

Victorian Emergency Minimum Dataset

Version 3.0 July 1998

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

Produced by the 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 Departments Association, the Australasian College for Emergency Medicine, the Emergency Nurses 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.

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 demographic, diagnosis, procedure and other details. Where necessary, explanatory notes are provided to ensure consistent interpretation of the Dataset fields.

Software Supplier Information

For software suppliers, additional information will be provided by the Department of Human Services as required.

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.

Additional text fields are not listed in the VEMD Structure table, page 1, as these data may be collected for local purposes but should not be transmitted to the Department of Human Services.

Statistical Local Area (SLA) files and ICD-10-AM files are available in soft copy format for those Software Suppliers interested. These reference files can be requested by contacting the RAPID Help Desk, refer page vi for details.

Continuing Development of VEMD

It is important to note that items and codes within items will be subject to ongoing monitoring, and it is expected that annual reviews of the VEMD will be undertaken to effect necessary changes.

Comments and suggestions regarding the VEMD from Emergency Department users and software developers are welcomed and should be directed to:

EDIS Review Committee

Emergency Department Information Systems Project
C/o 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 RAPID Helpdesk on **03) 9616 8141**. Calls will be answered 24 hours a day. If no one is available, leave a message on the helpdesk answering machine and someone will return your call as soon as possible. Alternatively contact can be made via the RAPID Help Desk e-mail address at **PRS2.Help-Desk@dhs.vic.gov.au**. E-mail queries will be checked regularly and answered promptly. Submission of data for the period of 1 January 1998 to 31 Dec 1998 can also be forwarded to this address.

Manual Development

Version 0.1 (1 September 1994)

This comprised the listing of the initial 32 items for the Victorian Emergency Minimum Dataset.

Version 0.2 (1 September 1994)

This version listed comparison of Emergency Minimum Dataset and Victorian Inpatient Minimum Dataset items.

Version 0.3 (21 February 1995)

As for Version 0.2, but Version 0.3 included additional subdivisions to ambulance service under mode of arrival and Medicare number.

Version 0.4 (March 1995)

First full version, titled Victorian Emergency Minimum Dataset items with definitions and codes, for Emergency Department information management systems in Victorian hospitals. (Note some copies of this version were labelled '1.1')

Version 0.5 (April 1995)

As for Version 0.4, but this version included first draft of diagnosis codes interleaved with sections detailing items.

Version 0.6 (May 1995)

This incorporated amendments which ensured consistency of items from the VEMD with the National Injury Surveillance Unit's Dataset as well as a number of amendments to items and codes to ensure greater access and ease of use.

Version 0.7 (May 1995)

As for Version 0.6, but Version 0.7 included the latest redraft of diagnosis codes mapped for both ICD-9-CM and ICD-10 and numerous amendments to items and codes to reflect input from members of the Subcommittee and the Steering Committee.

Version 1.0 (July 1995)

Development of this version followed substantial input from Victorian members of the Australasian College for Emergency Medicine, National Injury Surveillance Unit and many others.

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

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

Version 2.0 (July 1997)

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

Version 3.0 (May 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.

Data Collection and Reporting Requirements

Data Definition

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

Period of Extract

Hospitals should have already transferred existing emergency data for the period of 1 October 1995 to 31 December 1997 to the Department of Human Services. Data for the period of 1 January 1998 to 31 July 1998 should be forwarded to the Department via diskette or on e-mail (contact details provided on page vi) by 10 August 1998. After this date, data should be sent each month within 10 days of the end of the month.

Format

Data covering the period 1 January 1998 to 31 December 1998 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 Manual, VEMD - Structure, Page 1. All fields should be provided for every record including those instances where the fields are not mandatory. In cases where data in non-mandatory fields is not available the field position should still be denoted by a **tab**.

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 { regardless of whether numeric Procedure codes or acronyms are being sent.
- 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 that were detailed in versions 1 and 2 of this Manual have been removed. These data may still be collected locally, however, they should not be sent to the Department of Human Services.
- Data transmitted to the Department should only include the codes specified in this Manual. Local emergency department information systems may allow for collection of data through the use of codes, acronyms or text. These should then be converted for transmission to the Department. Acronyms will continue to be accepted for some fields for a short period of time to allow for systems to meet this requirement.
- ICD-10-AM diagnosis codes should be used from 1 July 1998. The edits for these Diagnosis codes will come into effect from 1 January 1999.

Edits will be implemented in a staggered manner with new edits introduced or existing edits changed from warning to rejection as time progresses. Data edits specified in this Manual should be maintained within the inhouse system wherever possible to minimise the rejection of records when transmitting to the Data Warehouse. Refer to Edits and Business Rules, Appendix 1a, page 1a-1 to 1a-12 and Appendix 1b, page 1b-1 to 1b-43 for further information.

From 1 January 1999, an alternative Health Level Seven (HL7) data transmission format will also be accepted. From this date, data will also be sent directly to Health Computing Services Australia for incorporation into the Department of Human Services Data Warehouse. Details of this format will be provided at a later date.

VEMD - Structure

For all *Conditional mandatory* fields, see key at foot of this table for conditions under which the field becomes mandatory.

	Field name	Maximum characters	Alpha/ numeric	Format/Values
M	Establishment identifier	3	A/N	ANN
M	Visit number	9	N	NNNNNNNNNN
<i>Patient biographic data</i>				
M	Patient identifier	10	A/N	
	Medicare number	10	N	NNNNNNNNNN or blank
	Medicare code	2	N	NN or N or blank
M	Sex	1	N	1, 2, 3
M	Birth Date	8	N	DDMMCCYY
M	Birth Place	4	N	NNNN
M	Aboriginality	1	N	1, 2
M	Preferred language	2	N	NN
M	Suburb	20	A/N	
M	Postcode	4	N	NNNN
<i>Patient management data</i>				
M	Arrival transport mode	2	N	1, 2, 3, 4, 5, 6, 7, 8, 9, 19
M	Referred by	2	N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 19
⊕	Transfer source	3	A/N	ANN
M	Type of visit	2	N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10
M	Compensable status	1	N	1, 2, 3, 4, 5, 6, 7
*	Ambulance case number	6	A/N	
M	Arrival date	8	N	DDMMCCYY

VEMD - Structure - continued

M	Arrival time	4	N	NNNN
M	Triage date	8	N	DDMMCCYY
M	Triage time	4	N	NNNN
M	Triage category	1	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
M	First seen by Doctor date	8	N	DDMMCCYY or blank
M	First seen by Doctor time	4	N	HHMM or blank
M	Procedures	2	N	NN x 30
M	Departure date	8	N	DDMMCCYY
M	Departure time	4	N	HHMM
M	Departure status	1	N	1, 2, 3, 4, 5, 6, 7, 8
P	Transfer destination	3	A/N	ANN
M	Referred to on departure	2	NN	1, 2, 3, 4, 5, 6, 7, 8, 16, 17, 18, 19
P	Reason for transfer	1	NN	1, 2, 3, 4, 5, 6, 7, 9
P	Escort source	1	N	1, 2, 3, 4, 5, 9
P	Departure transport mode	2	NN	1, 2, 3, 4, 5, 6, 7, 8, 9, 19
M	Primary diagnosis	6	A/N	ICD-10-AM code
	Additional diagnoses 1	6	A/N	ICD-10-AM code
	Additional diagnoses 2	6	A/N	ICD-10-AM code

VEMD Structure - continued

+	Nature of main injury	2	NN	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
#	Body region	2	A/N or NN	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
<i>Injury surveillance data</i>				
#	Description of injury event	100	A/N	
#	Injury cause	2	NN	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	NN	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
#	Type of place where injury occurred	1	A	H, I, S, M, P, A, R, T, C, Q, F, O, U
#	Activity when injured	1	A	L, S, E, W, C, N, V, O, U

M = Mandatory

Ⓐ = Mandatory if *Referred By* = 6

***** = Mandatory if *Arrival Transport Mode* = 1,2,3,4,5

Ⓜ = Mandatory if *Departure Status* = 4

+ = Primary Diagnosis is a mandatory field. If Diagnosis is an injury, it should be further specified by utilising Injury Surveillance fields.

= Mandatory if Diagnosis in *Nature of Main Injury* = 1 - 24.

VEMD Fields

ESTABLISHMENT IDENTIFIER

Three alpha/numeric character field. Hospcode as allocated by Health Computing Services; codes in Appendix 2.

Identifier for the establishment to which this department is attached.

VISIT NUMBER

Nine-character numeric field.

Consecutive number allocated to each presentation in the Emergency Department.

Patient Biographic Data

PATIENT IDENTIFIER

Ten character alpha/numeric field.

Patient identifier unique within establishment.

Unit record number or other local identifier. (e.g. first three letters of patient's surname).

MEDICARE NUMBER

Ten digit Medicare number as on the Medicare card.

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.

See also Medicare code below.

MEDICARE CODE

Up to two-digit numeric field.

The number to the left of *patient* name. If the Medicare number is not available or the patient is ineligible (eg, a prisoner or an overseas resident), the field should be left blank.

SEX

1	Male
2	Female
3	Indeterminate (only for patients aged less than 90 days)

BIRTH DATE

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

BIRTH PLACE

Four character numeric field. Codes in Appendix 3.

Code the patient's Birth Place as precisely as possible. The classification is the *Australian Standard Classification of Countries for Social Statistics*. (Australian Bureau of Statistics, catalogue no. 1269.0). 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 *Aboriginality*.

ABORIGINALITY

Aboriginality of patient as determined by patient self-identification.

1	Aboriginal or Torres Strait Islander
2	<i>Not</i> Aboriginal or Torres Strait Islander

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 is associated (Department of Aboriginal Affairs, Constitutional Section, 1981).

This information should be collected for every patient. The patient should be asked, 'Do you identify as an Aboriginal or Torres Strait Islander?' The question on Aboriginality should be asked at every attendance.

PREFERRED LANGUAGE

Two character numeric field. Codes in Appendix 4.

The language (including sign language) *most preferred* by the patient for communication. In situations where this is ambiguous, the patient should be asked, 'What language other than English is spoken at home?' The coding system is based on the Australian Bureau of Statistics' two digit classification of Birth Place.

SUBURB

Up to twenty alpha/numeric character field.

Geographic location (suburb/town/locality) of usual residence as stated by the patient at time of attendance (*not* postal address). Do *not* include the street address (number, name of road). The Suburb 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 Suburb fields must contain details of the patient's *residential* address.)

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

POSTCODE

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

The Suburb 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 Suburb fields must contain details of the patient's *residential* address.)

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

Other codes to use as Postcodes are:

Pseudo Postcode	Indicating
1000	No fixed abode
8888	Overseas
9988	Unknown Postcode

Patient Management Data

ARRIVAL TRANSPORT MODE

Up to two character numeric field.

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

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

REFERRED BY

Up to two character numeric field.

Source from which patient was referred to this Emergency Department.

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
6	Transfer from another hospital (<i>also record Transfer Source</i>)
7	Nursing Home
8	Prison
9	Crisis Assessment Team
10	Other Community Services
11	Hospital In The Home Service
19	Other

TRANSFER SOURCE

Three character alpha/numeric field. Codes in Appendix 2.

Mandatory if *Referred By* code is 6, indicating transfer from an acute hospital, extended care, rehabilitation or geriatric centre 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.

Field identifies *precise* acute health care facility from which the patient was transferred to your hospital. It is used to analyse patient transfer patterns.

Unknown transfer source is 999.

TYPE OF VISIT

Up to two character numeric field.

Reason patient presents to the Emergency Department.

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 has previously visited an ED and an assessment made that treatment has been 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 an appointment time has been made.
5	Privately referred and privately treated	Referred to the ED by a private medical officer (specialist or GP), ED treatment is delivered by the practitioner to whom the patient is specifically referred by name. Visit is usually by appointment, and practitioner bills patient privately.
<i>Pre-arranged admission: A patient who presents at the ED for either clerical, nursing or medical processes to be undertaken, and admission has been arranged by the referring medical officer and a bed allocated.</i>		
6	Pre-arranged admission - clerical only	
7	Pre-arranged admission - nursing and clerical	
8	Pre-arranged admission - full clinical	
9	Patient in transit	The ED is responsible for care and treatment of a patient awaiting transport to another institution.
10	Dead on arrival	

COMPENSABLE STATUS

One character numeric field.

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

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

AMBULANCE CASE NUMBER

Up to six character alpha/numeric field.

Unique identifier to each ambulance transport occasion.

Mandatory if *Arrival Transport Mode* code is 1, 2, 3, 4 or 5, indicating arrival by ambulance.

ARRIVAL DATE

Eight character numeric field.

A valid date (DDMMCCYY). Date patient first seen by clerical officer in the Emergency Department.

ARRIVAL TIME

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 are not accepted).]* Time patient first seen by clerical officer in the Emergency Department.

TRIAGE DATE

Eight character numeric field.

A valid date (DDMMCCYY). Date patient first seen by Triage nurse.

TRIAGE TIME

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 are not accepted).*] Time patient first seen by Triage nurse/doctor.

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.

TRIAGE CATEGORY

One character numeric field.

Classified according to urgency of need for medical and nursing care, using National Triage Scale (Australia College for Emergency Medicine).

Treatment acuity within:

Code	Category	Time
1	Immediate	≈ 2 minutes
2	Emergency	10 minutes
3	Urgent	30 minutes
4	Semi urgent	60 minutes
5	Non urgent	120 minutes
6	Dead on arrival	

FIRST SEEN BY TREATING NURSE DATE

Eight character numeric field.

Valid date (DDMMCCYY) or blank. Date baseline observations taken after triage.

First Seen By Treating Nurse Date & Time **must** be completed if *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*.

FIRST SEEN BY TREATING NURSE TIME

Four character numeric field.

Time baseline observations taken after triage.

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 are not accepted).*]

First Seen By Treating Nurse Date & Time **must** be completed if *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*.

FIRST SEEN BY DOCTOR DATE

Eight character numeric field.

Valid date (DDMMCCYY) or blank. Date first medical officer assesses patient.

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*.

FIRST SEEN BY DOCTOR TIME

Four character numeric field.

Time first Medical Officer assesses patient.

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 are not 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 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*.

PROCEDURES

Two character numeric field. Codes in Appendix 5.

Up to 30 procedure codes will be accepted.

Specific interventions/treatments performed in the Emergency Department.

DEPARTURE DATE

Eight character numeric field.

Valid date DDMMCCYY. Date patient leaves the Emergency Department.

DEPARTURE TIME

Four character numeric field.

Time patient leaves the Emergency Department.

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 are not accepted).]*

DEPARTURE STATUS

One character numeric field.

Status of patient at departure from the Emergency Department.

Select the **first** appropriate category.

Code	Departure status
1	Discharge to home, nursing home
2	Admission to ward (<i>including HITH</i>)
3	Admission within ED
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

TRANSFER DESTINATION

Three character alpha/numeric field. Codes in Appendix 2.

Mandatory if *Departure Status* code is 4, indicating transfer to an acute hospital, extended care, rehabilitation or geriatric facility 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.

Field identifies *precise* acute health care facility to which patient was transferred by your hospital. It is used to analyse patient transfer patterns. The code is made up in the same way as the Transfer Source code, page 10.

REFERRED TO ON DEPARTURE

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

REASON FOR TRANSFER

One character numeric field.

Mandatory if *Departure Status* code is 4, indicating transfer to an acute hospital, extended care, rehabilitation or geriatric facility 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

ESCORT SOURCE

Up to two character numeric field.

Mandatory if *Departure Status* code is 4, indicating transfer to an acute hospital, extended care, rehabilitation or geriatric facility 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

DEPARTURE TRANSPORT MODE

Up to two character numeric field.

Mandatory if *Departure Status* code is 4, indicating transfer to an acute hospital, extended care, rehabilitation or geriatric facility 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	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

PRIMARY DIAGNOSIS

Up to six character alpha/numeric field. Codes in Appendix 6 and 7.

The Diagnosis primarily responsible for presentation to the Emergency Department.

Primary Diagnosis is a mandatory field. If Diagnosis is an injury, it should be further specified by utilising Injury Surveillance fields.

Decimal points will not be accepted.

Diagnosis Codes should be submitted in ICD-10-AM format from 1 July 1998.

ADDITIONAL DIAGNOSES 1 and 2

Up to six character alpha/numeric field. Codes in Appendix 6 and 7.

Additional diagnoses are those which:

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

Decimal points will not be accepted.

Diagnosis Codes should be submitted in ICD-10-AM format from 1 July 1998.

NATURE OF MAIN INJURY

Up to two character numeric field. Patho-physical nature of injury.

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 eye (14) <i>plus</i> Body Region - Foreign Body, External eye (1)	22
14	Foreign body	8
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	22
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*

8 Requires code from *Body Region - Foreign Body*

BODY REGION FIELD

There are two sets of Body Region codes, depending on whether the Nature of Main Injury code indicates a Foreign Body or any other 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.

Mandatory if *Nature of Main Injury* code is completed.

BODY REGION - FOREIGN BODY INJURY

Two character alpha numeric field.

The body region of the (foreign body) injury indicated in Nature of Main Injury field; that is, the *Nature of Main Injury* code is 14.

Select the **first** appropriate category.

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

BODY REGION - NOT FOREIGN BODY INJURY

Up to two character numeric field.

The body region of the (non foreign body) injury indicated in Nature of Main Injury field; that is, the *Nature of Main Injury* code is *not* 14.

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 (22)
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

Injury Surveillance Data

DESCRIPTION OF INJURY EVENT

Free text field. Maximum of 100 characters.
Description of injury event by patient at triage.

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


Briefly and concisely describe the injury event. For example:

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


The above text thus outlines the sequence of events and includes the following items:

 **Specific location**


- a) own home, bathroom
- b) workshop
- c) Australian Rules football ground

 **Specific activity**


- a) playing
- b) working on forklift pallet
- c) playing competition Australian Rules football

 **Specific product** involved *where applicable*

- a) brand name of medicine, 50 mls
- b) wooden pallet
- c) football


 **Safety device** in use *at the time*


- a) child resistant close on bottle
- b) work boots
- c) 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*).

INJURY CAUSE

Up to two numeric character field. Circumstances and agencies of injury.

Select the *first* appropriate category.

Mandatory if *Nature of Main Injury* code is 1-24.

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)

Code	Injury Cause
23	Struck by or collision with person
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

HUMAN INTENT

Up to two character numeric field.

Most likely role of human intent in occurrence of injury. For this purpose, the issue is intent to produce the injury, not intent to undertake an activity which happened to result in injury.

Mandatory if *Nature of Main Injury* code is 1 - 24.

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

TYPE OF PLACE WHERE INJURY OCCURRED

One character alpha field.

Where person was situated when injury occurred.

Mandatory if *Nature of Main Injury* code = 1 - 24.

Select the **first** appropriate category.

Code	Type of 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)
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)

Code	Type of place	Includes	Excludes
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		

ACTIVITY WHEN INJURED

One character alpha field.

Activity the patient was engaged in when injured.

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	
V	Vital activity, resting, sleeping, eating	Personal hygiene, other personal activity	
O	Other specified activity		
U	Un-specified activity		