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

Emergency Department Patient Activity Data

Business Rules

July 2022

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

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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
HSP	Health Service Provider
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
VEM	Virtual Emergency Medicine
WA	Western Australia

1. Purpose

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

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

The Business Rules are to be read in conjunction with this policy and other Related Documents and Supporting Information as follows:

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

2. Background

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

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

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

3. Contact details

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

4. Scope

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

The scope includes physical presentations to EDs and Virtual Emergency Medicine (VEM). VEM, provided by telephone or videoconferencing to communicate with paramedics in ambulances or other settings, allows patients to be triaged and assessed prior to arrival. 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 present to 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 not triaged by VEM and are directly admitted to the hospital without attending the ED are out of scope.

For the purposes of the Business Rules:

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

4.1 COVID-19

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

IHPA has developed a compendium of advice that specifies rules for coding and reporting of COVID-19 episodes of care in Australian public hospitals for admitted care, ED care and non-admitted care that all HSPs and CHEs must comply with.

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

5. Definitions

For the purposes of the 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

A patient who receives treatment in a designated ED.

5.3 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 or is admitted directly to an inpatient unit (SSU), from triage without receiving treatment in the ED.

5.4 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 health complaint/condition
- is registered in an approved Information system with 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 (including undergoing a formal admission process).

5.5 Emergency department episode of care

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

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*.

5.7 Medical record

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

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

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

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 an approved information system.

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
- 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.

6.2 Arrival date and time

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 as the time the patient enters the ED or when the Triage and/or ED clinician first receives the patient.

6.3 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.

6.4 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

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

6.4.1 Virtual Emergency Medicine and tele-triage

HSPs have started trialling VEM with the aim of streamlining emergency medicine pathways. VEM uses direct video and telephone to link a command or operations centre, based at the hospital or HSP, with ambulances and other settings to allow patients to be assessed and triaged before they arrive at the ED or diverted to another suitable service. VEM may also be used to provide specialist emergency medicine remotely to another hospital and care team.

HSPs implementing VEM or tele-triage models must continue to follow the data recording requirements for Triage Category, Date, Time and related items specified in these business rules. As VEM is an emerging data collection, information is expected to be provided on a best endeavours basis.

In order to identify this activity for reporting, analysis and patient safety, all WA health system entities must provide patient level activity recording of patients who have received VEM triage or care to the Department of Health on a quarterly basis through DataRequests.EDDC@health.wa.gov.au

6.5 Arrival mode

The mode of transport to the emergency department 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.

6.5.1 Ambulance Case number

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.

6.6 Visit type

6.6.1 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 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 on the same day, 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 (SSU), and then subsequently re-presents to the ED within 24 hours, a new attendance must be recorded in this circumstance. In this circumstance, there may be no care provided between discharge and re-presentation. This may be a planned re-attendance, see 6.6.2 –

Planned re-attendance.

6.6.2 Planned re-attendance

A planned re-attendance is a planned return to the ED following a previous ED attendance. A new attendance (with a planned return Visit Type) must be recorded in this circumstance. 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.

6.7 Presenting complaint / diagnosis

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

6.8 Commencement of clinical care

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

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

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

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 in the approved information system and documented in the medical record.

Examples:

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

7.1 Did not wait

If a patient is triaged and registered but leaves the ED without clinical care commencing, it must be recorded that they did not wait. For example, a triaged and registered patient leaves due to long wait times. This includes where the patient

intends to attend another health service/urgent care facility but was not referred to the health service/urgent care facility as part of the triage process.

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

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

7.2 Left at own risk

If a patient chooses to leave the hospital:

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

it must be recorded in an approved information system and documented in the medical record that they 'Left at Own Risk'. If the patient has been admitted to the hospital for observation or treatment, refer to 'Discharge against medical advice or left at own risk' section 13.3 of the *Admitted Patient Activity Data Business Rules*.

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

When the patient leaves the hospital and it remains unclear whether they intend to return, it is a clinical decision whether to delay the discharge of the patient from the ED until this is confirmed. Every endeavor must be made to ensure the patient has in fact left the ED before being recorded as 'Left at Own Risk'. If the patient is located and returns to resume their care, a new ED 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, 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.

Patients who are admitted from ED but are then transferred to another hospital/health service must also have the ED departure status recorded in the approved information system 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 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
- factors/exceptional patient circumstances contributing to the admission.

7.5.1 ED short stay unit admissions

An ED SSU may also be known as Clinical Decision Unit, Emergency Observation Unit, Mental Health Observation Unit/Area, Urgent Care Clinic or Mental Health Emergency Centre. A 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 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

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

- the ED episode end date and time must be corrected to record the time the patient actually leaves the ED either from the SSU or ED, whichever is the later.

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

Specific information relevant to the EDIS:

- Admission of a patient to ED SSU using the EDIS Short Stay Module ends the ED 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'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. For further information, refer to the virtual ward section 10 of the *Admitted Patient Activity Data Business Rules*.

8. Classification of ED activity

ED activity is classified using the following classification system.

8.1 Australian Emergency Care Classification

All public hospital ED activity is classified using the Australian Emergency Care Classification (AECC) which was introduced in July 2021.The AECC has three hierarchical levels that categorises 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.

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 in the medical record that includes:

- administrative documentation (for example, registration on an approved information system)
- documentation by a medical practitioner or authorised clinician to evidence the provision of care including:
  - Assessment and treatment plan including
    - commencement of care date and time
    - conditions identified
    - contributing factors/exceptional patient circumstances
    - the reason for presentation
    - the intended clinical treatment plan for inpatient activity
    - 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

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 (e.g. corrections to ED activity data for July – September activity can be made through to 30 November). This timeframe ensures all activity is included in national data submissions required for activity based funding.

11. WA Emergency Access Target

The WA Emergency Access Target (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 the Business Rules. Refer to the *Performance Management Policy* for further information.

12. High-cost therapy

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 each year. This includes, but is not limited to, the provision of Chimeric Antigen Receptor Therapy (CAR-T), Luxturna™, Yescarta® and Qarziba®.

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

The specifications are available on the IHPA website, under Alternative funding source, however the Department of Health requires HSP's to provide the patient UMRN, activity type, and date of event to identify activity within central records.

This will enable the required reporting to IHPA and will ensure that highly specialised 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 the Business Rules

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

Audit findings will be communicated to the 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

Data quality validation is an essential tool used to ensure the accuracy and appropriateness of data submitted to the Emergency Department Data Collection (EDDC). Validations are applied to individual data elements and reflect national reporting obligations, best practice and policy, as well as the five data quality

principles of relevance, accuracy, timeliness, coherence and interpretability.

Validations are reliably used to support:

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

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.

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

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	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.

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