL
TP000	SOCIAL / BEHAVIOURAL; SUICIDAL
TR000	SOCIAL / BEHAVIOURAL -> VIOLENT BEHAVIOUR
TW000	SOCIAL / BEHAVIOURAL; INAPPROPRIATE BEHAVIOUR
TX000	SOCIAL / BEHAVIOURAL -> VIOLENT / AGGRESSIVE BEHAVIOUR

Methamphetamine Manual Date

Field name:	methm2
Source Data Element(s):	[Methamphetamine Manual Date] - EDIS
Definition:	The date that the manual entry took place for the meth manual flag.
Requirement status:	Conditional
Data type:	String
Format:	X(20)
Permitted values:	N/A

Guide for use

The collection of Methamphetamine Manual Date is conditional. The date must be entered in the dd mmm yyyy format, e.g. 15 JUL 2017.

Methamphetamine Manual Flag

Field name:	methm1
Source Data Element(s):	[Methamphetamine Manual Flag] - EDIS
Definition:	If at any time during the ED episode, a clinician believed the patient may have been under the influence of methamphetamine.
Requirement status:	Conditional
Data type:	String
Format:	X(5)
Permitted values:	1 Likely Yes 2 Likely No 3 Unsure

Guide for use

The collection of Methamphetamine Manual Flag is conditional.

Determination of Meth-Related ED Attendance at any time during the ED episode: If a patient presents to an ED without a pre-determined set of presenting complaints and/or primary diagnoses, which may be indicative of being Meth affected, but suspected to be Meth-related, the "Meth-related" pop-up can be triggered manually at any time during the ED episode using the projects button.

The intent of this pop-up is to prompt the ED staff to exercise judgement (if possible) to identify whether or not a patient is likely under the influence of Meth, or their ED attendance has resulted from taking Meth. If a patient has a known history of Meth use but is not under the influence of Meth in the current ED episode, the current ED episode must not be flagged as a Meth-related ED attendance at any time during the ED episode.

Examples

The following are common scenarios that an ED staff may encounter, and the information presented is intended to serve as a guide to identify and record a Meth-related ED attendance at any time during the ED episode in EDIS.

1. Patient presents to an ED with chest pain and admits to having used Meth within the last two hours. The triage nurse enters the presenting complaint code of BEA00 into the triage screen. As BEA00 does not match the presenting complaint codes in Table 1 (see Methamphetamine Flag at Triage), the Meth-related pop-up at triage is not triggered. To record the patient's ED attendance as Meth-related, the triage nurse will need to manually initiate the Meth-related pop-up using the projects button on the triage screen. The triage nurse selects the correct project code of "METHM" before going through the manual Meth-related pop-up and completing the pop-up response indicating "Likely Yes".
2. Patient presents to an ED with chest pain on breathing and admits to having used Meth within the last two hours. The ED doctor enters the primary diagnosis code of R07.1 into the clinical screen. As R07.1 does not match the primary diagnosis codes in Table 1 (see Methamphetamine Flag at Diagnosis), the Meth-related pop-up at clinical diagnosis is not triggered. To record the patient's ED attendance as

Meth-related, the ED doctor will need to manually initiate the Meth-related pop-up using the projects button on the triage screen. The ED doctor selects the correct project code of “METHM” before going through the manual Meth-related pop-up and completing the pop-up response indicating “Likely Yes”.

Methamphetamine Manual Time

Field name:	methm3
Source Data Element(s):	[Methamphetamine Manual Time] - EDIS
Definition:	The time that the manual entry took place for the meth manual flag.
Requirement status:	Conditional
Data type:	String
Format:	X(20)
Permitted values:	N/A

Guide for use

The collection of Methamphetamine Manual Time is conditional. Enter the time in the hh:mm format.

Mode of Arrival

Field name:	mode_of_arrival
Source Data Element(s):	[Mode of Arrival] - EDIS, webPAS, Midland webPAS
Definition:	Patient's mode of arrival at the ED.
Requirement status:	Mandatory
Data type:	String
Format:	N[N(1)]
Permitted values:	1 Private transport 2 Public transport 3 Ambulance 4 Hospital transport 5 Police/Correctional Services 6 Helicopter rescue 7 Royal Flying Doctor Service 8 Other 9 Not Stated/Unknown 10 Taxi

Guide for use

This field provides information regarding how they arrived at the ED.

If a patient is transported by the Royal Flying Doctor Service to an airport and then taken to hospital by ambulance, the Royal Flying Doctor Service must be coded as it takes priority over other forms of transport.

Nurse Seen Datetime

Field name:	nurse_seen
Source Data Element(s):	[Nurse Seen Datetime] - EDIS, webPAS, Midland webPAS
Definition:	Date and time that the patient is seen by a nurse (other than at triage) in the ED.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The Nurse seen date and time will be missing if the patient was not seen by a nurse.

The date and time that the patient was seen by a nurse is different to the date and time that they were triaged by a nurse. The nurse seen datetime is the datetime that the patient is thoroughly examined by a nurse.

Occupation

Field name:	occupation
Source Data Element(s):	[Occupation] - EDIS, webPAS, Midland webPAS
Definition:	Patient's occupation, as represented by a code.
Requirement status:	Optional
Data type:	String
Format:	[N(5)]
Permitted values:	N/A

Guide for use

The collection of Occupation is optional.

Place Where Injury Occurred

Field name:	place_where_injury_occurred
Source Data Element(s):	[Place where injury occurred] - EDIS
Definition:	Where the patient physically was when the injury occurred.
Requirement status:	Optional
Data type:	String
Format:	[X(5)]
Permitted values:	N/A

Guide for use

The collection of Place where injury occurred is optional.

Presenting Complaint

Field name:	presenting_complaint
Source Data Element(s):	N/A
Definition:	Patient's primary symptom upon presentation to the ED. Also known as Presenting Problem. The clinical interpretation of the problem or concern that is the main reason for seeking health care from the ED.
Requirement status:	Mandatory
Data type:	String
Format:	XXXXX
Permitted values:	N/A

Guide for use

Different symptom codes are used at different hospitals PAS system.

Note that the EDIS symptom list is an amalgamation of symptom codes used across all EDIS hospitals in WA. Duplication of codes and/or descriptors may occur because:

- codes may have been made inactive;
- different sites may have created different codes for the same symptom descriptor; and
- different sites may use the same code for different descriptors.

Principal Diagnosis

Field name:	primary_diagnosis
Source Data Element(s):	[Primary Diagnosis] - EDIS, webPAS, Midland webPAS
Definition:	Principal Diagnosis is the diagnosis established after study to be chiefly responsible for occasioning an episode of care or an attendance at the health care establishment.
Requirement status:	Mandatory
Data type:	String
Format:	ANN{.N[N]}
Permitted values:	Refer to ED ICD-10-AM 11th Edition Principal Diagnosis Short List

Guide for use

The principal diagnosis must be assigned at the end of the ED episode.

When two or more conditions co-exist at the time of the presentation and are treated equally, the clinician must nominate which one is the principal diagnosis.

Rules

Prior to November 2012, all rural sites (except for Bunbury Hospital) used HCARe, which did not capture Principal Diagnosis, but used Major Diagnostic Category (MDC) instead.

From November 2012 until September 2017, rural sites migrated from HCARe to webPAS on a rolling basis and hence began recording information in the Principal Diagnosis field.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/699598

Principal Diagnosis System Code EDIS

Field name:	di_code
Source Data Element(s):	[Diagnosis] - EDIS
Definition:	Principal diagnosis information system identifier to designate ICD-10-AM version, as represented by a code.
Requirement status:	Mandatory
Data type:	String
Format:	X(8)
Permitted values:	N/A

Guide for use

The collection of Principal Diagnosis System Code EDIS is Mandatory and applies to records in EDIS.

Examples

A clinician has chosen a ‘Suicide Risk’ in the EDIS Diagnosis description list.

The Principal Diagnosis System code in EDIS is recorded as ‘D00429’, which mapped to the Principal Diagnosis ICD-10-AM code as ‘R45.81’.

Record Loaded Datetime

Field name:	date_loaded
Source Data Element(s):	N/A
Definition:	The date and time the record was loaded into the EDDC.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

This date/time is generated during the routine loading processes of webPAS and Meditech. New records will simply have this field populated on load, while updated records will replace the existing loaded date time with the new loaded datetime.

Record Status

Field name:	record_status
Source Data Element(s):	N/A
Definition:	Specifies whether a record in new, update or deleted, comes from feeder system. Not available in EDIS.
Requirement status:	Mandatory
Data type:	String
Format:	A
Permitted values:	N New U Update D Delete

Guide for use

The Record Status is used during the feeder system extract load process.

Referral Source

Field name:	referral_source
Source Data Element(s):	[Referral Source] - EDIS, webPAS, Midland webPAS
Definition:	The source (person or organisation) from which the person presenting at the emergency department was referred or transferred.
Requirement status:	Mandatory
Data type:	String
Format:	N[N(1)]
Permitted values:	1 Appointment 2 GP – Letter 3 GP – No letter 4 Self/relative 5 Clinic 6 Other hospital 7 Other 8 Health Direct 9 No GP access 10 Recalled medical staff 11 Unknown 12 Nursing Home 13 Hospital in the Home 14 Mental Health

Guide for use

The collection of Referral Source is Mandatory.

Referred to on Departure

Field name:	referred_to_on_departure
Source Data Element(s):	[Referred to on Departure] - EDIS, webPAS, Midland webPAS
Definition:	Patient referral upon leaving the Emergency Department.
Requirement status:	Mandatory
Data type:	String
Format:	N[N(1)]
Permitted values:	1 Transferred to Tertiary Hospital 2 Transferred to non Tertiary Hospital 3 Other 4 Transferred to Nursing Home 9 Unknown

Guide for use

The collection of Referred to on Departure is Mandatory.

Residential Address

Field name:	base_address
Source Data Element(s):	[Base Address] - EDIS, webPAS, Midland webPAS
Definition:	The house number, street name and street type of the patient's place of usual residence.
Requirement status:	Mandatory
Data type:	String
Format:	X(50)
Permitted values:	N/A

Guide for use

The patient's home address at the time of their presentation to the ED cannot be missing. The house number, street name and street type must be on the first of two address lines to be sent. Suburb is to be recorded separately.

Non-residential addresses for accounts or billing purposes (e.g. PO Boxes) are not acceptable as residential addresses. Every effort must be made to collect the patient's actual residential address. Under Activity Based Funding arrangements, the patient's physical address may play an important role in funding calculations.

If the patient is an overseas visitor, their permanent residential address overseas must be recorded, not their local temporary address. The country of residence must be entered into the suburb line for overseas residential addresses. In these cases, suburbs are not required. Please note overseas residential addresses must have the postcode of 8888.

If the patient is homeless or does not have a fixed permanent address, 'NFPA' – No Fixed Permanent Address must be entered.

If a patient does not know their address or refuses to provide an address then 'UNKNOWN' must be entered into the base address.

If a patient is a current inmate of a prison, the base address must contain the name of the correctional facility.

Patients whose usual place of residence is a Residential Aged Care Service (e.g. nursing home or aged care hostel) must have the nursing home or hostel's address as their residential address.

Rules

Where 'no fixed address' has been entered in line one of the address and the suburb has been entered as 'unknown' then postcode 6999 representing WA must be used.

Residential Address 2

Field name:	base_address2
Source Data Element(s):	[Base Address 2] - EDIS, webPAS, Midland webPAS
Definition:	The second line of the house number, street name and street type of the patient's place of usual residence (if required).
Requirement status:	Optional
Data type:	String
Format:	[X(50)]
Permitted values:	N/A

Guide for use

The collection of the second line of the address is optional. Please refer to the Residential Address for the guide for use.

Second Given Name

Field name:	second_given_name
Source Data Element(s):	[Second Forename] - EDIS, webPAS, Midland webPAS
Definition:	The second given name of the patient.
Requirement status:	Optional
Data type:	String
Format:	[X(30)]
Permitted values:	N/A

Guide for use

The collection of Second Given Name is optional.

Alias names should be recorded in the Alias field in the hospital's CPI or PMI. The use of brackets () for alias names is not accepted.

Examples

1. Than Phoon, who is also known as Tony, was presented to ED. Do not enter Tony as the First Given Name. If your computer system has a function or field for storing the alias name (e.g. webPAS) use the latter.

   First Given Name = THAN

   Second Given Name = TONY

2. Edwin James Roberts was presented to ED.

   First Given Name = EDWIN

   Second Given Name = JAMES

3. Christine Jones was presented to ED.

   First Given Name = CHRISTINE

   Second Given Name = *[blank]*

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/453734

Senior Doctor Seen Datetime

Field name:	snr_doc_date
Source Data Element(s):	[Senior Doctor Seen Datetime] - EDIS, webPAS, Midland webPAS
Definition:	Date/Time when a patient is seen by a senior doctor.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The collection of Senior Doctor Seen Datetime is conditional.

A nurse practitioner can commence treatment of the patient and record the datetime in this Senior Doctor Seen Datetime. The Senior Doctor Type for a nurse practitioner must select "ZZ_Clinical_Care"

This field is used in the calculation of Doctor Seen Datetime.

Senior Doctor Type

Field name:	snr_doc_type
Source Data Element(s):	[Senior Doctor Type] - EDIS, webPAS, Midland webPAS
Definition:	Specifies the type of doctor that commenced treatment of the patient.
Requirement status:	Optional
Data type:	String
Format:	[X(5)]
Permitted values:	ADM Admitting Doctor ADMDR Admitting Doctor CN Charge Nurse CONS Consultant EDADM Doctor (only ED physicians have admitting rights to SSJ) EDCON Consultant EDJMO ED Junior Medical Officer EDMO ED Medical Officer EDREG ED Registrar EDSMO ED Senior Medical Officer EDSNR ED Senior Registrar INT Intern OTHER Other REG Registrar SREG Senior Registrar Unknown Unknown ZZCCC ZZ Clinical Care Commence

Guide for use

Specifies the type of doctor that commenced treatment of the patient.

A nurse practitioner must select "ZZ_Clinical_Care".

Sequence Number

Field name:	sequ
Source Data Element(s):	[Sequence Number] - EDIS, webPAS, Midland webPAS
Definition:	The unique record identifier when combined with the Establishment Code.
Requirement status:	Mandatory
Data type:	Numeric
Format:	N(10)
Permitted values:	N/A

Guide for use

The sequence number, when used in conjunction with the establishment code, is the primary key (main identifier) for records in EDDC. The establishment number and sequence number combination must be unique within the collection.

For hospitals that are on EDIS, the sequence number is generated and assigned to records by EDIS.

For hospitals not on EDIS, the sequence number is generated and assigned to records by the DoH.

Sex

Field name:	sex
Source Data Element(s):	[Sex] - EDIS, webPAS, Midland webPAS
Definition:	The distinction between male, female, and others who do not have biological characteristics typically associated with either the male or female sex, as represented by a code.
Requirement status:	Mandatory
Data type:	String
Format:	N
Permitted values:	1 Male 2 Female 3 Other 9 Not stated/Inadequately described

Guide for use

Gender cannot be missing.

The term “sex” refers to the biological differences between males and females, while the term gender refers to the socially expected/perceived dimensions of behaviour associated with males and females that are masculinity and femininity. The National Health Data Dictionary advises that the correct terminology for this data element is sex.

There are three categories for this data element — male, female and other. The latter category must only be used for neonates whose sex cannot be determined at birth. This includes babies diagnosed with gynandrous, hermaphroditism, ovotestis, pseudo hermaphroditism (male) (female) and pure gonadal dysgenesis. These persons may have either male and female sex organs or structural aberrations of the sex chromosomes.

Information collected about people who are transgender or gender diverse must be treated in the same manner. To avoid problems with edits, people undergoing a sex change operation must have their current (biological) sex at time of the ED presentation recorded as the sex of the episode of care.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/635126

Short Stay Unit Admission Datetime

Field name:	short_stay_unit_admission_date
Source Data Element(s):	[Short Stay Unit Admission Datetime] - EDIS, webPAS, Midland webPAS
Definition:	Date/time when the patient is admitted to a legitimate Short stay unit.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

This field is mandatory for Short Stay Unit (SSU) admission only.

The date and time the patient is discharged from the Emergency Department and admitted in to the SSU. Not all hospitals have the SSU and not all patients are admitted to the SSU.

Short Stay Unit Departure Status

Field name:	short_stay_unit_departure_status
Source Data Element(s):	[Short Stay Unit Departure Status] - EDIS, webPAS, Midland webPAS
Definition:	The outcome of the patient on leaving the short stay unit.
Requirement status:	Conditional
Data type:	String
Format:	N[N(1)]
Permitted values:	Under Development

Guide for use

Mandatory for SSU admissions only.

Short Stay Unit Destination on Departure

Field name:	short_stay_unit_destination_on_departure
Source Data Element(s):	[Short Stay Unit Destination on Departure] - EDIS, webPAS, Midland webPAS
Definition:	Patient's destination on departure from a legitimate short stay unit, as represented by a code. Will be blank for all other patients.
Requirement status:	Conditional
Data type:	String
Format:	N[N(1)]
Permitted values:	Under Development

Guide for use

Mandatory for SSU admission only.

Short Stay Unit Discharge Datetime

Field name:	short_stay_unit_discharge
Source Data Element(s):	[Short Stay Unit Discharge Datetime] - EDIS, webPAS, Midland webPAS
Definition:	The date/time when the patient is discharged from a legitimate short stay unit. Will be blank for all other patients.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

Mandatory for SSU admission only.

Stream

Field name:	stream
Source Data Element(s):	[Stream] - webPAS
Definition:	Pathway for patient care (includes COVID-19 pathway).
Requirement status:	Optional
Data type:	String
Format:	[X(30)]
Permitted values:	N/A

Guide for use

The collection of Stream is optional, which includes COVID-19 pathway.

Suburb

Field name:	suburb
Source Data Element(s):	[Suburb] - EDIS, webPAS, Midland webPAS
Definition:	The name of the locality/suburb of the address, as represented by text.
Requirement status:	Mandatory
Data type:	String
Format:	X(30)
Permitted values:	N/A

Guide for use

The collection of Suburb is mandatory.

Patients with no fixed permanent address = these patients must have NFPA recorded as their residential suburb.

Unknown residential address = these patients must have 'unknown' recorded as their residential suburb.

Prisoners = these patients must have the prison suburb recorded as their residential suburb.

Residential Aged Care Patients = these patients must have the nursing home or hostel's suburb recorded as their residential suburb.

Examples

1. A patient's address is 188 Fourth Avenue, Mount Lawley, WA 6050

- The Suburb is entered: Mount Lawley

2. A homeless patient with no fixed address presented to ED

- The Suburb is entered: NFPA

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/429889

Third Given Name

Field name:	third_given_name
Source Data Element(s):	[Third Forename] - EDIS, webPAS, Midland webPAS
Definition:	The person's third identifying name within the family group or by which the person is socially identified, as represented by text.
Requirement status:	Optional
Data type:	String
Format:	[X(30)]
Permitted values:	N/A

Guide for use

The collection of Third Given Name is optional.

Treating Doctor Seen Datetime

Field name:	treat_doc_date
Source Data Element(s):	[Treating Doctor Seen Datetime] - EDIS, webPAS, Midland webPAS
Definition:	Date/Time when a doctor commences treatment of the patient.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The collection of Treating Doctor Seen Datetime is Conditional.

A nurse practitioner can commence treatment of the patient and record the datetime in this Treating Doctor Seen Datetime. The Treating Doctor Type for a nurse practitioner must select "ZZ_Clinical_Care"

This field is used in the calculation of Doctor Seen Datetime.

Treating Doctor Type

Field name:	trt_doc_type
Source Data Element(s):	[Treating Doctor Type] - EDIS, webPAS, Midland webPAS
Definition:	Specifies the type of doctor that commenced treatment of the patient.
Requirement status:	Optional
Data type:	String
Format:	[X(5)]
Permitted values:	CLK Clerk CN Clinical Nurse CNS Clinical Nurse Specialist EDADM Admitting Doctor ED Observation EDCON ED Consultant EDJMO ED Junior Medical Officer EDMO Medical Officer EDREG ED Registrar EDSMO Senior Medical Officer EDSNR ED Senior Registrar EN Enrolled Nurse LCLK Liaison Clerk MHP Mental Health Practitioner NP Nurse Practitioner NUM Nurse Manager OTHER Other PLN Psychiatric Liaison Nurse RN Registered Nurse SDN Staff Development Nurse ZZCCC ZZ Clinical Care Commence

Guide for use

Specifies the type of doctor that commenced treatment of the patient.

A nurse practitioner must select "ZZ_Clinical_Care".

Triage Category

Field name:	triage_category
Source Data Element(s):	[Triage Category] - EDIS, webPAS, Midland webPAS
Definition:	The urgency of the patient's need for medical and nursing care, as represented by a code.
Requirement status:	Mandatory
Data type:	String
Format:	N(5)
Permitted values:	1 Resuscitation: immediate (within seconds) 2 Emergency: within 10 minutes 3 Urgent: within 30 minutes 4 Semi-urgent: within 60 minutes 5 Non-urgent: within 120 minutes 6 Dead on arrival 7 Direct Admission 8 Inpatient

Guide for use

The collection of Triage category is Mandatory.

A patient must be seen (assessed or treated) and 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). 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 and a second triage assessment was conducted to reflect a different triage category.

Examples

Patients who are referred to After Hours GP Clinic and received assessment ED clinicians are to be recorded as follows:

- Triage must be entered as '5 Non-urgent'
- Departure status entered as '8 Referred to After Hours GP'; and
- The patient must be clerically registered in the PAS where possible.

Dead on Arrival

Patients who are dead on arrival and receive assessment from ED clinicians are to be recorded as follows:

- Triage must be entered as '6 Dead on arrival'
- Departure status entered as '7 Dead on arrival, not treated in ED'; and
- Visit type is entered as '10 Dead on arrival'.

If patient is Dead on arrival does not receive an assessment by an ED clinician, they are not be recorded in the ED system.

Direct Admission

Direct admission patients who require some service from ED Clinicians are to be recorded. In capturing the data:

- Triage must be entered as '7 Direct admission'
- Departure status entered as '1 admitted to ward/other admitted patient unit'; and
- Visit Type entered as '16 Direct Admission'

Direct Admissions are not normally recorded in the ED.

Inpatient

If an admitted patient attends the ED for a procedure, such as having an intravenous cannula re-sited, and this activity is captured in the ED electronic system the following data must be entered

- Triage must be entered as '8Inpatient'
- Departure status as '14 Returned to Hospital in the Home'; and
- Visit type entered as '23 Inpatient' or '19 Hospital in the Home'

This approach will enable the patient to be identified as being a current inpatient and the activity can be removed from mainstream ED reporting.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/684872

Triage Datetime

Field name:	triage_datetime
Source Data Element(s):	[Triage Datetime] - EDIS, webPAS, Midland webPAS
Definition:	The date and time that the patient was triaged in the Emergency Department.
Requirement status:	Mandatory
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The collection of Triage Datetime is Mandatory.

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/684890

Type of Activity When Injury Occurred

Field name:	type_of_activity_when_injury_occurred
Source Data Element(s):	N/A
Definition:	What the patient was doing when the injury occurred.
Requirement status:	Optional
Data type:	String
Format:	[X(5)]
Permitted values:	N/A

Guide for use

The collection of Type of Activity when injury occurred is optional.

Unit Medical Record Number (UMRN)

Field name:	client_identifier
Source Data Element(s):	[Patient Identifier] - EDIS, webPAS, Midland webPAS
Definition:	Unit Medical Record Number, also referred to as Unique Medical Record Number. The same unique identifier is retained by the hospital for the patient for all events within that particular hospital.
Requirement status:	Mandatory
Data type:	String
Format:	X(10)
Permitted values:	N/A

Guide for use

The collection of Unit Medical Record Number (NMRN) is mandatory. Alternate names for the UMRN include unique patient identifier or client identifier.

The same unique identifier is retained by the hospital for the patient for all events within that particular hospital.

Examples

UMRN = L2309999

Related national definition

https://meteor.aihw.gov.au/content/index.phtml/itemId/290046

Visit Type

Field name:	visit_type
Source Data Element(s):	[Visit Type] - EDIS, webPAS, Midland webPAS
Definition:	Patient's reason for attending the ED
Requirement status:	Mandatory
Data type:	String
Format:	N(5)
Permitted values:	1 Emergency Presentation 2 Return Visit - Planned 3 Unplanned Return visit 4 Outpatient/Outpatient Clinic 5 Privately Referred: Non Admitted Patient 6 Prearranged Admission: Clerical Only 7 Pre-Arranged Admission: Nursing and Clerical 8 Pre-Arranged Admission: Full Clinical 9 Patient In Transit 10 Dead On Arrival 11 Health Direct Referral 12 GP Referral 13 Referral from Another Hospital 14 Referral from another facility 15 Transfer from other hospital 16 Direct Admission 17 No access to GP 18 Not Stated/Unknown 19 Hospital in the Home 20 Rehabilitation in the Home 21 Hospital at the Home 22 Other 23 Inpatient 24 For After Hours GP Referral 25 Returned from After Hours GP

Guide for use

The collection of Visit Type is Mandatory.

Ward Ready Datetime

Field name:	ward_ready_date
Source Data Element(s):	[Ward ready datetime] - EDIS
Definition:	The date and time the ward is ready for the patient to be admitted.
Requirement status:	Conditional
Data type:	Datetime
Format:	YYYY-MM-DD HH:MM:SS
Permitted values:	N/A

Guide for use

The collection of Ward Ready Datetime is Mandatory for patients who are admitted.

Work Phone Number

Field name:	work_ph
Source Data Element(s):	[Work Phone Number] - EDIS, webPAS, Midland webPAS
Definition:	Patient's work phone number at the time of the ED presentation.
Requirement status:	Optional
Data type:	Numeric
Format:	[N(12)]
Permitted values:	N/A

Guide for use

The collection of Work Phone Number is optional.

Appendix A – Summary of revisions

Version	Date Released	Author	Approval	Amendment
1.0	1 July 2021	Luisa Chou	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document created.

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