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

OPERATIONAL DIRECTIVE

Enquiries to: Michele Russell Tel: (08) 9222 4166
Manager, Non Admitted Data Collections

Number: OD0205/09

Date: 7 July 2009

Supersedes: OD 0171/09

File No: RSD-08683

Subject: **EMERGENCY DEPARTMENT AND EMERGENCY SERVICES PATIENT-LEVEL DATA COLLECTION AND REPORTING**

1.0 Distribution

For the attention of all public hospitals in Western Australia and Joondalup and Peel Health Campuses.

2.0 Purpose

The purpose of this bulletin is to describe the data collection and reporting rules for services provided to public patients in designated hospital Emergency Departments (ED) and Emergency Services in smaller hospitals, in order to meet the requirements for:

- Local reporting by the Department of Health Western Australia (DOH); and
- National reporting to the Department of Health and Ageing and the Australian Institute of Health and Welfare pursuant to the National Agreements, including the reporting of performance indicators.

3.0 Background

Data relating to activity in EDs have been collected in a centralised Statewide collection, the Emergency Department Data Collection (EDDC) since 2002-2003 although incomplete data are available from 2000-01.

The EDDC is used to provide data for several state and national requirements for ED data including health service planning, budget allocation, resource utilisation, revenue enhancement, state and national performance monitoring and reporting, and for research projects.

The EDDC is also used to meet DOH's national reporting requirements for the Non Admitted Patients Emergency Department National Minimum Data Set (NAPED NMDS).

4.0 Responsibility for data collection and provision

Data Collection in the Health Services

Health Services are responsible for ensuring that reporting timeframes are met and for providing high quality ED activity information via their ED data collection systems (EDIS, TOPAS, HCARe/CMS and ePAS), so that such data can be extracted to the EDDC.

Data Capture by Information Management and Reporting (IMR)

EDIS data are extracted daily and include updated information. Information Management and Reporting Directorate (IMR) is responsible for ensuring that EDIS data are extracted at approximately 2 am each day.

Systems Application Managers of TOPAS, HCARe/CMS and Peel Health Campus (ePAS) are responsible for sending data by electronic extracts to IMR on the third day of each month. In order to meet this timeframe, details of emergency activity should be completed by the second day of the month for the previous month, so that data can be extracted on the third day for transferring to the EDDC.

Changes to Data Collected

Systems Application Managers and Health Services are responsible for ensuring that early notification is to be provided to IMR of any changes required to be made to data elements and/or value domains in the collection of ED data, e.g. adding a new value to a value domain.. Common data elements must be defined and used consistently by stakeholders. Additional data elements should not be implemented until agreement has been reached between Systems Application Managers, Health Services and IMR.

5.0 Scope of patient-level reporting required for services provided in Emergency Departments/Services

The scope of patient-level reporting for emergency activity is limited to services provided to emergency patients at hospitals. These services could be provided through designated EDs or through Emergency Services at smaller hospitals. Nursing Posts and other areas that provide emergency services are not yet included in current reporting; however, data is to be provided from these sites where they operate in the absence of a hospital.

Patients who are admitted via the ED either into a holding or observation ward are within the scope of the EDDC. Data relating to activity in Emergency Departments/Services are collected in the centralised statewide collection (EDDC) for all patients attending, even if they are subsequently admitted.

Patients not meeting the criteria for an admitted patient, as defined below in 7.2 may receive treatment that was unplanned and performed in a designated ED or by an Emergency Service within a hospital.

Patients for whom a return visit is planned for treatment or follow up/reviews should, where possible, be serviced via the outpatient clinics, and data entered in the outpatient data collection system. For HCARe/CMS users, this is the Ambulatory, Other and Domiciliary module.

Under the National reporting rules[1], when classifying “Funding Source” for patients, the category “Private Patient” from the value domain should not be selected for a non-admitted emergency event at public hospitals.

A patient who is already admitted and returns (from a ward or Hospital in the Home (HITH)) to the ED for a procedure (e.g. to have intravenous cannula re-sited) is within scope and this activity is to be captured in the ED electronic system where possible, with the patient identified as an existing inpatient (see instruction below under 8.0 – Data Quality).

[1] See PART 6 – ELIGIBILITY, PATIENT STATUS, REFERRALS AND ELECTION, item 39. An eligible patient presenting at a public hospital emergency department will be treated as a public patient.

6.0 Reporting of counts of emergency activity - HA215B, HA215D and HA215E

Information has been collected for non admitted patients for many years, using the HA215 reporting format (refer to Operational Directive 0067). Reporting of counts of emergency activity via the HA215B will continue until further notice. The HA215D and HA215E forms were discontinued from 1 July 2006.

7.0 Definitions

This section of the Directive presents information about concepts related to Emergency Departments.

Attachment 1 to this Directive contains definitions for several data items collected about ED patients for the statewide EDDC. The data items include all those required to meet State reporting needs and required by the Commonwealth for the NAPED NMDS reporting. The complete list of data elements is included in Attachment 1.

All data elements listed in Attachment 1 are mandatory.

7.1 Emergency Department / Services

An Emergency Department is a set area in a hospital that provides triage, assessment, care and/or treatment for patients suffering from medical conditions and/or injury. Emergency Services are also provided in smaller hospitals; however, this activity is not necessarily in a set area of the hospital.

7.2 Non-admitted Patient

A non-admitted patient is a patient who receives care at a hospital or health service but has not undergone the hospital's formal admission process. There are several categories of non-admitted patients. This Operational Directive relates to emergency patients only.

7.3 Emergency Patient

Patients who require unplanned services, including those who have contacted a general practitioner and have been directed to the hospital by them, are emergency patients. This type of care is unplanned in that the illness or injury was sudden and the services unplanned. Thus the triage protocol should be followed.

A service does not have to be provided in person. A telephone service conducted as a substitute for face-to-face contact with the patient or the use of a Telehealth service may be counted as an occasion of service (see 7.4). The location of the provider and patient is not relevant. For this activity to be included in reporting, the usual criteria for an attendance must be met, that is, the service must have been provided by a clinician, a triage (1 to 5) must be recorded, and the patient must be clerically registered.

7.4 Occasion of Service[2]

Patients meeting the criteria for a non-admission may receive treatment in a designated department or clinic within a hospital. The required unit of measure for recording these visits is an "occasion of service".

2 The definitions of occasion of service, as per the NMDS definitions, are described in more detail in further guidelines available at:
http://meteor.aihw.gov.au/content/index.phtml/itemId/336947

An occasion of service is defined as any examination, consultation, treatment or other service provided to a patient, or a group of patients, in each functional unit of a health service or hospital on each occasion such a service was provided.

In WA, occasions of service for emergency patients are categorised as attendances or presentations. Attendance figures are used for all local reporting. Presentations are used for National reporting.

7.5 Attendance

An emergency *attendance* is recorded where a patient is registered in any manner in one of the electronic data collection systems. The patient may be missing a triage category, or may have a triage other than 1 to 5, or may not be clerically registered. Attendance counts may include patients who are Dead on Arrival (DOA) or those who did not wait to be seen.

7.6 Presentation

An emergency *presentation* is an occasion of service where a patient is registered clerically, has a Unit Medical Record Number (UMRN), and has been triaged, indicated by a code of 1, 2, 3, 4 or 5. The total presentation count is a subset of the total attendance count.

7.7 National Triage Scale

Emergency patients are triaged to assess the urgency of the required treatment. The National Triage Scale should be used to report the urgency category of the patient from the values listed below.

If the triage assessment is changed from say 3 to 2, then a triage category of 2 is to be recorded. The triage category can be changed to a more urgent category, but caution should be taken if changing to a less urgent category, and should not be altered once the episode is complete. NOTE: Changing the triage may adversely affect the achievement of the target times for treatment.

NATIONAL TRIAGE SCALE		
Urgency Category	**Broad Definition of Category**	**Triage Treatment Time Target**
1. Resuscitation	Definitely life threatening, requiring immediate medical care	Immediate (Less than or equal to 2 minutes)
2. Emergency	Probable threat to life or limb	Less than or equal to 10 minutes
3. Urgent	Possible threat to life or limb	Less than or equal to 30 minutes
4. Semi-urgent	No threat to life or limb but some incapacity or injury	Less than or equal to 1 hour
5. Non-urgent	No incapacity or threat to life or limb	Less than or equal to 2 hours

7.8 Other Triage Codes (Optional Codes used in WA)

Some hospitals use triage to record additional patient information including classifying patients who are Dead on Arrival, directly admitted or current inpatients. The codes shown below should be used if triaging is used to record this additional information. This approach will enable more detailed recording of the episode so that the activity can be included or excluded from emergency activity reporting, depending on requirements.

ADDITIONAL OPTIONAL CODES FOR WA		
Triage Category	**Description**	**Triage Treatment Time Target**
6. DOA	Dead on arrival	N/A
7. Direct Admission	Planned admission	N/A
8. Inpatient	Current inpatient	N/A

8.0 Data quality

This section of the Directive presents information about the quality of data collected within Emergency Departments.

8.1 Critical data items

It is vital that ED patient level information is of high quality and best practice standards of accuracy, timeliness and consistency must be applied to meet reporting requirements. Poor quality ED data can result in poor patient care and inaccurate reporting of Performance Indicators, which may adversely affect outcomes. All patients who attend an ED are to have the relevant data entered in as timely a manner as possible. Date and time fields should be checked for correct order e.g. Discharge date/time should be after arrival date/time.

The following data items are critical to ensuring the accurate and complete reporting of local and national Performance Indicators:

- Arrival Date/Time
- Triage Date/Time
- Triage Category
- Presenting Problem
- Visit Type
- Seen by doctor Date/Time
- Admission Date/Time
- Admitting doctor Type
- Discharge Date/Time
- Diagnosis Code / MDC
- Episode End Status (also known as Disposal Code, Treatment Outcome and Disposition)

8.2 Capturing data about patients admitted for observation

The DOH has been advised by the health services that patients admitted to the ED under an Emergency Physician (indicated by [Admitting doctor Type] = ‘EDADM’), are receiving appropriate care. Only those patients admitted for observation (i.e. they are *not* expected to be admitted to a general hospital ward) are to be recorded as admitted under the Emergency Physician. The table whereby Emergency Physicians are registered under the [Admitting doctor type] of ‘EDADM’ must be completed in a timely and correct manner, so that this information can be incorporated into the reporting process.

The consequence of not maintaining up-to-date registrations is that patients, who should be recorded as admitted for observation under the care of a registered Emergency Physician, will be recorded as an admission only and the length of episode in ED for these patients will be compromised. An incorrect length of episode in ED will impact on indicators such as those related to Access Block.

8.3 Data consistency - examples

To ensure reporting consistency for other critical items such as length of episode, transfer to other hospitals and unplanned re-attendances, data should be recorded as in the examples outlined in the following table:

If Patient Episode Detail is:	Triage should be:	And Visit Type should be:	And Episode End Status should be:	And Admit date/time should be:
Admission (to ED or hospital ward)	*	*	Admission	Entered
ED service event completed; departed under own care	*	*	ED service event completed; departed under own care	Not entered
Direct Admission	7	Direct Admission	Admission	Entered
Dead on Arrival	6	Dead on Arrival	Dead on Arrival	Not entered
Transferred (to another hospital)	*	*	Transferred	Not entered
Unplanned reattendance	*	Unplanned Return Visit	*	*
Inpatient	8	Current Inpatient	Returned to Ward	Not entered
Hospital in the Home (HITH)	8	HITH	Returned to HITH	Not entered
Referred to After Hours GP Clinics	5	*	Referred to After Hours GP Clinic	Not entered
Note: * Use the appropriate recording from the value domain.				

NOTE: Additional codes are not to be created without consultation and agreement between IMR, Health Information Network and the Health Services, including ratification by the appropriate user groups.

9. Assistance

Should you have any queries, please contact the Manager, Non Admitted Data Collections, IMR.
Phone: 08 9222 4166
Email: Michele.Russell@health.wa.gov.au

Dr Peter Flett
DIRECTOR GENERAL
DEPARTMENT OF HEALTH

ATTACHMENT 1: DATA ELEMENT DEFINITIONS FOR RECORDING EMERGENCY ACTIVITY

Refer to the Emergency Activity Data Collection Data Dictionary[3] for full details.

Data Element Title	Data Element Description
*Account Number	A unique identifier of a hospital episode of care.
*Episode Number	An identifier in the source system that distinguishes related non admitted services.
#*Establishment Identifier	The identifier for the establishment in which the episode or event occurred.
#*Person Identifier	Person identifier unique within an establishment or agency. A logical combination of valid alphanumeric characters that identify an entity.
*Surname	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names, as represented by text.
*First Name(s)	The person's identifying name within the family group or by which the person is socially identified, as represented by text.
*Street Address	The concatenation of a person's street type and street suffix resulting in a name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality, as represented by text.
#*Suburb	The full name of the locality contained within the specific address of a person, as represented by text.
#*Postcode	The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of a person.
#*Sex	The biological distinction between male and female, as represented by a code.
*Marital Status	A person's current relationship status in terms of a couple relationship or, for those not in a couple relationship, the existence of a current or previous registered marriage, as represented by a code.
#*Date of Birth	The date of birth of the person.
#*Country of Birth	The country in which the person was born, as represented by a code.
#*Indigenous Status	Whether a person identifies as being of Aboriginal or Torres Strait Islander origin, as represented by a code.

3 http://intranet.health.wa.gov.au/ICAM/publications/pubdocs/EDDC%20dictionary%20final%20191207.pdf

Data Element Title	Data Element Description
#*Funding Source for Hospital Patient	An indicator of the source of payment for the hospital account.
*DVA Authorisation Date	The date on which a hospital receives the authorisation of treatment eligibility from the DVA.
*DVA Authorisation Number	The DVA Authorisation Number refers to the confirmation of eligibility of the patient to receive treatment that will be funded by the DVA. This applies to White cardholders only.
#*DVA Card Colour	An eligible Veteran beneficiary is a patient who holds a current Department of Veterans' Affairs Repatriation Health entitlement card: • Gold (Treatment entitlement card for all conditions). • White (Treatment entitlement card for specific conditions).
*DVA File Number	The Number located below the person's name on the Repatriation Health Card that is issued by the DVA to eligible Veteran beneficiaries.
*Source of Referral	The person or agency responsible for the referral of a client to a service provider agency, as represented by a code.
*Diagnosis Code	The diagnosis established after study to be chiefly responsible for occasioning an episode of patient care, as represented by a code.
*Major Diagnostic Category	The category into which the patient's diagnosis and the associated Australian Refined Diagnosis Related Group (ARDRG) falls, as represented by a two-digit code *(HCARe/CMS only).*
*Home Phone	The home telephone number recorded for a person, as represented by a code.
*Work Phone	The work telephone number recorded for a person, as represented by a code.
*Employment Status	The self-reported employment status of a person, immediately prior to admission.
*Interpreter Required	The need for use of an interpreter service by the patient.
#*Triage Date	The date on which the patient is triaged.
#*Triage Time	The time at which the patient is triaged.
#*Triage Category	The urgency of the patient's need for medical and nursing care, as represented by a code.

Data Element Title	Data Element Description
#*Arrival Date	The date on which the patient/client presents for the delivery of a service.
#*Arrival Time	The time at which the patient/client presents for the delivery of a service.
#*Transport Mode (Arrival)	The mode of transport by which the person arrives at the Emergency Department/Service, as represented by a code.
#*Date Seen by Doctor/Senior Doctor/Nurse Practitioner	The date on which a patient is seen by a clinician and the non admitted patient Emergency Department/Service event commences.
#*Time Seen by Doctor/Senior Doctor/Nurse Practitioner	The time at which a patient is seen by a clinician and the non admitted patient Emergency Department/Service event commences.
#*Date Seen by Nurse	The date on which a patient is seen by a nurse and the non admitted patient Emergency Department/Service event commences.
#*Time Seen by Nurse	The time at which a patient is seen by a nurse and the non admitted patient Emergency Department/Service event commences.
*Consultation Code	The specialty of the consultation provider, to whom a patient has been referred, as represented by a code, e.g. ANAE – Anaesthetics, CARD – Cardiology, PSYCL – Psychiatric Liaison Nurse.
*Presenting Problem Code	The clinical interpretation of the problem or concern that is the person's main reason for seeking health care from the Emergency Department/Service, as represented by a code.
*Presenting Problem Description	The description of the clinical interpretation of the problem or concern that is the person's main reason for seeking health care from the Emergency Department/Service.
#*Type of Visit	The reason the patient presents to an Emergency Department/Service, as represented by a code.
*External Cause of Injury	The environmental event, circumstance or other condition that caused an injury, poisoning or adverse effect (e.g., Falls).
*Human Intent Code	The clinician’s assessment identifying the most likely role of human intent in the occurrence of the injury or poisoning (e.g., Self Harm).
*Investigation Code	The type of investigation as represented by a code, e.g., ECG – electrocardiogram.

Data Element Title	Data Element Description
*Procedure Category Code	A clinical intervention category represented by a code.
*Procedure Code	A clinical intervention represented by a code.
*Departure Ready Date	The date on which the patient is ready to leave the ED but may be waiting on a final procedure or to be collected.
*Departure Ready Time	The time at which the patient is ready to leave the ED but may be waiting on a final procedure or to be collected.
*Departure Destination on Discharge from Emergency Department	The place to where the patient was discharged or transferred when they left the Emergency Department/Service, as represented by a code.
#*Episode End Status (Departure Status)	The status of the patient at the end of the non admitted patient Emergency Department/Service episode, as represented by a code. Locally known as departure status, disposition or treatment outcome.
#*Admission Date (Date Admitted as Inpatient)	The date on which the patient was formally or statistically admitted to a hospital and commenced an inpatient episode of care.
#*Admission Time (Time Admitted as Inpatient)	The time at which the patient was formally or statistically admitted to a hospital and commenced an inpatient episode of care.
#*Physical Departure Date (Discharge Date)	The date on which a patient physically departs an Emergency Department/Service after a stay.
#*Physical Departure Time (Discharge Time)	The time at which a patient physically departs an Emergency Department/Service after a stay.
*Admitting Doctor Code	The code used to indicate that a doctor has admitting rights.
*Admitting Doctor Type	The type that indicates that a doctor has admitting rights to the Emergency Department e.g. Observation area.
*Referred to on departure	The place to where the patient was referred when they left the Emergency Department/Service, as represented by a code.
*Bed Request Date	The date a request for an inpatient bed is made.
*Bed Request Time	The time a request for an inpatient bed is made.

Item required for NMDS reporting.
* Item required for WA reporting.

This information is available in alternative formats upon a request from a person with a disability.