Government of Western Australia
Department of Health

Emergency Department Patient Activity Data
Business Rules

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

Contents

Abbreviations

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

1. Purpose

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

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

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

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

2. Background

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

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

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

3. Contact details

Queries and feedback on the Business Rules can be submitted to the Emergency Department Data Collection (EDDC) Custodian at DataRequests.EDDC@health.wa.gov.au.

4. Scope

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

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

- EVC uses a direct video and telephone link to allow patients to receive clinical care which may be completed virtually, or occur before ED arrival or diversion to another service. It may also be used to provide specialist emergency medicine remotely to another hospital and care team.
- Virtual models of care which provide only triage and diversion to a suitable service may be referred to as virtual triage or tele-triage.
- Advice received by telehealth may form part of care provided to patients physically receiving care in an ED.
- Patients who were dead on arrival are in scope if an ED clinician examined and certified the death of the patient.
- Patients who attend an ED and leave after being triaged and advised of alternative treatment options at another health service/urgent care facility are in scope.
- Patients who are directly admitted to the hospital without triage or care in an ED or by EVC are out of scope.

For the purposes of the Business Rules:

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

5. Documentation

5.1 Medical record

A medical record is the formal and authoritative collection of information relating to an individual's healthcare plan, medical history, clinical assessments, treatment, and other health-related documentation. Medical records may exist in paper-based, digital, or electronic form. They are typically created when a patient first presents to a healthcare facility and are subsequently used to document all ongoing care, interventions and admissions throughout the patient's interactions with the health service.

Where a digital or electronic medical record is created in addition to or as a substitute for a paper-based record, it must be managed and maintained in the same manner as a paper-based record to ensure consistency, accuracy and compliance with statutory obligations.

While the primary purpose of the medical record is to serve the patient by providing a complete, accurate and contemporaneous history of their care and clinical interactions, it also functions as a necessary evidentiary document for the assessment of compliance, health service activity reporting and funding obligations.

5.2 Requirements

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

- administrative documentation (for example, registration on an approved information system – ED webPAS, EDIS, WAVED VCC and Midland webPAS)
- documentation in the medical record by a medical practitioner or authorised clinician to provide evidence in relation to the provision of care including triage assessment and treatment plan. Documentation must include:
    - commencement of care date and time
    - conditions and presenting complaint identified
    - contributing factors/exceptional patient circumstances
    - the reason for presentation
    - the intended clinical treatment plan for ED presentation
    - conditions treated and care provided
    - principal/discharge diagnosis
- decision to admit (including date and time), refer to *Section 6 Admission categories* in the Admitted Activity Patient Activity Data Business Rules.
- departure from ED (including including discharge date and time documented in either a paper, or manually entered text, record).

Medical record documentation requirements outlined above not written or recorded within a conventional paper-based or digital medical record but captured electronically via an appropriate administrative and/or clinical application (e.g. webPAS or EDIS clinician notes) may, by definition, be considered an extended part of the medical record. Where such an application is used to document any item in relation to an ED attendance, local procedures must evidence this as standard

practice and the information must be documented consistently. Documentation must be clearly delineated, with information recorded according to the type of activity being undertaken. To discuss secondary evidence requirements or other concerns in relation to documentation, sites can contact the Department at DataRequests.EDDC@health.wa.gov.au.

6. Terminology

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

6.1 Emergency department

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

An ED must meet all of the following criteria:

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

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

6.2 Emergency patient

A patient who receives treatment in a designated ED.

6.3 Emergency attendance

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

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

- Patients who receive treatment in the designated ED and are subsequently discharged from ED, including cases where the patient is admitted to hospital from ED.
- Patients who are triaged and/or registered in an approved information system but choose to leave the hospital before receiving treatment.
- Patients who are triaged and/or registered in an approved information system but choose to leave the hospital before the completion of assessment or treatment.
- Patients who leave the ED after being registered to receive care and then advised of alternative treatment options.
- A patient is dead on arrival and an ED clinician certifies death.
  Refer to Section 8.5 - Deceased in ED for more information.
- Patients who receive virtual emergency care meeting the criteria defined in Section 9 - Emergency Virtual Care (EVC).

An ED attendance excludes the following:

- A patient attends a physical ED but is not triaged or clerically registered.

- Where only a clerical service is provided to people supporting pre-arranged admission.
- The patient is physically present while waiting transit to another facility. The patient receives no clinical care from the ED team and is not recorded as an emergency attendance.

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

6.4 Emergency department episode of care

The period between when a patient attends the ED to when that person is recorded as having physically departed the ED. For patients receiving virtual emergency care, the episode ends on completion of virtual emergency care.

6.5 Emergency department activity

Includes all treatment and care provided in an ED.

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

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

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

Emergency department activity is recorded where non-admitted care occurs within EDs in alignment with the above rules. For other forms of non-admitted activity, refer to *Section 5 Definitions* in the *Non-Admitted Patient Activity Data Business Rules*.

7. ED Episode of care

7.1 Identification and registration

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

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

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

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

7.2 Arrival date and time

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

7.3 Triage date and time

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

If the patient's condition deteriorates during the course of their episode of care, a second triage assessment may be conducted, and triage category updated to reflect this. This is not relevant to WACHS at this time

7.4 Triage

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

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

Table 1: Australasian Triage Scale 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 of care so that the activity can be included or excluded from ED activity reporting, depending on requirements.

Table 2: Optional Administrative Triage Categories

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

7.5 Arrival mode

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

7.5.1 Ambulance Case number

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

[1] Adapted from *Australasian College for Emergency Medicine - Australasian Triage Scale*

7.6 Visit type

7.6.1 Emergency presentation

Occurs when a patient presents to the ED for an actual or suspected condition which is sufficiently serious to require acute unscheduled care. This includes patients awaiting transit to another facility who receive clinical care in the ED and patients for whom resuscitation is attempted.

If a patient is awaiting transit to another facility and does not receive clinical care in the ED, the ED episode should not be recorded.

7.6.2 Planned re-attendance

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

Where a visit follows general advice to return if feeling unwell, this should not be recorded as a planned re-attendance for visit type.

7.6.3 Unplanned re-attendances

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

- If a patient returns to the same ED after receiving part of their care outside of the ED, the preceding episode must be recommenced. For example, admitted for management of toxic effects of drugs and alcohol, and then returned to the ED for continuation of treatment. As the ED episode had been temporarily interrupted the patient must not have two ED episodes recorded as it is a continuation of care.
- If a patient is assumed to have left at their own risk and re-attends within 24 hours, for example, left temporarily without advising staff, the preceding episode must be recommenced and continued if treating the same condition as initial presentation
- If a patient is discharged home from the ED or to a SSU, and then subsequently re-attends the ED within 24 hours, a new episode (with an unplanned return Visit Type) must be recorded in this circumstance.
- If a patient attends the ED and is not triaged or clerically registered, then reattends the ED within 24 hours and is subsequently triaged and/or registered, a new episode must be recorded in this circumstance.

7.7 Presenting complaint / initial diagnosis

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

7.8 Commencement of clinical care

Emergency services clinical care can be commenced by a medical practitioner or other authorised clinician (nurse practitioner, nurse, mental health practitioner or other health professional), when investigation, care and/or treatment is provided in accordance with an established clinical pathway defined by the emergency services. Placement of a patient in a cubicle and observations taken to monitor a patient prior to a final clinical decision regarding commencement of a clinical pathway, do not constitute commencement.

In the EDIS system, two placeholder names exist to indicate the start of clinical care and to record the start date and time in either the Treating Doctor or the Senior Doctor fields.

- “ZZ_CLINICIAN_CARE_COMMENCED” is used for any autonomous clinician who initiates a treatment but will not personally provide follow up care.
- “ZZ_NURSE_INITIATED_PATHWAY” is used by any nurse who initiates a nursing treatment pathway.

The commencement of clinical care date and time must be recorded in an approved information system and documented in the medical record.

8. Departure from ED

Departure from ED is where the patient's ED episode of care is completed. Status, date, time and destination must reflect the actual departure time and be recorded in the approved information system and documented in the medical record, refer to Section 5 - Documentation. The most appropriate departure status should be selected based on the circumstances. Guidance is available in this section and in data elements' guide for use, see EDDC Data Dictionary.

Examples:

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

8.1 Referred from triage

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

It should be noted that Referred from/at Triage is distinct from 'Transferred to another hospital for admission'. A referral to another health care service, such as a different specialist ED, may occur at triage before any care is provided by the ED team. A transfer applies once ED clinical care (assessment, treatment, investigations etc.) has commenced and the decision has been made to transfer the patient to another hospital for admission.

8.2 Did not wait

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

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

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

8.3 Left at own risk

If a patient chooses to leave the hospital:

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

It must be recorded in an approved information system and documented in the medical record that they 'Left at Own Risk/Against advice'. If the patient has been admitted to the hospital for observation or treatment, refer to *Section 14.3 Self-discharge* in the *Admitted Patient Activity Data Business Rules.*

The date and time a patient left ED, or if unknown, an approximation based on when the patient was observed to be absent, must be recorded in the approved information system and documented in the medical record as the discharge date and time. A valid principal diagnosis must also be recorded.

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

8.4 Transfer to another health service

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

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

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

It should be noted that transferred to another hospital for admission applies only once ED clinical care (assessment, treatment, investigations etc.) has commenced and the decision has been made to transfer the patient to another hospital for admission. If a patient is directed to another health service at triage, transferred to another hospital for admission does not apply, see Section 8.1 - Referred from triage.

8.5 Deceased in ED

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

- the death must be recorded in the 'departure status' as '6 - Died in ED'
- the destination on departure is recorded as '5 - Mortuary'
- the discharge datetime is the date and time the patient was certified deceased.

If a patient (other than a stillbirth) is pronounced 'dead on arrival' to the ED and is assessed or issued death certification by an ED clinician, an ED attendance must be recorded as below:

- the triage category is recorded as '6 - Dead on arrival'
- the departure status is entered as '7 - Dead on arrival, not treated in ED'
- the destination on departure is recorded as '5 - Mortuary'
- the discharge datetime is the date and time the patient was certified dead.

Note the visit type 'Dead on Arrival' requires the emergency consultant to complete a death certificate and should be entered as 'Dead on arrival'. However, where source system is unable to capture this selection, the visit type is updated retrospectively by the Department once confirmed with site that patient was dead on arrival to the ED.

8.5.1 Stillbirth in ED

A stillbirth (fetal death) in the ED, arriving alone, or arriving with mother, is not to have an ED attendance recorded. A stillbirth is not registered in the Patient Administration System (PAS).

8.6 Admission from ED

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

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

- the date and time of the decision to admit
- the reason for admission
- the intended clinical treatment plan for admitted activity, and
- factors/exceptional patient circumstances contributing to the admission.

8.6.1 ED short stay unit admissions

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

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

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

[2] *National Health Information Standard - ED SSU*

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 *Section 6.1.5 ED short stay admissions* the *Admitted Patient Activity Data Business Rules.*

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

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

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

Specific information relevant to the EDIS:

- admission of a patient to ED SSU using the EDIS Short Stay Module ends the ED episode and records this as the departure date and time
- when admitting a patient using the EDIS Short Stay Module the patient must physically leave the ED and be admitted to the SSU and recorded in EDIS at the date and time of actual departure from ED
- the admit date and time field in the EDIS system must match the actual date and time of admission to the SSU or inpatient ward recorded in the Patient Administration System (PAS). Where the functionality is available this is to be automatically populated from the PAS and not manually overwritten or disabled.

8.6.2 Mental Health Observation Area

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

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

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

8.6.3 Virtual bed / Virtual ward admissions

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

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

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

For further information, refer to *Section 10.2 Virtual Beds/Wards* in the *Admitted Patient Activity Data Business Rules*.

9. Emergency Virtual Care (EVC)

Emergency Virtual Care (EVC) may be used with the aim of streamlining emergency medicine pathways. EVC involves the use of digital technology(ies) to deliver emergency care to a range of locations, including rural hospitals, private residences and aged care homes. EVC allows patients to receive clinical care before they physically arrive at an ED or are diverted to another suitable service. EVC may also be used to provide specialist emergency medicine remotely to another hospital and care team.

EVC must meet all of the criteria below to be considered in scope for national data reporting:

- care must be equivalent to a face to face consultation
- the patient and emergency clinician must interact in a mutually responsive manner
- interactions must be via an audio-visual link
- the patient's presenting condition/injury must be visible to the remote clinician
- the virtual care must be delivered by a clinician providing emergency care as part of a hospital department/emergency service.

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

9.1 Tele-/ Virtual Triage

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

9.2 WA Virtual Emergency Department (WAVED)

The WA Virtual Emergency Department (WAVED) is a system-led initiative that enables patients to be seen virtually in the comfort of their own home when safe and appropriate to do so, rather than waiting to be seen in a physical ED.

Patients are assessed by an experienced ED clinician and connected with the care that they need, whether that is in their home, the hospital, or an alternative service. WAVED ED teams provide clinical advice, assessment, prescriptions and referral to other appropriate care pathways.

WAVED activity data is captured via approved information systems and submitted in line with the business rules. Where WAVED activity data cannot be recorded in the approved information system, it is to be stored and submitted per the business rules for EVC.

9.2.1 Transfers to hospital and Referral Source - WAVED

Completed WAVED episodes of care may result in the patient attending a physical ED for care that cannot be provided virtually. If a patient is transported or advised to attend hospital from WAVED, the receiving hospital must create a new ED episode of care and record the Referral Source as – “Other hospital”, and select hospital as “WA Virtual Emergency Department”.

9.2.2 Departure Status

A WAVED Departure Status may be referred to as the consult outcome. These episode end statuses are mapped to the EDDC Departure Status permitted values as detailed in the *Emergency Department Data Collection Data Dictionary.*

9.2.3 Unplanned re-attendances

When a patient receives care through WAVED, but then is transferred to an ED for further care, this should not be counted as an unplanned return visit in ED.

If a patient returns to the same WAVED within 48 hours after a previous WAVED episode with the same condition, a new episode must be entered with an unplanned return visit type.

10. Classification of ED activity

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

For details on data elements required for recording ED activity, refer to the 'Emergency department activity' definition and the *Emergency Department Data Collection Data Specifications*.

10.1 Australian Emergency Care Classification

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

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

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

The IHACPA Emergency Care ICD-10-AM Principal Diagnosis Short List (also known as the EPD Short List) is a set of medical terms and codes used for reporting emergency care principal diagnoses to national activity datasets. It is also used to calculate AECC end classes. The EPD Short List is a subset of the ICD-10-AM classification and aims to provide a nationally consistent approach to classifying principal diagnosis reporting for emergency departments and emergency services. The EDDC will only accept valid ED principal diagnoses with descriptors and codes which can be mapped to the EPD Short List as specified by the ICD-10-AM 13th edition. The clinical systems that are required to report these must be aligned with the EPD short list codes. Further information on the AECC is available from the IHACPA website.

11. Rules for recording activity

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

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

12. WA Emergency Access Measures

The WA Emergency Access Measures are monitored performance indicators measuring systemwide demand, capacity and access to emergency services.

These indicators are reliant on the accurate recording of ED activity data as outlined within the Business Rules. Refer to the MP 0111/19 *Performance Management Policy* for further information.

13. High-cost, highly specialised therapies

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

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

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

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

14. Wearable Technology

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

Data generated from wearable devices that cannot be stored in an approved information system should be recorded in another secure system. As this is an emerging method of data collection, activity relating to wearable devices should be provided when requested by the EDDC.

15. Compliance and audits

15.1 Audit of the Business Rules

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

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

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

Further information regarding audits conducted by the Health Information Audit Team is contained in the *Health Information Audit Practice Statement.*

15.2 Validation and compliance monitoring

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

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

Validations are reliably used to support:

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

16. Definitions

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

Term	Definition
Approved Information System	An information system approved for use to record patient activity data in compliance with the Information Management Policy Framework. For WA public hospital Emergency Departments this refers to the Emergency Department Information System (EDIS), ED webPAS and Midland webPAS.
Contracted health entity	A non-government entity that provides health services to the State under a contract or other agreement entered into with – (a) a Health Service Provider; or (b) the Department CEO, the Minister or the Premier on behalf of the State.
Data Collection	Refer to Information Asset.
Health Service Provider	A Health Service Provider established by an order made under section 32(1)(b) of the *Health Services Act 2016* and may include North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS), Child and Adolescent Health Service (CAHS), WA Country Health Service (WACHS), East Metropolitan Health Service (EMHS), PathWest, Quadriplegic Centre and Health Support Services (HSS).
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.
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, as the System Manager.
System Manager	The term used to describe the Department CEO's role in managing the WA health system to the extent necessary to provide stewardship, strategic leadership and direction and to allocate resources for the provision of public health services in the State under section 19 of the Health Services Act 2016.
WA health entities	WA health entities include: (i) Health Service Providers as established by an order made under section 32 (1)(b) of the *Health Services Act 2016;*

Term	Definition
	(ii) Department of Health as an administrative division of the State of Western Australia pursuant to section 35 of the *Public Sector Management Act 1994*.
WA health system	The WA health system is comprised of: (i) the Department; (ii) Health Service Providers; and (iii) Contracted health entities, to the extent they provide health services to the State.

17. References

1. Definition of emergency services for ABF purposes
https://www.ihacpa.gov.au/resources/definitions-emergency-services

2. Australian Institute of Health and Welfare – Glossary
https://www.aihw.gov.au/reports-data/myhospitals/content/glossary

3. Australian Institute of Health and Welfare – Emergency department stay – waiting time
https://meteor.aihw.gov.au/content/746117
https://meteor.aihw.gov.au/content/index.phtml/itemId/472951

Appendix A – Summary of revisions

Date Released	Author	Approval	Amendment
1 July 2021	Shani Shiham	Rob Anderson, Assistant Director General, Purchasing and System Performance	Document created.
1 July 2022	Gwynedd Spicer-Wensley	Rob Anderson, Assistant Director General, Purchasing and System Performance	Amendments as listed below.
• Dates updated • Replaced “EDIS and/WebPAS” and with approved information system for consistency. • Added Virtual Emergency Medicine and Tele-Triage to scope and on recording in an information system. • Amended content on COVID-19 to include updated information. • Separated “Arrival date and time and Triage date and time” into two different sections. • Removed ICD-10-AM diagnosis code Z53.9 as it can no longer be mapped to IHPA Short List. • Updated High Cost Therapy section. • Added Virtual Emergency Medicine and Tele-Triage sections. • Added the definition for Medical Record.			
1 July 2023	Gwynedd Spicer-Wensley & Francesca McGrath	Rob Anderson, Assistant Director General, Purchasing and System Performance	Amendments as listed below.
• Dates updated. • Updated references to the Independent Health and Aged Care Pricing Authority (IHACPA). • Throughout the document references to “presentation” have been removed and replaced with “attendance”. • Amended content to comply with style guide. • Content updated for: - Abbreviations - Background - Scope - Emergency Attendance - Emergency department episode of care - Emergency department activity - Identification and registration - Emergency Virtual Care and (tele-) virtual triage (formerly Virtual Emergency Medicine and tele-triage) - Transfer to another health service - Deceased in ED - ED Short stay unit admissions - Virtual bed/virtual ward admissions - Australian Emergency Care Classification - High-cost therapies - Validation and compliance monitoring - Glossary • Removed sections: - Emergency presentation - Emergency activity • New sections:			

Date Released	Author	Approval	Amendment
- Referred from triage - Mental Health Observation Area - Wearable Technology			
1 July 2024	Luisa Chou & Gwynedd Spicer-Wensley& Yu Wu	Rob Anderson, Assistant Director General, Purchasing and System Performance	Amendments as listed below.
• Dates updated. • Amended content to correct any typographical and grammatical errors and update links to latest versions. • Abbreviations have been added for: - FDV – Family and Domestic Violence - WACHS – WA Country Health Service - WAVED – WA Virtual Emergency Department • Content updated for: - Requirements - Visit type - Commencement of clinical care - Departure from ED - Referred from triage - Transfer to another health service - Deceased in ED - WA Emergency Access Measures (formerly WA Emergency Access Targets) • Moved sections: - Emergency Virtual Care and (tele-) virtual triage moved under - Section 9 Emergency Virtual Care - Section 9.1 Tele-/ Virtual Triage • New sections: - WA Virtual Emergency Department (WAVED) - Pathway into WAVED - Transfers to hospital and Referral Source - WAVED - Departure Status			
30 June 2025	Luisa Chou & Yu Wu & Peeyusha Meethal	Rob Anderson, Assistant Director General, Purchasing and System Performance	Amendments as listed below.
• Document reviewed. • Dates updated. • Removed section: -COVID-19 • Content updated for: -Contact Details -Emergency Department -Triage date and time -Unplanned reattendance -Left at own risk -Emergency Virtual Care (EVC)			

Date Released	Author	Approval	Amendment
-Departure Status -Australian Emergency Care Classification			
30 June 2026	Luisa Chou & Bianca Nguyen	Jordan Kelly, A/Deputy Director General, Purchasing and System Performance	Amendments as listed below.
• Document reviewed. • Dates updated. • Correction to grammatical errors and sentence structure. • Content updated for: -Abbreviations -Scope -Documentation requirements-Requirements -Emergency attendance -Commencement of clinical care -Departure from ED -Did not wait -Left at own risk -Australian Emergency Care Classification			

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The Department of Health Western Australia

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