

# **Victorian Emergency Minimum Dataset**

Version 4.0 July 1999

**Manual of the  
Victorian Emergency Minimum Dataset items,  
with definitions and codes,  
for Emergency Department  
information management systems  
in Victorian hospitals**

**Produced by the EDIS Review Committee on the  
Emergency Department Information Systems Project**



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# Introduction

## Background to the Collection

The VEMD is an initiative of significant importance, undertaken by the Department of Human Services (DHS) in collaboration with the Victorian Emergency Department's Association, the Australasian College for Emergency Medicine Victoria Faculty, the Emergency Nurse's Association and the Monash University Accident Research Centre. The collection of patient level data provides valuable information for epidemiological purposes, for the operation of emergency departments, clinical research and quality improvement and for performance monitoring and planning.

The Victorian Emergency Minimum Dataset can aid in the improvement of treatment and prevention of illness and injury. Effective use of the information provided by the dataset will also enable hospitals to improve the management of patients and staffing resources.

The VEMD also enables categorisation of injuries and poisonings according to factors important for injury control and necessary for defining and monitoring injury control targets. It also provides the basis for injury costing and the identification of cases for further in-depth research.

## Purpose of this Manual

This manual acts as a reference source for data input to the Minimum Dataset. It is intended to provide clinical, nursing and clerical staff with the level of detail necessary to accurately record patient demographics, diagnoses, procedures, injury surveillance and other data. Where necessary, explanatory notes are provided to ensure consistent interpretation of the Dataset fields.

## Software Supplier Information

Software suppliers should bear in mind that this manual describes the data as it should be transmitted to the Department of Human Services. The hospitals' systems need not exactly replicate the manual in all respects. However, the interface must be capable of formatting the data appropriately for transmission to DHS.

Campus Code, Statistical Local Area (SLA), Country of Birth, Preferred Language and ICD-10-AM files are available to software suppliers in soft copy excel format. These reference files can be requested by contacting the HDSS Help Desk or by accessing the VEMD web site, refer page x for details.

## Continuing Development of VEMD

Fields and codes within fields will be subject to ongoing monitoring, therefore annual reviews of the VEMD will be undertaken to effect necessary changes.

Comments and suggestions regarding the VEMD are welcomed and should be directed to:

VEMD Coordinator  
Health Data Standards & Systems Unit  
Acute Health Division  
Department of Human Services  
17/555 Collins Street  
MELBOURNE 3000

Should you require assistance with any aspect of the VEMD implementation, please contact the HDSS Helpdesk on **(03) 9616 8141**. You are required to log your call by leaving your name, number and a short message. Your call will be returned as soon as possible. Alternatively contact can be made via the HDSS/VEMD Help Desk e-mail address at **submit.vemd@dhs.vic.gov.au**. E-mail queries will be checked regularly and answered promptly. From 1 July 1999, monthly patient level data files should also be forwarded to this e-mail address.

VEMD related documents and reference files are also located on the VEMD web site at **[www.dhs.vic.gov.au/ahs/hdss/vemd.htm](http://www.dhs.vic.gov.au/ahs/hdss/vemd.htm)**

# Manual Development

## **Version 1.0 (July 1995)**

Following substantial input from Victorian members of the Australasian College for Emergency Medicine, National Injury Surveillance Unit and many others, the first version of the Dataset was published.

## **Version 1.0 (July 1995, including addendum and errata October 1995)**

Corrections and additions to the options available under certain fields and codes were published as addendum and errata in October 1995.

## **Version 2.0 (July 1997)**

This update included corrections and additions to the options available under several fields and codes of the previous version.

## **Version 3.0 (July 1998)**

This update included clarification of fields and codes of the previous version relevant to the central collection of data, details of reporting requirements, edit and business rules and a summary of ICD code changes with codes mapped to ICD-10-AM.

## **Version 4.0 (July 1999)**

This update included revisions to existing data items, the inclusion of four new fields to the dataset, the implementation of new edits and business rules and details of reporting requirements, policies and procedures.

# Data Collection and Reporting Requirements

## Data Definition

The definition of data elements and code sets are as published throughout this manual.

## Period of Extract

VEMD patient level data for a calendar month should be sent within **10 days** of the end of that month. Hospitals are required to correct data and resubmit the entire monthly file within **one week** of the receipt of the DHS rejection file. The entire month's file should be resubmitted for further editing until **all** records pass the editing process. A clean monthly file should be received by DHS by the end of the following month. For further details, refer to *VEMD Data Quality and Timeliness*, page xiv.

All records for those patients who **depart** in a calendar month should be submitted in a single monthly file. That is, if a patient attends the emergency department on the 30<sup>th</sup> of April 1999 and departs on the 1<sup>st</sup> of May 1999, the record should be submitted in the May file, **NOT** the April file. Refer to *Policies for Collection of Data - Submission and Re-submission of VEMD data*, page 52.

## Format

Monthly VEMD patient level data files should be sent on a DOS formatted diskette or via e-mail, in **tab** delimited ASCII format with each record separated by a carriage return and line feed.

Data items should be in the order as specified in the Version 4.0 Manual, VEMD - Structure, Page 1. All fields should be provided for every record including those instances where the data provision is not mandatory. In cases where data in non-mandatory fields is not available the field position should still be denoted by a **tab**.

## Data Collection and Reporting Requirements continued

Also note in relation to data format that:

- Procedures will count as one field even though the Manual allows for the transmission of up to 30 Procedure codes.
- Each Procedure code should be separated by a left curly bracket {.
- The text for the Description of Injury Event does not need to be enclosed in quotation marks (i.e. “textual information”) due to the use of tabs for separating fields. Quotation marks may be used to emphasise words within the text, if desired.
- Free text fields may still be collected locally, however, they should not be sent to the Department.
- Data transmitted to the Department should only include the codes specified in this Manual. Local systems may allow for collection of data through the use of codes, acronyms or text. These should then be converted into appropriate VEMD Version 4.0 format for transmission to the Department.
- ICD-10-AM diagnosis codes **must** be utilised for submission.

Progress of the emergency component of the RAPID Data Warehouse will continue throughout the 1999/2000 financial year. From 1 July 1999, hospitals will have the option of submitting data utilising the modified VEMD tab delimited format (as specified in this manual) or the alternative Health Level Seven (HL7) data transmission format. It is anticipated that hospitals will be required to submit data utilising the HL7 format by 1 July 2000. Hospitals interested in testing the HL7 format should contact Shahn Campbell on 9616-8449 or via email at [shahn.campbell@dhs.vic.gov.au](mailto:shahn.campbell@dhs.vic.gov.au).

Until further notice, files should be forwarded to DHS utilising the new VEMD e-mail address at **[submit.vemd@dhs.vic.gov.au](mailto:submit.vemd@dhs.vic.gov.au)**. Queries can also be forwarded to this address and will be checked regularly and answered promptly. Accordingly reports will continue to be forwarded via e-mail or disk from DHS.

Aggregate paper based reports, which contain information derived from the VEMD, are to continue to be forwarded to the Quality Branch of DHS in accordance with current processes. These reports will eventually become obsolete when the electronic data system has been fully tested and the aggregate reports can be satisfactorily extracted from the system.

## Data Collection and Reporting Requirements continued

The current DHS electronic system and the VEMD component of the RAPID Data Warehouse will operate in parallel until the Warehouse is operating at an optimum level. The emergency attendance data held in the Warehouse will continue to be known as the Victorian Emergency Minimum Dataset (VEMD).

This Version 4.0 VEMD manual contains the specification for the modified VEMD format. Refer to the document *Victorian Health Level 7 (HL7) DWH and ODS Interface Specification* for details on the HL7 messaging protocol.

### Data Quality and Timeliness

Sections of the extract below have been taken from the 1999/2000 *Policy and Funding Guidelines*.

Improvements to data quality and timeliness of submission to the VEMD will be encouraged in the 1999-2000 financial year.

During 1998/99, edits were implemented in a staggered manner with new edits introduced or existing edits changed from warning to rejection as time progressed. Additional edits as specified in this manual will take effect from 1 July 1999. Where ever possible, edits should be maintained within the emergency department's in-house system to minimise rejection of records from the Department's editing program. Refer to *Edits and Business Rules*, Appendix 1a, page 1a-1 to 1a-11 and Appendix 1b, page 1b-1 to 1b-56 for further information.

In addition, as part of the VEMD quality assurance processes, the Department will be comparing the VEMD electronic data with aggregate paper based reports to check consistency. This process has commenced for data supplied from October 1998 onwards. If inconsistencies are found hospitals will be informed and requested to respond by resubmitting corrected data and/or providing the Department with a report outlining the reasons for the inconsistency.

Timelines have also been established for:

- **1999-2000** electronic data and aggregate paper based reports
- electronic patient level data for the period **Aug 1998 - June 1999 inclusive**
- hospitals' response to inconsistencies in the comparison of electronic data and aggregate paper based reports.

Timelines are detailed in the table below.

<b>Data/Reports</b>	<b>Timeline</b>
Submission of monthly patient level data electronic files for 1999-2000	by the 10 <sup>th</sup> day of the following month (ie Aug data by 10 <sup>th</sup> Sep)
Monthly 1999-2000 electronic file passed all edits (ie re-submission process completed)	by the end of the following month (ie Aug data by 30 <sup>th</sup> Sep)
Submission of aggregate paper based reports for 1999-2000	by the 10 <sup>th</sup> day of the following month (ie Aug data by 10 <sup>th</sup> Sep)
Electronic data from Aug 1998-Jun 1999 submitted and passed all associated edits	by 30 <sup>th</sup> Sep 1999
Response to inconsistencies in the comparison of electronic data and paper based aggregate reports	by the date outlined in Departmental correspondence

Hospitals participating in the emergency services component of the Hospital Access Program have these timelines linked to incentive funding. Refer to *1999/2000 Policy & Funding Guidelines* for further information.

# ABBREVIATIONS

DHS	Department of Human Services
DWH	Data Warehouse
RAPID	Redevelopment of Acute and Psychiatric Information Directions (Project)
ODS	Operational Data Store
HL7	Health Level 7
ICD-10-AM	Statistical Classification of Diseases and Related Health Problems, 10 <sup>th</sup> Revision, Australian Modification
NHDD	National Health Data Dictionary
VEMD	Victorian Emergency Minimum Dataset
HAP	Hospital Access Program

# VEMD - Structure

For all *Conditional mandatory* fields, see key on page 4 for conditions under which the field becomes mandatory.

	Field name	Maximum characters	Alpha/ numeric	Format/Values
M	Campus Code	4	A/N	NNNN
M	Unique Key	9	A/N	NNNNNNNNNN
<b><i>Patient biographic data</i></b>				
M	Patient Identifier	10	A/N	NNNNNNNNNNNN
⌘	Medicare Number	11	N	NNNNNNNNNNNNN or blank
M	Medicare Suffix	3	A/N	AAA
M	Sex	1	A/N	1, 2, 3
M	Date of Birth	8	N	DDMMCCYY
M	Country of Birth	4	A/N	NNNN
M	Indigenous Status	1	A/N	2, 5, 6, 7
M	Preferred Language	2	A/N	NN
M	Locality	20	A/N	
M	Postcode	4	N	NNNN
<b><i>Patient management data</i></b>				
M	Arrival Transport Mode	2	A/N	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 19
M	Referred By	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9,10, 11,19
§	Transfer Source	4	A/N	NNNN
M	Type of Visit	2	A/N	1, 2, 3, 4, 5, 8, 9, 10
M	Compensable Status	1	A/N	1, 2, 3, 4, 5, 6, 7

*Version 4.0 VEMD File Structure cont*

	<b>Field name</b>	<b>Maximum characters</b>	<b>Alpha/ numeric</b>	<b>Format/Values</b>
*	Ambulance Case Number	6	A/N	
M	Arrival Date	8	N	DDMMCCYY
M	Arrival Time	4	N	NNNN
M	Triage Date	8	N	DDMMCCYY
M	Triage Time	4	N	NNNN
M	Triage Category	1	A/N	1, 2, 3, 4, 5, 6
▼	First Seen by Treating Nurse Date	8	N	DDMMCCYY or blank
▼	First Seen by Treating Nurse Time	4	N	HHMM or blank
❖	First Seen by Doctor Date	8	N	DDMMCCYY or blank
❖	First Seen by Doctor Time	4	N	HHMM or blank
⌘	Procedures	89	A/N	NN x 30
M	Inpatient Bed Request	1	A/N	Y,N
∩	Inpatient Bed Request Date	8	N	DDMMCCYY or blank
∩	Inpatient Bed Request Time	4	N	HHMM or blank
M	Departure Date	8	N	DDMMCCYY
M	Departure Time	4	N	HHMM
M	Departure Status	1	A/N	1, 2, 4, 5, 6, 7, 8
†	Transfer Destination	4	A/N	NNNN
M	Referred to on Departure	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 16, 17, 18, 19

*Version 4.0 VEMD File Structure cont*

	<b>Field name</b>	<b>Maximum characters</b>	<b>Alpha/ numeric</b>	<b>Format/Values</b>
†	Reason for Transfer	1	A/N	1, 2, 3, 4, 5, 6, 7, 9
†	Escort Source	1	A/N	1, 2, 3, 4, 5, 9
†	Departure Transport Mode	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 19
+	Primary Diagnosis	5	A/N	ICD-10-AM code
	Additional Diagnosis 1	5	A/N	ICD-10-AM code
	Additional Diagnosis 2	5	A/N	ICD-10-AM code
	<b><i>Injury surveillance data</i></b>			
⊙	Nature of Main Injury	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26
⊙	Body region	2	A/N	F1, F2, F3, F4, F5, F6, F7 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22
⊙	Description of Injury Event	100	A/N	
⊙	Injury Cause	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30
⊙	Human Intent	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
⊙	Place Where Injury Occurred	1	A/N	H, I, S, M, P, A, R, T, C, Q, F, O, U
⊙	Activity When Injured	1	A/N	L, S, E, W, C, N, V, O, U

### Conditional mandatory fields:

- M = Mandatory
- ⌞ = Mandatory if Medicare Suffix does not equal C-U, N-E or P-N
- § = Mandatory if Referred By = 6
- \* = Mandatory if Arrival Transport Mode = 1,2,3,4,10
- † = Mandatory if Departure Status = 4
- + = Primary Diagnosis is a mandatory field, except where Departure Status = 6 - *Left before being seen by doctor (or definitive service provider)* or 8 - *DOA*. If Diagnosis is an injury, it should be further specified by utilising Injury Surveillance fields
- ⊙ = Mandatory if any other Injury Surveillance fields are completed, indicating that the attendance was due to an injury
- ▼ = Mandatory if the Nurse is the definitive service provider (except where Departure Status = 6 *Left before being seen by definitive service provider*)
- ❖ = Mandatory if the Doctor is the definitive service provider (except where Departure Status = 6 *Left before being seen by definitive service provider*)
- ∩ = Mandatory if Inpatient Bed Request = Y
- ⌘ = Mandatory if Primary Diagnosis field is completed

# VEMD Fields

## CAMPUS CODE

**Definition:** *Campus Code for the establishment to which this department is attached.*

Four character numeric field.

The first digit of the new Campus Code indicates whether the hospital is

- Public (1-5)
- Private (6-8).

The second and third digits are the same (in most cases) as the previous Establishment Identifier digits two and three. The fourth digit indicates the site identifier.

Where the hospital transferring or receiving the patient is outside Victoria, the code format is set out in Appendix 2, page 2-3.

Prison Hospitals and Armed Forces Hospitals are not generally recognised as hospitals by Department of Health and Family Services and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

The Campus Code field *cannot* be corrected. The record would have to be deleted and re-submitted with the correct Campus Code. Refer to *Policies for collection of data - Procedure for deletion of record or alteration of Campus Code and Unique Key*, page 50.

For details of editing, refer to Appendix 1a, page 1 and 1b, page 4.

## UNIQUE KEY

**Definition:** *Consecutive number allocated to each presentation to the Emergency Department.*

Nine-character numeric field.

Field should be right justified and zero filled.

A Unique Key *cannot* be corrected. The record would have to be deleted and re-submitted with the correct Unique Key. Refer to *Policies for collection of data - Procedure for deletion of record or alteration of Campus Code and Unique Key*, page 50.

Do *not* re-use a Unique Key; a Unique Key must not be re-assigned to another attendance for the same patient or to another patient.

For details of editing, refer to Appendix 1a, page 1 and 1b, page 5.

## PATIENT BIOGRAPHIC DATA

### PATIENT IDENTIFIER

**Definition:** *Patient identifier unique within the establishment. Unit record number or other local identifier. (e.g. first three letters of patient's surname).*

Ten character alpha/numeric field.

Field should be right justified and zero filled.

For details of editing, refer to Appendix 1a, page 1 and 1b, page 5.

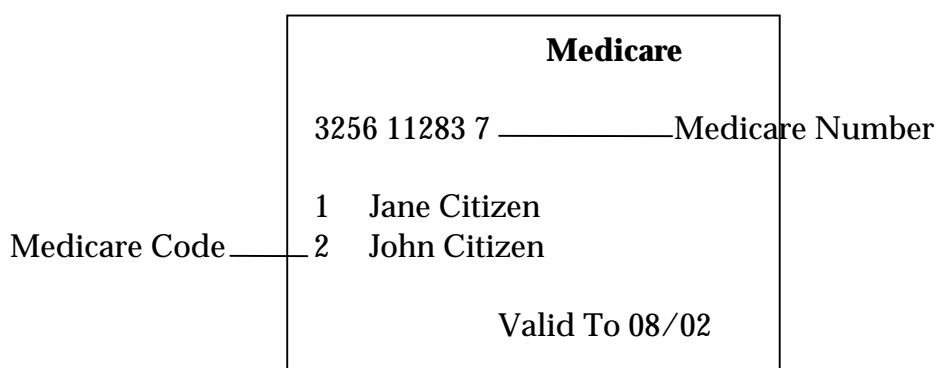
## MEDICARE NUMBER

**Definition:** *Personal identifier allocated by the Health Insurance Commission to eligible persons under the Medicare scheme.*

Eleven digit field, consisting of a ten digit Medicare Number and one digit Medicare code as indicated on the Medicare card.

Under Medicare, each eligible family in the population is assigned a unique identifying number. This number, together with age and sex, provides an essentially unique identifier. (National Health Data Dictionary, Version 8.0)

The Medicare Number should be reported first, with the Medicare Code reported as the eleventh character. For example, 32561128372



When the Medicare Number is provided, it must be numeric and contain the appropriate check-digit (second last digit shown on card). Can be blank if the Medicare Number is not available. In these instances an appropriate Medicare Suffix = C-U, N-E or P-N is required, refer to Medicare Suffix, page 8.

For unnamed neonates where the family has a Medicare Number, use the mother's/family's Medicare Number with suffix BAB and Medicare Code '0' (zero).

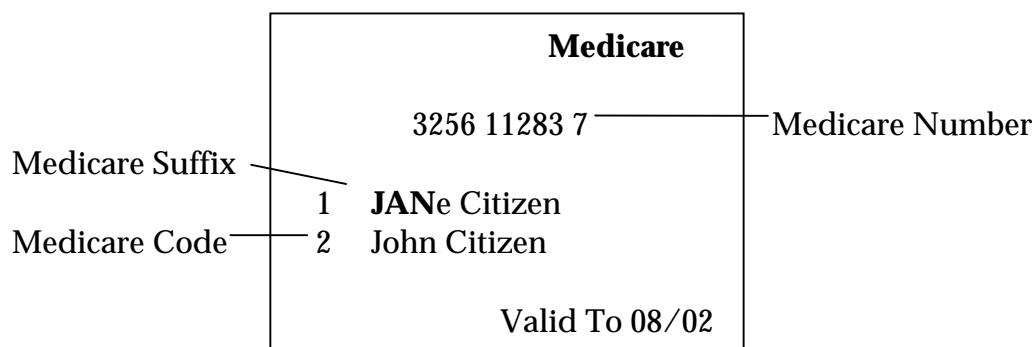
The Medicare Number field may be used to delete a record or to alter the Campus Code or Unique Key, refer to *Policies for collection of data - Procedure for deletion of record or alteration of Campus Code and Unique Key*, page 50.

For details of editing, refer to Appendix 1a, page 1 and 1b, page 6.

## MEDICARE SUFFIX

**Definition:** *The Medicare Suffix is the first three characters of the patient's first given name (as it appears on the Medicare card) to identify the family member being treated.*

The name is printed on the Medicare Card, beneath the Medicare Number.



Edits permit:

- upper case alphas (edits will reject lower case alphas)
- space as second and third characters
- space as third character
- hyphen *or* apostrophe as second character or third character

The Medicare Suffix also allows for the entry of codes for

- C-U = Card unavailable
- N-E = Not eligible for Medicare
- P-N = Prisoner
- BAB = Unnamed neonate

If the Medicare Number is unavailable or the patient is not eligible for a Medicare Number, leave the Medicare Number field blank and enter the appropriate suffix.

For an unnamed neonate where the family has a Medicare Number, use the mother's/family's Medicare Number with suffix BAB and Medicare Code '0' (zero).

For details of editing, refer to Appendix 1a, page 1 and 1b, page 7.

## SEX

**Definition:** *The patient's sex.*

Required for analyses of service utilisation, needs for services and epidemiological studies. (National Health Data Dictionary, Version 8.0)

Select the **first** appropriate category.

Code	Sex
1	Male
2	Female
3	Indeterminate (only for infants aged less than 90 days)

For details of editing, refer to Appendix 1a, page 1 and 1b, page 8.

## DATE OF BIRTH

**Definition:** *Patient's Date of Birth (DDMMCCYY).*

If unknown, estimate year of birth and enter 0000 (zeros) in DDMM and estimated year in CCYY. 00MMCCYY will not be accepted.

For details of editing, refer to Appendix 1a, page 2 and 1b, page 9.

## COUNTRY OF BIRTH

**Definition:** *The Country in which the patient is born.*

Country of Birth is important in the study of access to services by different population sub-groups. Country of Birth is the most easily collected and consistently reported of possible data items. (National Health Data Dictionary, Version 8.0)

Four character numeric field.

The classification has been obtained from the *Australian Standard Classification of Countries for Social Statistics*. (Australian Bureau of Statistics, catalogue no. 1269.0). This data item is also included in the National Health Data Dictionary. (Knowledgebase ID 000035: *Country of Birth*). A computer readable list of countries and codes is available from the ABS.

If the person is an Aboriginal or Torres Strait Islander, this is shown in the field Indigenous Status, refer to page 11 for description of Indigenous Status field.

Patients born in Australia should be reported under the State in which they were born. Code 1100 *Australia not otherwise specified*, should be used only when no further details are available.

Refer to Appendix 3.1, 3.2 & 3.3 for *Country of Birth* codes.

For details of editing, refer to Appendix 1a, page 2 and 1b, page 11.

## INDIGENOUS STATUS

**Definition:** *Indigenous Status of patient as determined by patient self-identification.*

*Select the **first** appropriate category.*

Code	Indigenous Status
2	Not indigenous - Not Aboriginal or Torres Strait Islander origin
5	Indigenous - Aboriginal but not Torres Strait Islander origin
6	Indigenous - Torres Strait Islander but not Aboriginal origin
7	Indigenous - Aboriginal and Torres Strait Islander origin

An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he/she lives (High Court of Australia in *Commonwealth V Tasmania* (1983) 46 ALR).

Given the gross inequalities in health status between Indigenous and non-Indigenous peoples in Australia, the size of the Aboriginal and Torres Strait Islander populations and their historical and political context, there is a strong case for ensuring that information on Indigenous Status is collected for planning and service delivery purposes and for monitoring Aboriginal and Torres Strait Islander health. (National Health Data Dictionary, Version 8.0)

This information *must* be collected for every patient and it must be collected at every attendance.

Rather than asking the patient about their Indigenous Status, first ask the patient 'Were you born in Australia?':

- If 'No', the patient should be asked 'What country were you born in?'
- If 'Yes', the patient should be asked 'Are you of Aboriginal and/or Torres Strait Islander origin?'

Any response which is not affirmative must be coded to 2 - *Not Aboriginal or Torres Strait Islander*.

When a baby or child attends the emergency department, the parent or guardian should be asked whether the child's mother or father is of Aboriginal or Torres Strait Islander origin. If either parent identifies as being of Aboriginal or Torres Strait Islander origin, then the baby or child should be recorded as being of Aboriginal or Torres Strait Islander origin. If the mother of a newborn baby identifies as not indigenous, staff must not assume that the baby is also not indigenous. The indigenous status of the father must also be established.

The Koori Health Unit within the Department of Human Services has issued a booklet that provides information for hospital staff responsible for collecting information on Aboriginal or Torres Strait Islander patients. This booklet can be located on the internet at **[www.dhs.vic.gov.au/ahs/prs2/Infoshee.htm](http://www.dhs.vic.gov.au/ahs/prs2/Infoshee.htm)**

For details of editing, refer to Appendix 1a, page 2 and 1b, page 12.

## PREFERRED LANGUAGE

**Definition:** *The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English.*

Two character numeric field.

Preferred Language is an important indicator of ethnicity, especially for persons born in non-English speaking countries. Its collection will assist in the planning and provision of multilingual services and will facilitate program and service delivery for migrant and other non-English speakers. (National Health Data Dictionary, Version 8.0)

This classification is from NHDD Version 8.0 and is a modification of the 2-digit level Australian Standard Classification of Languages (ABS) classification.

Refer to Appendix 4 for *Preferred Language* codes.

For details of editing, refer to Appendix 1a, page 2 and 1b, page 13.

## LOCALITY

**Definition:** *Geographic location (locality/suburb/town) of usual residence as stated by the patient at time of attendance (not postal address).*

Up to twenty alpha/numeric character field.

- Do *not* include the street address (number, name of road).
- Do not use non-residential localities (such as mail delivery centres)

The hospital may collect the patient's postal address for its own purposes. However, for transmission to DHS, the Postcode and Locality fields must contain details of the patient's *residential* address.

The Locality and Postcode codes are used to assign a Statistical Local Area (SLA) code for DHS purposes.

Statistical Local Area (SLA) Reference files are available from DHS, contact the HDSS Help Desk by phone or via e-mail to request a copy. Refer page x for details.

Alternatively access the Australia Post web-site which provides an up to date postcode and localities listing at **[www.auspost.com.au](http://www.auspost.com.au)**.

From this list, the VEMD editing program will exclude non-residential localities but will add common variations of locality spellings as used in Melway references and the Australian Bureau of Statistics Locality Index (Cat. No. 1252)

For newborns, use the mother's residential address.

For details of editing, refer to Appendix 1a, page 2 and 1b, page 15.

## POSTCODE

**Definition:** *Postcode of locality/suburb/town in which patient usually resides (not postal address).*

The Locality and Postcode codes are used to assign a Statistical Local Area (SLA) code for DHS purposes.

The hospital may collect the patient's postal address for its own purposes. However, for transmission to DHS, the Postcode and Locality fields must contain details of the patient's *residential* address. The VEMD editing program will reject non-residential Postcodes (such as mail delivery centres).

Statistical Local Area (SLA) Reference files are available from DHS, contact the HDSS Help Desk by phone or via e-mail to request a copy. Refer page x for details.

Alternatively access the Australia Post web-site which provides an up to date postcode and localities listing at **[www.auspost.com.au](http://www.auspost.com.au)**.

From this list, the VEMD editing program will exclude non-residential localities but will add common variations of locality spellings as used in Melway references and the Australian Bureau of Statistics Locality Index (Cat. No. 1252)

For newborns, use the mother's residential address.

Other codes to use as Postcodes are:

<b>Pseudo Postcode</b>	<b>Indicating</b>
1000	No fixed abode
8888	Overseas
9988	Unknown Postcode

For details of editing, refer to Appendix 1a, page 2 and 1b, page 15.

# PATIENT MANAGEMENT DATA

## ARRIVAL TRANSPORT MODE

**Definition:** *Transport used to arrive at the Emergency Department.*

For journeys using more than one transport mode, select the mode occurring first in this list.

Up to two character numeric field.

Select the **first** appropriate category.

Code	Transport Mode
1	Air ambulance - fixed wing aircraft for all or <i>any part</i> of journey. Excludes where air plane is helicopter (2)
2	Helicopter
3	Ambulance service - MICA
4	Ambulance service - road car
6	Community/public transport (includes council / philanthropic services)
7	Private car
8	Police vehicle
9	Undertaker
10	Ambulance service - private ambulance car - MAS / RAV contracted
11	Ambulance service - private ambulance car - hospital contracted
19	Other

For details of editing, refer to Appendix 1a, page 2 and 1b, page 17

## REFERRED BY

**Definition:** *Source from which patient was referred to this Emergency Department.*

Up to two character numeric field.

Select the **first** appropriate category.

Code	Referral source
1	Self, family, friends
2	Local medical officer, includes local GP/Doctor
3	Outpatients, includes from this or another hospital
4	Private specialist
5	Emergency Department Review from this hospital
6	Transfer from another hospital ( <i>also record Transfer Source</i> ) Includes both admitted and non-admitted transfers
7	Nursing Home
8	Prison / person in custodial care
9	Crisis Assessment Team
10	Other Community Services
11	Hospital In The Home Service
19	Other

For details of editing, refer to Appendix 1a, page 3 and 1b, page 17.

## TRANSFER SOURCE

**Definition:** *The acute health care facility from which the patient was transferred to this Emergency Department.*

Four character numeric field.

This field includes all patients who were transferred, whether admitted or not admitted at the transferring hospital and identifies the *precise* acute health care facility from which the patient was transferred to your hospital. It is used to analyse patient transfer patterns.

Mandatory if Referred By code is 6, indicating transfer from another hospital, except if from a nursing home within such a facility.

Field should be left blank if transfer does not apply or if transfer is from a nursing home.

Unknown Transfer Source is 9999.

Refer to Appendix 2 for *Transfer Source* codes.

For details of editing, refer to Appendix 1a, page 3 and 1b, page 18.

## TYPE OF VISIT

**Definition:** Reason patient presents to the Emergency Department.

Up to two character numeric field.

Select the **first** appropriate category.

Code	Type of visit	Includes
1	Emergency presentation	Visit is a result of a clinical condition which has <i>not</i> been treated by a hospital (inpatient or ED) recently.
2	Return visit - planned	Presentation is planned and is a result of a previous ED presentation or return visit. It may be for planned follow-up treatment or as a consequence of test results indicating need for further treatment.
3	Unplanned attendance for continuing condition	Patient previously visited an ED and treatment was completed with no further visit planned. The visit may be following a previous admitted patient episode.
4	Outpatient or Outpatient clinic	Planned presentation to either a formal or informal clinic where the distinguishing criterion is that an appointment has been made.
5	Privately referred and privately treated	Referred to the ED by a private medical officer (specialist or GP) and treated within the ED by the practitioner who referred the patient. Visit is usually by appointment, and practitioner bills patient privately.
8	Pre-arranged admission - clerical, nursing, clinical	A patient who presents at the ED for either clerical, nursing or medical processes to be undertaken. Admission has been arranged by the referring medical officer and a bed allocated.
9	Patient in transit	The ED is responsible for care and treatment of a patient awaiting transport to another institution.
10	Dead on arrival	

For details of editing, refer to Appendix 1a, page 3 and 1b, page 20.

## COMPENSABLE STATUS

**Definition:** *Source of compensation for any patient entitled to payment for injury/illness for which the patient is receiving care.*

One character numeric field.

Select the **first** appropriate category.

Code	Compensation Class
1	Transport Accident Commission
2	Department of Veterans' Affairs
3	WorkCover
4	Common Law, Public liability, Other compensable, Service personnel
5	Ineligible not compensable
6	Medicare patient/Overseas eligible/Ineligible hospital exempt
7	Compensable status unknown

For details of editing, refer to Appendix 1a, page 3 and 1b, page 21.

## AMBULANCE CASE NUMBER

**Definition:** *Unique identifier to each ambulance transport occasion.*

Up to six character alpha/numeric field.

Mandatory if *Arrival Transport Mode* is 1, 2, 3, 4 or 10, indicating arrival by ambulance, other than hospital contracted private ambulance car.

For details of editing, refer to Appendix 1a, page 3 and 1b, page 22.

## ARRIVAL DATE

**Definition:** *Date patient first registered or triaged (which ever comes first), by clerical officer, triage nurse or doctor in the Emergency Department.*

Eight character numeric field.

A valid date (DDMMCCYY).

For details of editing, refer to Appendix 1a, page 3 and 1b, page 23.

## ARRIVAL TIME

**Definition:** *Time patient first registered or triaged (which ever comes first), by clerical officer, triage nurse or doctor in the Emergency Department.*

Four character numeric field.

A valid time in 24-hour format. Range: 0001-2359. *[Following international convention midnight is either 2359 of preceding date or 0001 of following date (that is, 0000 and 2400 will not be accepted).]*

For details of editing, refer to Appendix 1a, page 3 and 1b, page 23.

## TRIAGE DATE

**Definition:** *Date patient first seen by Triage nurse/doctor.*

Eight character numeric field.

A valid date (DDMMCCYY).

For details of editing, refer to Appendix 1a, page 3 and 1b, page 24.

## TRIAGE TIME

**Definition:** *Time patient first seen by Triage nurse/doctor.*

Four character numeric field.

A valid time in 24-hour format. Range: 0001-2359. *[Following international convention midnight is either 2359 of preceding date or 0001 of following date (that is, 0000 and 2400 will not be accepted).]*

If local work practices dictate that the Triage process occurs immediately upon arrival, then the Triage Date and time will equal Arrival Date and time.

For details of editing, refer to Appendix 1a, page 3 and 1b, page 25.

## TRIAGE CATEGORY

**Definition:** *Classification according to urgency of need for medical and nursing care, using National Triage Scale (Australasian College for Emergency Medicine).*

The Triage Category is allocated by an experienced registered nurse or medical practitioner. (National Health Data Dictionary, Version 8.0)

One character numeric field.

Treatment acuity within:

Code	Category	Recommended time for treatment to commence
1	Resuscitation	Immediate - within 1 minute
2	Emergency	Within 10 minutes
3	Urgent	Within 30 minutes
4	Semi urgent	Within 60 minutes
5	Non urgent	Within 120 minutes
*6	Dead on arrival	

\*Collected for VEMD purposes, is not included in the National Triage Scale.

Also refer to *Policies for collection of data - Guideline for changes in Triage Category during attendance*, page 51.

For details of editing, refer to Appendix 1a, page 4 and 1b, page 26.

## FIRST SEEN BY TREATING NURSE DATE

**Definition:** *Date patient is first seen by Treating Nurse, includes date baseline observations are taken after triage.*

Eight character numeric field.

Valid date (DDMMCCYY) or blank.

First Seen By Treating Nurse Date & Time **must** be completed if First Seen By Doctor Date & Time, is blank, except where Departure Status = 6 - *Left before being seen by doctor or definitive service provider*. In this instance the First Seen By Treating Nurse Date/Time and First Seen By Doctor Date/Time should be left blank.

Where a valid date has been entered in First Seen By Treating Nurse Date, a valid time **must** be entered in First Seen By Treating Nurse Time.

For details of editing, refer to Appendix 1a, page 4 and 1b, page 27.

## FIRST SEEN BY TREATING NURSE TIME

**Definition:** *Time patient is first seen by Treating Nurse, includes time baseline observations are taken after triage.*

Four character numeric field.

A valid time in 24-hour format or blank. Range: 0001-2359. *[Following international convention midnight is either 2359 of preceding date or 0001 of following date (that is, 0000 and 2400 will not be accepted).]*

First Seen By Treating Nurse Date & Time **must** be completed if First Seen By Doctor Date & Time is blank, except where Departure Status = 6 - *Left before being seen by doctor or definitive service provider*. In this instance the First Seen By Treating Nurse Date/Time and First Seen By Doctor Date/Time fields should be left blank.

Where a valid date has been entered in First Seen By Treating Nurse Date, a valid time **must** be entered in First Seen By Treating Nurse Time.

For details of editing, refer to Appendix 1a, page 4 and 1b, page 28.

## FIRST SEEN BY DOCTOR DATE

**Definition:** *Date first medical officer assesses the patient.*

Eight character numeric field.

Valid date (DDMMCCYY) or blank.

First Seen By Doctor Date & Time **must** be completed if First Seen By Treating Nurse Date & Time is blank, except where Departure Status = 6 - Left before being seen by doctor or definitive service provider. In this instance the First Seen By Doctor Date/Time and First Seen By Treating Nurse Date/Time should be left blank.

Where a valid date has been entered in First Seen By Doctor Date, a valid time **must** be entered in First Seen By Doctor Time.

For details of editing, refer to Appendix 1a, page 4 and 1b, page 30.

## FIRST SEEN BY DOCTOR TIME

**Definition:** *Time first Medical Officer assesses patient.*

Four character numeric field.

A valid time in 24-hour format or blank. Range: 0001-2359. *[Following international convention midnight is either 2359 of preceding date or 0001 of following date (that is, 0000 and 2400 will not be accepted).]*

First Seen By Doctor Date & Time **must** be completed if First Seen By Treating Nurse Date & Time is blank, except where Departure Status = 6 - *Left before being seen by doctor or definitive service provider*. In this instance First Seen By Doctor Date/Time and First Seen By Treating Nurse Date/Time fields should be left blank.

Where a valid date has been entered in First Seen By Doctor Date, a valid time **must** be entered in First Seen By Doctor Time.

For details of editing, refer to Appendix 1a, page 4 and 1b, page 31.

## PROCEDURES

**Definition:** *Specific interventions/treatments performed in the Emergency Department.*

Two character numeric field.

Up to 30 procedure codes will be accepted.

Refer to Appendix 5 for *Procedure* codes.

For details of editing, refer to Appendix 1a, page 5 and 1b, page 32.

## INPATIENT BED REQUEST

**Definition:** *Indication of whether a request has/has not been made for the allocation of an inpatient bed.*

**Definition of 'inpatient bed':** *An inpatient bed is a hospital bed outside the physical confines of the emergency department which is staffed by an inpatient team. It does not include beds in areas variously described by hospitals as emergency wards, observation wards or observation units.*

One character, alpha field.

Select the **first** appropriate category.

Code	Inpatient Bed Request
Y	Yes. An inpatient bed has been requested for this patient.
N	No. An inpatient bed has <i>not</i> been requested for this patient.

This field is utilised to indicate the emergency department's intent to admit a patient to an inpatient bed. If there is no request for an inpatient bed then it can be assumed that the patient is to be fully treated within the emergency department, this would include those patients in observation wards or units. The date and time of this request are recorded in the Inpatient Bed Request Date and Time fields. Refer to Inpatient Bed Request Date & Time, page 27.

Further study of observation medicine will be undertaken in the 1999/2000 financial year.

For details of editing, refer to Appendix 1a, page 8 and 1b, page 54.

## INPATIENT BED REQUEST DATE

**Definition:** *Date request was made for the allocation of an inpatient bed.*

Eight character numeric field.

Valid date (DDMMCCYY) or blank.

The Inpatient Bed Request Date is mandatory only where the Inpatient Bed Request field is completed with a Y- Yes. It would therefore be appropriate for software systems to be set up so that the Inpatient Bed Request Date field is triggered by the entry of a 'Y' in the Inpatient Bed Request field.

For details of editing, refer to Appendix 1a, page 7 and 1b, page 52.

## INPATIENT BED REQUEST TIME

**Definition:** *Time request was made for the allocation of an inpatient bed.*

Four character numeric field.

A valid time in 24-hour format or blank. Range: 0001-2359. *[Following international convention midnight is either 2359 of preceding date or 0001 of following date (that is, 0000 and 2400 will not be accepted).]*

The Inpatient Bed Request Time is mandatory only where the Inpatient Bed Request Date field has been completed. It would therefore be appropriate for software systems to be set up so that the Inpatient Bed Request Time field is triggered by the entry of a date in the Inpatient Bed Request Date field.

The Inpatient Bed Request Date and Time fields will provide an indication of the time taken to decide to admit a patient to an inpatient bed. These fields should, therefore be completed as much as possible in real time.

For details of editing, refer to Appendix 1a, page 7 and 1b, page 52.

## DEPARTURE DATE

**Definition:** *Date patient physically leaves the Emergency Department.*

Eight character numeric field.

Valid date DDMMCCYY.

For details of editing, refer to Appendix 1a, page 5 and 1b, page 33.

## DEPARTURE TIME

**Definition:** *Time patient physically leaves the Emergency Department.*

Four character numeric field.

A valid time in 24-hour format. Range: 0001-2359. *[Following international convention midnight is either 2359 of preceding date or 0001 of following date (that is, 0000 and 2400 will not be accepted).]*

For details of editing, refer to Appendix 1a, page 5 and 1b, page 36.

## DEPARTURE STATUS

**Definition:** *Status of patient at departure from the Emergency Department.*

One character numeric field.

Select the **first** appropriate category.

Code	Departure status
1	Discharge to home, nursing home
2	Admission to ward ( <i>including HITH</i> )
4	Transfer out of this hospital to another hospital ( <i>also record Transfer Destination</i> )
5	Left at own risk, <i>after</i> treatment started
6	Left before being seen by doctor ( <i>or definitive service provider</i> )
7	Died within ED
8	Dead on arrival

For details of editing, refer to Appendix 1a, page 5 and 1b, page 38.

## TRANSFER DESTINATION

**Definition:** *The acute health care facility to which the patient was transferred.*

Four character numeric field.

This field includes all patients transferred to another hospital, whether admitted or not admitted at the transferring hospital and identifies the *precise* acute health care facility to which the patient was transferred from your hospital. It is used to analyse patient transfer patterns.

Mandatory if Departure Status code is 4, indicating transfer out of this hospital to another hospital except if to a Nursing Home within such a facility.

Field should be left blank if transfer does not apply or if transfer is to a Nursing Home.

Refer to Appendix 2 for *Transfer Destination* codes.

For details of editing, refer to Appendix 1a, page 5 and 1b, page 39.

## REFERRED TO ON DEPARTURE

**Definition:** Agency patient was referred to for continuing care.

Up to two character numeric field.

Select the **first** appropriate category.

Code	Referral Agency	Includes
1	Review in ED - scheduled	Planned return to ED
2	Review in ED - as required	Return to ED if problems persist
3	Outpatients	
4	LMO	Referred to local doctor
5	Medical Specialist	
6	Other Specialist Health Practitioner	Physiotherapist, Dentist, etc.
7	Home Nursing Services	RDNS
8	Specialised Community Service	Detox Centre, Rape Crisis Centre, Crisis Assessment Team, etc.
16	No referral	Treatment complete
17	Not known	
18	Other	
19	Not applicable	Admitted to inpatient bed, Transferred, Died, Dead on Arrival, Left at own risk. Can include: Left before seen by doctor /nurse

For details of editing, refer to Appendix 1a, page 6 and 1b, page 40.

## REASON FOR TRANSFER

**Definition:** Reason for transfer to another hospital or health service.

One character numeric field.

Mandatory if Departure Status code is 4, indicating transfer out of this hospital to another hospital, except if to a Nursing Home within such a facility.

Field should be left blank if transfer does not apply or if transfer is to a Nursing Home.

Select the **first** appropriate category.

Code	Reason for Transfer
1	ICU bed not available
2	CCU bed not available
3	General bed not available
4	Specialty not available
5	Previous patient of destination hospital
6	Insured/Compensable
7	Patient preference
9	Other reason

For details of editing, refer to Appendix 1a, page 6 and 1b, page 41.

## ESCORT SOURCE

**Definition:** *The work location or source of the medical or nursing assistant(s) accompanying a patient whilst being transferred to another hospital.*

Up to two character numeric field.

Mandatory if Departure Status code is 4, indicating transfer out of this hospital to another hospital, except if to a Nursing Home within such a facility.

Field should be left blank if transfer does not apply or if transfer is to a Nursing Home.

Select the **first** appropriate category.

Code	Source
1	Emergency Department
2	ICU/CCU
3	Ward
4	Retrieval Service
5	Nil ( <i>no escort</i> )
9	Other

For details of editing, refer to Appendix 1a, page 6 and 1b, page 41.

## DEPARTURE TRANSPORT MODE

**Definition:** *Transport used in transferring the patient from the Emergency Department.*

Up to two character numeric field.

Mandatory if Departure Status code is 4, indicating transfer out of this hospital to another hospital, except if to a Nursing Home within such a facility or 8, indicating that the patient was Dead on Arrival.

Field should be left blank if transfer does not apply, if transfer is to a Nursing Home, or if patient was not Dead on Arrival (DOA).

Select the **first** appropriate category.

Code	Transport Mode
1	Air ambulance - fixed wing aircraft for all or <i>any part</i> of journey. Excludes where air plane is helicopter (2)
2	Helicopter
3	Ambulance service - MICA
4	Ambulance service - road car
5	Ambulance service - private ambulance car
6	Community/public transport, includes council/philanthropic services
7	Private Car
8	Police vehicle
9	Undertaker
19	Other

For details of editing, refer to Appendix 1a, page 6 and 1b, page 42.

## PRIMARY DIAGNOSIS

**Definition:** *The diagnosis primarily responsible for presentation to the Emergency Department.*

Up to six character alpha/numeric field.

Primary Diagnosis is a mandatory field. If Diagnosis is an injury, it should be further specified by utilising Injury Surveillance fields. The *Body Region Matrix*, Appendix 7.1 & 7.2, identifies the appropriate Nature of Main Injury, Body Region and Primary Diagnosis combinations. Software suppliers should note the ideal implementation would be to automatically insert the appropriate Primary Diagnosis code for associated injuries by utilising the Body Region Matrix.

The Primary Diagnosis is derived from and must be substantiated by clinical documentation. (National Health Data Dictionary, Version 8.0)

Diagnosis codes should be submitted in ICD-10-AM format. Omit punctuation from ICD-10-AM codes, that is, no decimal points or obliques will be accepted.

Refer to Appendix 6.1 & 6.2 for *Diagnosis* codes and Appendix 7.1 & 7.2 for *Body Region Matrix* and associated edits.

For details of editing, refer to Appendix 1a, page 6 and 1b, page 42.

## ADDITIONAL DIAGNOSES 1 and 2

**Definition:** *Additional diagnoses are those which:*

- *existed at the time of presentation*
- *arose while patient was in the emergency department*
- *are expected to affect treatment plan or length of stay in the emergency department.*

Additional diagnoses give information on factors which result in increased length of stay, more intensive treatment or the use of greater resources. Additional diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing the patients health status.

Additional diagnoses are derived from and must be substantiated by clinical documentation. (National Health Data Dictionary, Version 8.0)

Up to six character alpha/numeric field.

Diagnosis codes should be submitted in ICD-10-AM format. Omit punctuation from ICD-10-AM codes, that is, no decimal points or obliques will be accepted.

Refer to Appendix 6.1 & 6.2 for *Diagnosis* codes and Appendix 7.1 & 7.2 for *Body Region Matrix* and associated edits.

For details of editing, refer to Appendix 1a, page 6 and 1b, page 43.

# INJURY SURVEILLANCE DATA

## NATURE OF MAIN INJURY

**Definition:** *The patho-physical nature of the injury responsible for the patients attendance at the emergency department.*

Up to two character numeric field.

Nature of Main Injury is mandatory if any other Injury Surveillance fields are completed.

Select the item which best characterises the nature of the injury responsible for the attendance, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. A major injury, if present, should be coded rather than a minor injury. If a major injury has been sustained (e.g. fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'. As a general rule, an injury which, on its own, would be unlikely to have led to the attendance may be regarded as minor. (National Health Data Dictionary, Version 8.0)

Select the **first** appropriate category.

Code	Nature of Injury	Body Region
1	Superficial (includes abrasion, blister, contusion). Excludes Eye (13)	⊕
2	Open wound. Excludes Eye (13)	⊕
3	Fracture. Excludes Tooth (16)	⊕
4	Dislocation	⊕
5	Sprain or strain	⊕
6	Injury to nerve (includes spinal cord). Excludes Intracranial injury (15)	⊕
7	Injury to blood vessel (major or named vessel)	⊕
8	Injury to muscle or tendon	⊕
9	Crushing injury	⊕
10	Traumatic amputation	⊕
11	Injury to internal organ	⊕
12	Burn or corrosion	⊕
13	Eye injury (includes burn) Excludes Foreign Body in external	22

Code	Nature of Injury	Body Region
	eye (14) <i>plus</i> Body Region - Foreign Body, External eye (F1)	
14	Foreign body	☆
15	Intracranial injury (includes concussion)	22
16	Dental injury (includes fractured tooth)	22
17	Drowning, immersion	22
18	Asphyxia or other threat to breathing	22
19	Electrical injury	22
20	Poisoning, toxic effect. Excludes Bites (21)	22
21	Bites (venomous)	⊕
22	Other specified nature of injury	⊕
23	Injury of unspecified nature	⊕
24	Multiple injuries (more than one nature of injury)	⊕
25	No injury detected	22
26	Bites (non-venomous)	⊕

⊕ Requires code from *Body Region - Not Foreign Body*

☆ Requires code from *Body Region - Foreign Body*

Refer to Appendix 7.1 & 7.2 for *Body Region Matrix* and associated edits.

For details of editing, refer to Appendix 1a, page 7 and 1b, page 45.

## BODY REGION FIELD

**Definition:** *The region of the body which sustained the injury.*

There are two sets of Body Region codes, depending on whether the Nature of Main Injury code indicates a Foreign Body or another type of injury. Software suppliers should note the ideal implementation would restrict the look-up screens to present only the Body Region screen that is valid for the Nature of Main Injury code.

Body Region is mandatory if any other Injury Surveillance fields are completed.

Refer to Appendix 7.1 & 7.2 for *Body Region Matrix* and associated edits.

For details of editing, refer to Appendix 1a, page 7 and 1b, page 46.

## BODY REGION - FOREIGN BODY INJURY

**Definition:** *The region of the body which sustained the foreign body injury.*

This field must only be completed when the Nature of Main Injury code is 14.

Two character alpha numeric field.

Select the **first** appropriate category.

<b>Code</b>	<b>Body Region if injury caused by Foreign Body</b>
F1	Eye
F2	Ear
F3	Nose
F4	Respiratory tract. Excludes Nose (F3)
F5	Alimentary tract
F6	Genitourinary tract
F7	Soft tissue

## BODY REGION - NON FOREIGN BODY INJURY

**Definition:** *The region of the body which sustained the non-foreign body injury.*

This field must be completed when the Nature of Main Injury code is 1-13, 15-26.

Up to two character numeric field.

Select the **first** appropriate category.

Code	Body Region if injury <i>not</i> caused by Foreign Body
1	Head. Excludes Face (2)
2	Face. Excludes Eye (F1)
3	Neck
4	Thorax
5	Abdomen
6	Lower back (includes loin)
7	Pelvis (includes ano-genital and perineum)
8	Shoulder
9	Upper arm
10	Elbow
11	Forearm
12	Wrist
13	Hand (includes fingers)
14	Hip
15	Thigh
16	Knee
17	Lower leg
18	Ankle
19	Foot (includes toes)
20	Unspecified body region
21	Multiple injuries involving more than one body region
22	Body Region code not required

## DESCRIPTION OF INJURY EVENT

**Definition:** *Description of injury event by patient at triage.*

Free text field. Maximum of 100 characters.

Description of Injury Event is mandatory if any other Injury Surveillance fields are completed.

The purpose of the field is to clarify the injury event (vital for identifying the interventions) and provide additional information relevant to the injury (product type, brand name, safety precautions, etc).

The narrative of the injury event is very important as it identifies features of the event not revealed by coded data. (National Health Data Dictionary)

Briefly and concisely describe the injury event. For example:

- Child opened home bathroom cabinet and ingested 50 ml, Brand X from bottle, CRC.
- Victim fell off forklift pallet when fellow worker raised lift, safety boots.
- Ball struck face while marking in Australian Rules football competition, mouthguard.

The above examples outline the sequence of events and includes the following items:

### ➤ Specific **location**

- own home, bathroom
- workshop
- Australian Rules football ground

### ➤ Specific **activity**

- playing
- working on forklift pallet
- playing competition Australian Rules football

- Specific **product** involved *where applicable*
  - brand name of medicine, 50 mls
  - wooden pallet
  - football
- **Safety device** in use *at the time*
  - child resistant close (CRC) on bottle
  - work boots
  - mouthguard
- **Seating position** in vehicle *where applicable*
  - (not applicable in these examples)

These items can generally be incorporated into a description with the following elements:

- *How* did things go wrong to precipitate the injury sequence (*verb*).
- *What* (thing or person) went wrong (*subject*).
- *How* were the injuries caused (*verb*).
- *What* caused the injuries (*subject*).

For details of editing, refer to Appendix 1a, page 7 and 1b, page 47.

## INJURY CAUSE

**Definition:** *Event, circumstances or condition associated with the occurrence of injury, poisoning or adverse effect.*

Up to two numeric character field.

Injury Cause is mandatory if any other Injury Surveillance fields are completed.

Select the **first** appropriate category.

Code	Injury Cause
1	Motor vehicle - driver
2	Motor vehicle - passenger
3	Motorcycle - driver
4	Motorcycle - passenger
5	Pedal cyclist - rider or passenger
6	Pedestrian
7	Horse related (fall from, struck or bitten by)
8	Other transport-related circumstance
9	Fall - low (same level or <1 metre, or no information on height)
10	Fall - high (>1 metre)
11	Submersion or drowning - swimming pool
12	Submersion or drowning - other
13	Other threat to breathing (includes strangulation, asphyxiation)
14	Fire, flames, smoke
15	Scalds (hot drink, food, water, other fluid, steam, gas or vapour)
16	Contact burn (hot object or substance)
17	Poisoning - medication
18	Poisoning - other or unspecified substance
19	Firearm
20	Cutting, piercing object
21	Dog related
22	Other animal related. Excludes Dog (21), Horse (7)
23	Struck by or collision with person

<b>Code</b>	<b>Injury Cause</b>
24	Struck by or collision with object
25	Machinery
26	Electricity
27	Hot conditions (natural origin, includes sunlight)
28	Cold conditions (natural origin)
29	Other specified external cause
30	Unspecified external cause

For details of editing, refer to Appendix 1a, page 7 and 1b, page 48.

## HUMAN INTENT

**Definition:** *Most likely role of human intent in occurrence of injury or poisoning as assessed by clinician.*

Human Intent is mandatory if any other Injury Surveillance fields are completed.

For this field, the issue is the intent to produce the injury, not the intent to undertake an activity which happened to result in injury.

Select the item which best characterises the role of intent in the occurrence of the injury, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code set. (National Health Data Dictionary, Version 8.0)

Up to two character numeric field.

Select the **first** appropriate category.

Code	Most likely human intent in occurrence of injury
1	Accident
2	Intentional self-harm
3	Sexual assault
4	Child neglect, maltreatment by parent, guardian
5	Maltreatment, assault by domestic partner
6	Police, legal intervention or operations of war
7	Assault not otherwise specified
8	Adverse effect or complication of medical or surgical care
9	Intent cannot be determined
10	Other specified intent
11	Intent not specified

For details of editing, refer to Appendix 1a, page 7 and 1b, page 49.

## PLACE WHERE INJURY OCCURRED

**Definition:** *Where person was situated when injury occurred.*

One character alpha field.

Place Where Injury Occurred is mandatory if any other Injury Surveillance fields are completed.

Select the **first** appropriate category.

Code	Place	Includes	Excludes
H	Home	House, farm house, non-institutional place of residence, apartment, boarding house, caravan park (resident), private: driveway to home, garage, garden/yard or home, path to home, swimming pool in private house, garden	Institutional place of residence (I), abandoned or derelict house (O), home under construction and not yet occupied (C)
I	Residential institution	Children's home, orphanage, home for the sick, nursing home, old people's home, hospice, military camp, reform school, prison	Hospital (M)
S	School, day care centre, public administration area	Building (including adjacent grounds) used by the general public or by a particular group of the public such as: assembly hall, public hall, church, clubhouse, court house, post office, day care centre, preschool, youth centre, gallery, library, museum, cinema, theatre, opera house, concert hall, dance hall, school (public or private), college, university, institution for higher education	Hospital (M), recreation area (P), athletics and sports area (A), trade or service area (T), building under construction (C)
M	Medical hospital	Hospital	Hospice, nursing home (I)

<b>Code</b>	<b>Place</b>	<b>Includes</b>	<b>Excludes</b>
P	Place for recreation	Public park, amusement park	Athletics and sports area (A)
A	Athletics and sports area	Cricket ground, riding school, basketball court, golf course, stadium, skating rink	Public park, amusement park (P)
R	Road, street or highway	Freeway, footpath	Private driveway (H)
T	Trade or service area	Bank, petrol station, supermarket	
C	Industrial or construction area	Any building under construction, industrial yard, workshop, dry dock	Mine, quarry, tunnel under construction (Q)
Q	Mine or quarry	Mine or quarry tunnel under construction	
F	Farm	Farm buildings and land, ranch	Farm house (H)
O	Other specified place	Forest, beach, pond, abandoned or derelict house	
U	Unspecified place		

For details of editing, refer to Appendix 1a, page 7 and 1b, page 50.

## ACTIVITY WHEN INJURED

**Definition:** *Activity the patient was engaged in when injured.*

Activity When Injured is mandatory if any other Injury Surveillance fields are completed.

This field provides the basis for identifying work-related and sport-related injuries.

Select the code which best characterises the type of activity being undertaken by the person when injured, on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one that comes first in the code list. (National Health Data Dictionary, Version 8.0)

One character alpha field.

Select the **first** appropriate category.

Code	Activity	Includes	Excludes
L	Leisure	Hobby activities; leisure-time activities with an entertainment element such as being at a cinema, a dance or party; participating in activities of a voluntary organisation	
S	Sports	Physical exercise with a described functional element such as: golf, jogging, riding, school athletics, skiing, swimming, trekking, water-skiing	
E	Education	Formal education, learning activities (eg attending school, university)	
W	Working for income	Paid work for salary, bonus and other types of income; transportation (time) to and from such activities	Voluntary work (L)
C	Other work	Unpaid domestic duties such as: caring for children and relatives, cleaning, gardening, household maintenance. Other duties for which income is not gained (eg unpaid work in family business)	Voluntary work (L)
N	Being nursed, cared for	Care of infant by parent, patient by nurse	

<b>Code</b>	<b>Activity</b>	<b>Includes</b>	<b>Exclude s</b>
V	Vital activity, resting, sleeping, eating	Personal hygiene, other personal activity	
O	Other specified activity		
U	Un-specified activity		

For details of editing, refer to Appendix 1a, page 7 and 1b, page 51.

# POLICIES FOR COLLECTION OF DATA

## HEALTH LEVEL 7

Health Level 7 (HL7) is the new messaging protocol to be implemented with the RAPID Data Warehouse (DWH). HL7 is an automatic trigger based transmission format with on-line validation and acknowledgment of receipt of data.

From 1 July 1999, hospitals will have the option of submitting data utilising the revised tab delimited VEMD format (as specified in this manual) or the alternative HL7 data transmission format. It is anticipated that hospitals will be required to submit data utilising the HL7 format by 1 July 2000. Hospitals interested in testing the HL7 format should contact Shahn Campbell on 9616-8449 or via email at **shahn.campbell@dhs.vic.gov.au**

Changes to collection procedures due to the HL7 protocol include

- The ability to record unlimited diagnosis and procedures, and
- The unification of Date and Time fields.

Refer to the document *Victorian Health Level 7 (HL7) DWH and ODS Interface Specification* for further details on the HL7 messaging protocol.

## PROCEDURE FOR DELETION OF RECORD OR ALTERATION OF CAMPUS CODE AND UNIQUE KEY

For tab delimited ASCII format (modified VEMD format):

- To delete a record already on the data base, enter 99999999999 in the Medicare Number field. The record will then be deleted from the VEMD.
- To change the Campus Code or Unique key, delete the record (by sending the record with 99999999999 in the Medicare Number field) and then resubmit the new record with the correct Campus Code or Unique key. Ensure the deletion record is submitted before the correction record.
- To change data in any other field (not the Campus Code or Unique key) simply correct the erroneous field and resubmit the record. This new record will overwrite the previous submission.

For further details on deletion of records / alteration of Campus Code or Unique Key for the new HL7 messaging protocol, refer to the document *Victorian Health Level 7 (HL7) DWH and ODS Interface Specification*.

## **GUIDELINE FOR CHANGES IN TRIAGE CATEGORY DURING ATTENDANCE**

The following guideline should be followed when a patient changes Triage Category during an emergency attendance;

- If the triage category of a patient is altered during their attendance, the original Triage Category is to be transmitted to the VEMD (regardless of whether the re-categorisation is higher or lower)
- Changes in Triage Categories may be recorded locally but should **not** be submitted to the VEMD; only the original Triage Category should be reported.

### **Comments**

- Triage is an initial decision which is used as the basis for determining how quickly a patient should be treated.
- The same rules should apply regardless of whether the patient's Triage Category becomes higher or lower.

It is recognised that triage categories may alter during an attendance, as specified in the following extract from the Australasian College for Emergency Medicine's Policy Document - Triage (November 1993), 'The triage of patients continues within the emergency department following initial assessment and treatment. Patients may be re-triaged to a different category as the diagnostic process develops and particularly in response to significant changes in physiological status'.

## **REPORTING OF TRIAGED PATIENTS TO THE VEMD**

It is imperative that the VEMD accurately reflects the demand placed on emergency department services, therefore, if a patient is triaged, to one of the VEMD triage categories, their attendance must be recorded within the VEMD in **all** instances. This applies even when the patient absconds before treatment has commenced **OR** if registration was commenced but not completed.

## SUBMISSION OF VEMD DATA

All records for those patients who **depart** in a calendar month should be submitted in a single monthly file. That is, if a patient attends the emergency department on the 30<sup>th</sup> of April 1999 and departs on the 1<sup>st</sup> of May 1999, the record should be submitted in the May file, **NOT** the April file. Refer to *Policies for collection of data - Resubmission of VEMD data*, page 52.

## RESUBMISSION OF VEMD DATA

Data submitted to the VEMD are run through the VEMD editing program and a summary report detailing the number of records submitted, the number of records accepted and the number of records rejected is forwarded to the hospital. An excel spreadsheet is also forwarded indicating what records have rejected due to particular edit/s.

VEMD patient level data for a calendar month should be sent within **10 days** of the end of that month. Hospitals are required to correct data and resubmit the entire monthly file within **one week** of the receipt of the DHS rejection file. The entire month's file should be resubmitted for further editing until **all** records pass the editing process. A clean monthly file should be received by DHS by the end of the following month. For further details, refer to *VEMD Data Quality and Timeliness*, page xiv.

The current VEMD editing program has been designed so that all records that are accepted and/or have a warning, are retained in one file, and all rejected data is retained in another. (This 'reject' file also displays any warning messages for correction when possible.)

When the file is resubmitted, the records that pass the editing process will now be included in the 'accepted' file. This process will continue until all records have been accepted.

Data in the 'accepted' file is compared with the monthly aggregate reports submitted to the Quality Unit, therefore it is important to continue to resubmit any rejections (with the whole months data) until 100% quality is achieved.

## POLICY FOR PATIENTS 'REMAINING IN' ON 30 JUNE 1999

The Version 4.0 VEMD format is to be implemented on 1 July 1999. Therefore, **all** information for patients who depart the emergency department on or after this date must be submitted in the new 1999/2000 format. This includes patients who remain in the emergency department after midnight on the 30<sup>th</sup> of June 1999.

For example, **Indigenous Status and Aboriginality;**

Patients remaining in the ED after midnight on 30 <sup>th</sup> June 1999	Patients departing the ED before midnight on 30 <sup>th</sup> June 1999
<b>Version 4.0 - 1999/2000 format</b>	<b>Version 3.0 - 1998/1999 format</b>
<p>Indigenous Status</p> <p>Valid codes = <b>2</b> - Not indigenous - Not Aboriginal or Torres Strait Islander origin  <b>5</b> - Indigenous - Aboriginal but not Torres Strait Islander origin  <b>6</b> - Indigenous - Torres Strait Islander but not Aboriginal origin  <b>7</b> - Indigenous - Aboriginal and Torres Strait Islander origin</p>	<p>Aboriginality</p> <p>Valid codes = <b>1</b> - Aboriginal or Torres Strait Islander  <b>2</b> - Not Aboriginal or Torres Strait Islander</p>

# **FUTURE DIRECTIONS**

During the VEMD Forum held on 6 November 1998, several suggestions were put forward as future directions for the VEMD. These proposals are outlined below and will be further defined closer to the time of implementation, (post July 1999).

## **ONGOING CARE COMMUNICATION**

This proposal consisted of a new field indicating communication of ongoing care. The field values would be Yes/No:

**Yes**, indicating that active transfer of knowledge and information to the provider of ongoing care was undertaken; and

**No**, indicating that the transfer of knowledge and information to the provider of ongoing care was not performed.

It was suggested that this field be collected electronically by the clinician, nurse or clerk at the time of discharge. It is felt that this field is necessary as a quality marker and would be utilised to assess follow-up arrangements with primary health care workers.

Upon completion of this field, an automatic trigger may be generated creating a summary of the patient's attendance. This summary may then be automatically e-mailed or manually faxed to the patient's General Practitioner or other primary health care worker.

## **TRAUMA TASK FORCE**

It is anticipated that, in the future, adult physiological recordings such as respiratory rate, systolic blood pressure and the Glasgow coma scale, and paediatric physiological recordings such as the size of the child, airway access, systolic blood pressure, CNS, skeletal fractures, cutaneous injury and loss of consciousness, may be collected from the emergency electronic record and transmitted to the Department for analysis against predetermined Major Trauma scores. Patients who fall into a certain category as specified by the Major Trauma Score, are required to be transferred to a facility able to provide definitive care, that is, a Major Trauma Service. Hospitals designated as a Major Trauma Service are required to provide expert care to major trauma patients (which will be determined by comparison to set criteria/specifications.)

The main principle of the Trauma Task Force model is the delivery of the best possible outcome for the majority of patients. The main advantages of this model are that it maximises the use of available skills and resources, and allows for inclusion of tertiary hospitals with substantial sub-specialisation and critical care expertise.