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

Emergency Department Patient Activity Data

Business Rules

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Contact:	Information and Performance Governance
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Contents

Abbreviations

ABF	Activity Based Funding
AECC	Australian Emergency Care Classification
ATS	Australasian Triage Score
ED	Emergency Department
EDDC	Emergency Department Data Collection
EDIS	Emergency Department Information System
HITH	Hospital In The Home
ID	Identifier
IHPA	Independent Hospital Pricing Authority
MRN	Medical Record Number
PAS	Patient Administration System
SJA	St John Ambulance
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* 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 the *MP 0164/21* *Patient Activity Data Policy*.

These 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 in dedicated specialist multidisciplinary units that are purposely designed and equipped to provide 24 hour emergency care. 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.

Business rules ensure that the collection of ED activity is standardised across the WA health system and that Health Service Providers and Contracted Health Entities 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.

These Business Rules are revised annually, with reference to national policy and legislation, to ensure relevance and currency. Revisions are made following extensive consultation with stakeholders.

3. Contact details

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

4. Scope

The emergency department services provided in all public hospitals and Contracted Health Entities are in scope for the *Emergency Department Patient Activity Data Business Rules*.

All data relating to activity in designated EDs are in scope including for patients who are subsequently or currently admitted and attend the ED.

Patients who were dead on arrival are in scope if an ED clinician certified the death of the patient. Patients who present to ED and leave after being triaged and advised of alternative treatment options at another health service/urgent care facility are in scope. The scope includes only physical presentations to EDs. Advice provided by telephone or videoconferencing is not in scope, although it is recognised that advice received by telehealth may form part of the care provided to patients physically receiving care in the emergency department.

For the purposes of these Business Rules, Patient Administration System (PAS) for WA hospital emergency departments refers to Emergency Department Information System (EDIS), ED webPAS and Midland webPAS.

5. Definitions

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

5.1 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.

5.2 Emergency patient

An emergency patient is defined as a patient who receives treatment in a designated ED. This type of care is usually unplanned, in that the illness or injury was sudden and the services were unplanned.

5.3 Emergency presentation

An emergency presentation occurs where a patient has presented to the ED but does not receive treatment within the ED and is not recorded as an ED attendance. For example, a patient presents for a direct planned admission.

5.4 Emergency attendance

An emergency attendance occurs where a patient attends a designated ED and meets all of the following criteria:

- is assigned a triage category based upon the presenting complaint/condition
- is registered in the approved PAS and has a Unit Medical Record Number (UMRN)/client identifier/Unique Record Number (URN)/medical record number (MRN) or Patient ID
- receives treatment and is subsequently discharged.

A patient being treated in a designated ED may subsequently undergo a formal admission process.

5.5 Emergency department episode of care

An ED episode of care is defined as the period between when a patient presents at the ED, and when that person is recorded as having physically departed the ED.

5.6 Emergency department activity

ED 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 clerically registered in the approved PAS
- treatment provided by a medical practitioner or other authorised clinician
- at least one discharge diagnosis must also be recorded for this activity.

For detail on data elements required for recording ED activity, refer to the *Emergency Department Data Collection Data Specifications*.

6. ED Episode of care

6.1 Identification and registration

When a patient attends a designated ED for treatment, the patient must be correctly identified and registered in EDIS and/or webPAS.

When patient identification cannot be obtained due to the patient's presenting state or condition (e.g. 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
- allocate a patient identifier: UMRN
- enter 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 can 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.

6.2 Arrival date and time / Triage date and time

The arrival date and time must reflect the date and time that the patient first presents to the ED. For patients that arrive via St John Ambulance (SJA WA), this time is recorded and documented where applicable, as the time the patient enters the ED or when the Triage and/or ED clinician first receives the patient.

The triage date and time must 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 date and time updated to reflect this.

6.3 Triage

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

Table 1: Australasian Triage Scale Description[1]

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 so that the activity can be included or excluded from emergency activity reporting, depending on requirements.

Table 2: Australasian Triage Scale Optional Codes for WA

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

6.4 Arrival mode

The arrival mode to the ED must be recorded in EDIS and/orwebPAS. If the patient arrives at the ED via ambulance, the ambulance handover and case number details are also required to be recorded.

6.4.1 Ambulance Case number

An ambulance case number is a unique identifier issued by SJA WA for each transport. This number must be recorded as soon as possible when patients arrive and are triaged.

6.5 Visit type

6.5.1 Planned / Unplanned re-presentations

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

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

to be recommenced:

- If a patient returns to the same ED after receiving part of their care outside of the ED, the preceding attendance 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 attendance had been temporarily interrupted (on leave) the patient must not have two ED attendances recorded as it is a continuation of care.
- If a patient is assumed to have left at their own risk and re-presents within 24 hours, for example, left temporarily without advising staff, the preceding attendance must be recommenced and continued.
- If a patient is discharged home from the ED or to a Short Stay Unit, and then subsequently re-presents to the ED, a new attendance must be recorded in this circumstance.

6.5.2 Planned re-attendance

A planned re-attendance is a planned return to the ED following a previous ED attendance. This re-attendance 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. A new attendance for the planned return must be recorded in this circumstance.

6.6 Presenting complaint / diagnosis

A presenting complaint/diagnosis must be recorded in EDIS and/or webPAS. Observations related to the presenting complaint/diagnosis must be recorded and documented in the medical record.

6.7 Commencement of clinical care

Treatment in the ED is deemed to commence at the time that a medical practitioner (earliest of doctor/nurse for regional and doctor 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 the EDIS and/or webPAS 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.

7. 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 and documented in the medical record.

Examples:

- a patient is admitted to an inpatient ward/unit, or to a short stay unit 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.

7.1 Did not wait

If a patient is triaged and registered but leaves the ED without being clinically treated, it must be recorded that they did not wait. For example, a triaged and registered patient leaves due to long wait times or to attend another health service/urgent care facility.

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. In this circumstance, every endeavor must be made to ensure the patient has in fact left the ED before being recorded as 'Did Not Wait'.

In this circumstance, the patient must not be given a commencement of clinical care date and time as they did not wait to receive treatment.

A diagnosis code (Z53.9 Procedure not carried out, unspecified reason) must also be recorded for any patient who did not wait to be treated.

7.2 Left at own risk

If a patient chooses to leave the hospital after assessment and/or treatment before the completion of treatment and/or against the advice of the treating medical practitioner, it must be recorded in the EDIS and/or webPAS and documented in the medical record that they 'left at own risk'.

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 as the discharge date and time.

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. If the patient is located and returns to resume their care, a new ED attendance must not be recorded, and the patient is to continue their current episode of care.

7.3 Transfer to another health service

If a patient is transferred to another hospital/health service, the ED departure status and time must be recorded as 'transferred to another hospital' and the time the patient was transferred.

Patients who are admitted from ED but are then transferred to another hospital/health service must also have the ED departure status recorded as 'transferred to another hospital'. The departure status of 'admitted' can only be applied to ED patients who complete their care within the same hospital.

The destination health service must be recorded with a valid establishment code from the Establishment Code List.

7.4 Deceased in ED

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

- the death must be recorded in the 'departure status'
- the time of death must be recorded as the patient's 'departure time'
- if the patient is pronounced 'dead on arrival' to the ED and no treatment or care was provided, an ED presentation (not attendance) must be recorded only. An administrative triage category must be recorded for 'dead on arrival'.

7.5 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 short stay unit, inpatient ward or operating theatre/procedure room at the same hospital.

The decision to admit the patient and time must be documented in the patient's medical record by a medical practitioner.

7.5.1 ED short stay admissions

An ED SSU may also be known as Clinical Decision Unit, Emergency Observation Unit, Mental Health Observation Unit or Urgent Care Clinic. An SSU is a designated inpatient unit with all of the following characteristics[2]:

- are designated for the short-term treatment, observation, assessment and reassessment of patients initially seen (assessed and triaged) 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*

[2] National Health Information Standard - ED SSU

Rules.

If an ED patient is relocated to, but not admitted to a 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
- 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 latter.

Activity for patients admitted directly to the SSU from Triage or another source, without receiving 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 attendance 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.
- 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 PAS. Where the functionality is available this is to be automatically populated from the PAS and not manually overwritten or disabled.

7.5.2 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 PAS.

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. For further information, refer to the virtual ward section 7.3 of the *Admitted Patient Activity Data Business Rules*.

8. Classification of ED activity

ED activity is classified using the following classification systems.

8.1 Urgency related groups and urgency disposition groups

In public hospitals within Australia emergency activity must be classified to reflect urgency related groups (URGs) for ED Activity and urgency disposition groups (UDGs) for emergency services. Several factors influence the classification of emergency care activity with patient activity grouped into categories which reflect:

- the type of visit of the patient attendance (i.e. whether it is an emergency presentation, planned return visit or current inpatient)
- what happens to the patient once the ED attendance is finished (for example the patient may be admitted to hospital; be discharged or transferred to another hospital; or may choose to leave before treatment is completed)
- how urgently the patient needs to receive treatment (based on the triage category given to the patient upon initial assessment)
- the diagnosis given for the patients' episode of care, represented by a major diagnostic block.

URG and UDG classification codes are maintained by IHPA and available on their website: Urgency Related Groups and Urgency Disposition Groups.

8.2 Australian emergency care classification

The URG classification system will be replaced by the Australian Emergency Care Classification (AECC) Version 1.0 in 2021-2022. From July 2021 onwards, emergency care activity must be classified according to the AECC which has three hierarchical levels that represent how the classification sorts the ED activity into different end classes. 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.

Further information on the AECC is available from the IHPA website: Australian Emergency Care Classification.

9. Documentation

All ED attendances must be supported by documentation and a record of treatment and/or care in the medical record that includes:

- administrative documentation (for example registration on EDIS and/or webPAS)
- documentation in the medical record by a medical practitioner or 12uthorized clinician to evidence the provision of care including:
    - Assessment and treatment plan (including dates and times)
        - the reason for presentation
        - the intended clinical treatment plan for admitted activity
        - contributing factors/exceptional patient circumstances
        - conditions identified
        - conditions treated, and care provided
        - principal/discharge diagnosis
    - decision to admit (including date and time)
    - departure from ED (including date and time)

10. Rules for recording activity

Health Service Providers and Contracted Health Entities are responsible for ensuring that data are entered correctly in a timely manner in EDIS and/webPAS so that up to date data can be provided for reporting purposes.

Data can be retrospectively entered, and resubmissions are permitted. However, data entry and corrections for the previous quarter must be entered by the second month of the current quarter (e.g. for July – September quarter, data entry and correction cut-off is 30 November) to ensure activity is included in the data submissions to the IHPA and Australian Institute of Health and Welfare.

11. WA Emergency Access Target

The WA Emergency Access Target (WEAT), 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 these Business Rules. Refer to the Performance Management Policy for further information.

12. High-cost therapy

Access to high-cost, cutting edge 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 high-cost therapies each year. This includes, but is not limited to, the provision of CAR-T therapy.

IHPA has developed guidelines for the costing, counting and reconciliation of its funding and in order to comply, all HSPs must discuss activity recording of high-cost therapies

with the DoH, through the Principal Data Management Officer (DataRequests.EDDC@health.wa.gov.au) to ensure it is appropriately captured. Additionally, this will ensure that high-cost therapy can be identified and reported for a range of purposes, including patient safety, research and funding.

13. Compliance and audits

13.1 Audit of 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 WA health system entity, to Information Stewards, Chief Executives of WA health system entities, the Director General and other relevant persons regarding the findings of compliance monitoring activities.

WA health system entities 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.

13.2 Validation and compliance monitoring

A data quality validation is an essential tool used to ensure the accuracy and appropriateness of data submitted to the Emergency Department Data Collection. 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 as the basis for:

- 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.

14. Glossary

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

Term	Definition
Contracted Health Entity	As per section 6 of the *Health Services Act 2016*, 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 *Health Services Act 2016*, 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 *Health Services Act 2016*, means the Department of Health, Health Service Providers, and to the extent that Contracted Health Entities provide health services to the State, the Contracted Health Entities.

Term	Definition
WA health system entities	• All Health Service Providers as established by an order made under section 32(1)(b) of the Health Services Act 2016 • The Department of Health as an administrative division of the State of Western Australia pursuant to section 35 of the Public Sector Management Act 1994. Note: Contracted health entities are not considered WA health system entities.

15. References

1. Definition of emergency services for ABF purposes
   https://www.ihpa.gov.au/sites/default/files/definition_of_emergency_services_for_abf_purposes.pdf

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 (to commencement of clinical care)
   https://meteor.aihw.gov.au/content/index.phtml/itemId/472951

Appendix A – Summary of revisions

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

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