

**Proposals for Revisions to the  
Victorian Emergency Minimum Dataset  
(VEMD) for 1 July 2003**

(November 2002)

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# ***Proposals for Revisions to the VEMD for 1 July 2003***

## ***Background***

The Department of Human Services (DHS) conducts an annual review of the Victorian Emergency Minimum Dataset (VEMD) data elements and format. This process is undertaken to maintain and enhance the patient level data reported to the VEMD by the participating Emergency Departments (ED).

The proposals contained within this document should not be regarded as an absolute list of changes to be made to the VEMD for the 2003—2004 financial year. Items in this publication cannot be guaranteed to change or to change in the form suggested here; nor does the absence of an item from this publication indicate that it will not change from 1 July 2003. Final changes will be released in the *Specifications for Revisions to the Victorian Emergency Minimum Dataset* document.

This 'Proposals' document is being distributed to ED Directors and Submission Officers at all VEMD participating Victorian hospitals, software suppliers, and a range of industry associations.

It is expected that the release of these proposals will stimulate discussion within the health industry. Hospitals, emergency associations and software suppliers should review this document carefully and provide any queries or comments to the Health Data Standards and Systems Unit (HDSS) on the attached proforma by **Wednesday 20 November 2002**.

A representative of the proposing organisation will present their proposal, outlined in this document, at the HDSS forum. Those who have an interest in the VEMD are invited to attend the HDSS forum, scheduled for:

**Monday, 25 November 2002,**

**9:00am — 4:30pm**

**Michael Chamberlin Theatre**

**St Vincent's Public Hospital**

**Cnr of Nicholson Street and Victoria Street FITZROY**

Please remember to bring this document and forum agenda to the HDSS forum.

# ***Introduction***

Since implementation of the seventh edition of the VEMD dataset, additional issues have been noted by the Department and highlighted by data users and participating hospitals.

The proposals for the Eighth Edition (1 July 2003), listed in this document comprise modifications to existing data items' including some deletions, addition and deletion of edits and two new data items. Associated business rules and edits for new and amended data items will be added or modified as necessary but should be complete in the Final Specifications for Revisions to the VEMD document, due for release by the end of February.

Proposed additional text for existing data items is underlined and text proposed for deletion from existing data items is ~~struck through~~.

Complete details of existing data item formats, codes and edits are located in the Seventh Edition of the VEMD Manual, 1 July 2002.

# ***Data Definition Structure***

The below table provides descriptions of the attributes common to every data item located in Section 3, Data Definitions (VEMD User Manual, Seventh Edition).

## **Specification**

<b><i>Definition</i></b>	A statement that expresses the essential nature of a data item and its differentiation from all other data items.
<b><i>Datatype</i></b>	The type of symbol, character or other designation used to represent a data item. For example: Alpha/Numeric - a field on which calculations are not performed Numeric - a field on which calculations are performed
<b><i>Form</i></b>	Name or description of the form of representation for the data item, such as: Date, Code (code set), and Quantitative value. For example, the representational form for Country of Birth is 'Code' because individual codes drawn from the codeset represent a different country.
<b><i>Field size</i></b>	The maximum number of characters that can be used to represent this data item.
<b><i>Layout</i></b>	The layout of characters in the data item, expressed by a character string representation (see also Field size). For example: 'DDMMCCYY' for dates 'NNN' for a numeric value of 3 digits
<b><i>Reported for</i></b>	The presentation types that require this data item to be reported.
<b><i>Code set</i></b>	The set of valid values for the data item, according to the form, layout, datatype and field size.
<b><i>Reporting guide</i></b>	Additional comments or assistance on interpreting, applying and reporting the data item and code set.

<b><i>Edits</i></b>	Edits that relate to this data item.
<b><i>Related items</i></b>	Non-exhaustive reference between the data item and related subjects within this collection.

## **Administration**

<b><i>Purpose</i></b>	The main reason for the collection of this data item.
<b><i>Principal data users</i></b>	The key/primary users of the information collected by this data item.
<b><i>Collection start</i></b>	The date the collection of this data item commenced.
<b><i>Version</i></b>	A version number for each data item, beginning with 1 for the initial version of the data item and 2, 3 etcetera, for each subsequent revision.
<b><i>Definition source</i></b>	The source from which the data item was defined.
<b><i>Code set source</i></b>	The source from which the data item code set was developed.

# ***Proposed New Data Items***

## **Proposal #1**

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### **Type of Usual Accommodation**

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#### **Proposed by:**

Hospital Demand Management, DHS.

Contact: David Gardner, telephone: 9616 7798

#### **Reason for Proposed Change:**

The data will be used in the evaluation of acute / residential care interface issues which affect exit block, allowing focus on service planning and the implementation of strategies to address these issues.

Hospitals will be able to use the data as a flag for care coordination and to improve discharge planning for these patients.

#### **Collection Mechanism:**

It is anticipated that the data item would be collected at the same time as all other demographic data. As the information relates to the type of accommodation in which patient usually resides, it is envisaged that the data item would be collected after the address details with the introductory questions of:

- 'Is this a private residence?'
- 'What kind of accommodation is this?'

## Proposed Specification

**Definition** Statement of the type of accommodation setting in which the patient usually lives.

**Datatype** Alphanumeric *Form* Code

**Field size** Two *Layout* NN

**Reported for** Every public hospital emergency department attendance

<b>Code Set</b>	Code	Descriptor
	1	Private Residence, living alone
	2	Private Residence, living with other(s)
	3	Residential Age Care Service
	4	Boarding House / Rooming House / Hostel or Hostel Type Accommodation, not including aged person's hostel
	5	Community-based residential support living facility (e.g. group home for people with disabilities) or other supported accommodation
	6	Psychiatric Hospital
	7	Other Hospital Setting
	8	Specialised Alcohol / Other Drug Treatment Residence
	9	Homeless Person's Shelter
	10	Shelter / Refuge (excluding Homeless Persons' Shelter)
	11	Prison / Remand Centre / Youth Training Centre
	12	Public Place (homeless)
	18	Unknown / Unable to Determine
	19	Other Accommodation, not elsewhere classified

**Reporting guide** 'Usual' is defined as the type of accommodation the patient has lived in for the majority of the three months prior to Emergency Department presentation.

If a person stays in a particular place of accommodation for four or more nights a week over the period, that is deemed to be the 'Usual Type of Accommodation'.

In practice, receiving an answer strictly in accordance with the above definition may be difficult to achieve. The place the patient perceives, as their usual accommodation will often prove to be the best approximation of their type of usual accommodation.

2 – Private Residence - Living with Other(s)

Includes family or friends. Intended to capture those who would provide support on discharge.

3 – Residential Aged Care Facility

Includes: Both high (nursing home) and low (hostel) care as well as Nursing Home Type beds in acute care hospital.

5 – Community Based residential supported living facility (e.g. group home for people with disabilities) or other supported accommodation.

Includes:

- Community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provide 24-hour support/rehabilitation on a residential basis
- Group homes for people with disabilities, cluster apartments where a support worker lives on-site, community residential apartments, congregate care arrangements. Staff on either a live-in or rostered basis provide support, and they may or may not have 24-hour supervision and care.
- Other supported accommodation facilities such as hostels for people with disabilities and Residential Services/Facilities (Victoria and South Australia only). These facilities provide board and lodging with rostered care workers providing client support services.

7 - Other Hospital Setting

Includes: Respite and Palliative Care Facilities

8 - Specialised Alcohol / Other Drug Treatment Residence

Includes: Alcohol and Drug Treatment units in Psychiatric facilities.

***Edits (Proposed)***

Type of Usual Accommodation Blank

Type of Usual Accommodation Invalid

Type of Usual Accommodation and Age Combination Invalid

Type of Usual Accommodation and Locality Combination Invalid

***Related items***

Date of Birth, Locality, Postcode

## **Administration**

***Purpose*** To assist in the evaluation of acute / residential care interface issues and the implementation of strategies to address these issues.

***Principal data users*** Metropolitan Health and Aged Care Services, DHS.

***Proposed Collection start*** 1 July 2003

***Definition source*** DHS ***Code set source*** DHS

## Proposal #2

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### Interpreter Required

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#### **Proposed by:**

Jackie Kearney, Performance Unit, DHS  
Telephone : 9616 8381  
Email: jackie.kearney@dhs.vic.gov.au

#### **Reason for Proposal:**

Approximately 23% of all Victorians are born in a country other than Australia. Currently at least 167 different languages are spoken within our State. According to current admitted patient data, 24.2% of all hospital inpatient separations have a country of birth where English is not the main language.

Information from the 2001 census tells us that 17.3% of Victorians speak a main language other than English at home, of these 43.7% report speaking English not at all, or not well. Importantly, 33% of all people who reported speaking a language other than English at home are born in Australia or another country that is predominately English speaking.

#### **Purpose**

It is recognised that people from Culturally and Linguistically Diverse (CALD) backgrounds are high users of public hospital services. In addition, reports from the Health Services Commissioner identify 'communication' issues to be a primary or secondary cause of complaints about hospital services in 13% of all complaints recorded. It was established that there are elements of communication problems in every complaint received and this continues to be an issue in the resolution of complaints. While complaints from patients from CALD backgrounds are under-represented in this data, it is likely that not speaking English very well, or not at all, may result in disadvantaged health outcomes and services quality compromises.

This data field, in conjunction with the other cultural indicator 'Preferred Language', will form the basis for improved hospital and state-wide planning and monitoring of the expressed need for, and provision of, interpreter services.

In addition, the proposed fields provide more information about which language groups are the main users of hospital services, and within what geographical regions. This data is currently not consistently available using existing data fields, making sensitive statewide planning difficult. This will provide information about workforce capacity in interpreting services in specific language groups, as well as monitor those languages most likely to require an interpreter, ie recent arrivals. Data obtained from these fields will be analysed on an annual basis by the DHS for state-wide planning and policy development and will be reported back to hospitals for hospital level use in planning, monitoring and resource allocation decisions.

## Specification

<b>Definition</b>	The need for an interpreter, as perceived by the person.		
<b>Datatype</b>	Numeric	<b>Form</b>	Code
<b>Field size</b>	One	<b>Layout</b>	N
<b>Reported for</b>	Every Emergency Department presentation (Mandatory item).		
<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	
	1	Yes	
	2	No	
	3	Not Stated	
<b>Reporting guide</b>	Preferred Language to be asked before Interpreter Required.		

This information must:

- Be checked for every admitted patient episode.
- Not be set up to a default code on computer systems.
- Be collected on, or as soon as possible after, admission.

The standard question to ask is:

[Do you] [Does the person] [Does (name)] require an interpreter?

The provision of the question 'Do you require an interpreter?' is asked to determine patient need for an interpreter, not the capacity of the hospital to provide an interpreter.

**1 – Yes**

Use code 1 if the patient indicates they need an interpreter.

**2 – No**

Use code 2 if the patient indicates they do not need an interpreter.

*Includes:* Where the Preferred Language is English.

**3 - Not Stated**

Use code 3 if the neither Yes nor No can be accurately ascertained.

*Includes:*

- Where the Preferred Language is 98 *Not Stated*.
- Some instances where the Preferred Language is 95 *Other Languages, nfd* or 96 *Inadequately described*.

**Patient is unable to consent (eg baby, child or elderly):**

Where a person is not able to consent for themselves (eg baby, child or elderly) then the need for an interpreter should be recorded for the person or persons consenting. For example a parent/guardian or someone with enduring power of attorney.

- Edits**
- ### Interpreter Required Blank (rejection)
  - ### Interpreter Required Invalid (rejection)
  - ### Preferred language = English but Interpreter Required (rejection)
  - ### ATSI identification but language ≠ English or Aboriginal (rejection) *[Include 02, 05, 07, 12, 19, 41, 42, 54, 55, 76, 82, 83, 85]*
  - ### Language is unspecified (warning) *[Include 95, 96, 98]*
  - ### Language Not Stated must = Interpreter Required Not Stated (rejection)
  - ### Interpreter Required Not Stated; Language Invalid (rejection) *[Can only be in combination with 95, 96, 98]*

**Related items** Country of Birth, Indigenous Status, Preferred Language

## Administration

**Purpose** For planning and to form the basis for future funding allocation for CALD hospital service provision.

**Principal data users** Performance Unit, DHS

**Proposed Collection start** 1 July 2003      **Version** 1 (Effective 01.07.03)

**Definition source** DHS      **Code set source** DHS

# ***Proposed Modifications to Existing Data Items***

## **Proposal #3**

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### **Preferred Language**

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#### **Proposed by:**

Jackie Kearney, Performance Unit, DHS  
Telephone : 9616 8381  
Email: jackie.kearney@dhs.vic.gov.au

#### **Reason for Proposal:**

A clarification of the Preferred Language data item to allow the patient, parent or guardian to identify the optimal language preferred in certain situations, such as times of stress or the provision of clinical information. This data field should be used in combination with the Interpreter Required data field to determine the CALD of the facility.

#### **Specification**

<b><i>Definition</i></b>	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.		
<b><i>Datatype</i></b>	Alpha/numeric	<b><i>Form</i></b>	Code
<b><i>Field size</i></b>	Two	<b><i>Layout</i></b>	NN
<b><i>Reported for</i></b>	Every Emergency Department presentation (Mandatory item).		
<b><i>Reporting guide</i></b>	Report valid codes as documented in Page 4 – 64, Preferred Language.		

This information must:

- Be checked for every emergency presentation.
- Not be set up to a default code on computer Emergency Department Information systems.
- Be collected on, or as soon as possible after, admission.

The standard question to ask is:

What is [your] [the person's] preferred language?

**Patient is unable to consent (eg baby, child or elderly):**

Where a person is not able to consent for themselves (eg baby, child or elderly) then the language of the person who is consenting will be recorded. For example a parent/guardian or someone with enduring power of attorney.

### **07 - Australian Indigenous languages, NEC**

Includes:

- All Australian Indigenous languages not shown separately on the code list.

### **98 - Not Stated**

Includes:

- Patients who are not able to respond to this question during their admission (eg unconscious).
- Child unaccompanied by an adult, who is too young to identify preferred language in relation to the ability to consent.
- This question on the form was not filled in or filled in correctly and cannot be verified throughout the admission.

Further reference:

<http://www.sil.org/ethnologue/countries/>

<http://babel.uoregon.edu/yamada/geoguides.html>

**Edits**

E110 : Preferred Language Blank

E111 : Preferred Language Code Invalid

### Preferred language = English but Interpreter Required (rejection)

### ATSI identification but language ≠ English or Aboriginal (rejection) [Include 02, 05, 07, 12, 19, 41, 42, 54, 55, 76, 82, 83, 85]

### Language is unspecified (warning) [Include 95, 96, 98]

### Language Not Stated must = Interpreter Required Not Stated (rejection)

### Interpreter Required Not Stated; Language Invalid (rejection) [Can only be in combination with 95, 96, 98]

**Related Items** Country of Birth, Indigenous Status, Interpreter Required

## Administration

**Purpose** Provide an indication of ethnicity and assists multilingual service planning and provision.

**Principal data users** Monash University Accident Research Centre; Emergency Demand Co-ordination Group, Performance Unit, DHS

**Collection start** 1 July 1995                      **Version** 1 (Effective 01.07.95)

**Definition source** NHDD                      **Code set source** NHDD; ABS mod Aust. Stand. Classification

## Proposal #4

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### Referred By

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**Proposed by:**

Health Data Standards and Systems, DHS.

**Reason for Proposal:**

To clarify the VEMD codeset for this data item by specifying the individual(s) responsible for the referral to the ED, as opposed to an organisation or facility.

### Specification

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

**Datatype** Alpha/numeric      **Form** Code

**Field size** Two      **Layout** NN

**Reported for** Every Emergency Department presentation (Mandatory item).

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	<u>0</u>	<u>Staff from this hospital</u>
	1	Self, family, friends
	2	Local medical officer, includes local GP/Doctor/ <u>Dentist</u>
	<del>3</del>	<del>Outpatients, from this hospital</del>
	4	Private specialist
	<del>5</del>	<del>Emergency Department Review from this hospital</del>
	6	<u>Staff from</u> another hospital <del>campus</del> (includes both admitted and non-admitted transfers. Also record Transfer Source)
	7	<u>Nursing Home</u>
	<del>8</del>	<del>Prison / Custodial care</del> <u>Correctional Officer / Police</u>
	9	Crisis Assessment Team

- 10 ~~Other Community Services Staff~~
- 11 ~~Hospital In The Home Service, from this hospital~~
- 12 ~~Inpatient ward in this hospital campus~~
- 13 ~~Nurse (Excludes above)~~
- 19 ~~Other~~

**Reporting guide**

~~5—Emergency Department Review from this hospital:~~

~~The Emergency Department at this hospital campus has organised a review presentation for the patient.~~

~~NB: Type of Visit should also reflect this appropriately.~~

**13 Nurse:**

Includes District Nurse, Nurse Practitioner and Nurses employed within Aged Care Residential Care Facility (both high and low level care), Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility.

Excludes: Personal Care Attendants (PCA), and nurses within this hospital or other acute care facility.

**7 Nursing Home**

- ~~• If patient has come from a nursing home with a referral from a GP (eg accompanying letter or phone call);~~
- ~~Referred by equals 2 Local medical officer, includes GP/Doctor~~

- ~~• If patient has come from a nursing home without GP referral, that is patient, nursing home staff or relatives have initiated the referral, Referred by equals 7 Nursing Home~~

~~It is recommended that the following working definition of Nursing Home/Aged Residential Care Facility be used to assist the coding process:~~

~~Nursing Homes (also called High Level Care facilities) accommodate elderly people who:~~

- ~~▪ Require 24 hour nursing care~~
- ~~▪ Have been assessed by an Aged Care Assessment Service as requiring nursing home care.~~

~~Exclude people from Low Level care facilities such as hostels (Use Code 19 Other).~~

### **Armed Forces and Prison Hospitals:**

Armed Forces and Prison Hospitals are not recognised by the Commonwealth Department of Health and Aged Care and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

If a patient is transferred to the ED by Armed Forces hospital staff, Referred By is 19 - Other.

If a patient is transferred to the ED by Prison hospital staff, Referred By is 8 – Correctional Officer / Police

Select the first appropriate category.

**Edits**

- E130 : Referred By Blank
- E131 : Referred By Code Invalid
- E132 : Referred By and Type of Visit Combination Invalid
- E136 : Referred By and Transfer Source Combination Invalid

**Related items**      Arrival Transport Mode

## **Administration**

**Purpose**      Analysis of referral patterns.

**Principal data users**      Monash University Accident Research Centre; Emergency Demand Co-ordination Group, DHS

<b>Collection start</b>	1 July 1995	<b>Version</b>	1	(Effective 01.07.95)
			2	(Effective 01.07.97)
			3	(Effective 01.07.01)
			4	(Effective 01.07.02)
			5	(Effective 01.07.03)

<b>Definition source</b>	DHS	<b>Code set source</b>	DHS
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## Proposal #5

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### Human Intent

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#### Proposed by:

Australasian College for Emergency Medicine, Victoria Faculty  
Contact: Harry Karipis, Telephone: 9764 6249

#### Reason for Proposal:

A revision of the codeset to replace the description of 'accident' with 'misadventure/NON-Intentional Self-harm'. The word accident takes away the notion that there is any element of predictability or preventability in the incident.

#### Specification

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

**Datatype** Alpha/numeric      **Form** Code

**Field size** Two      **Layout** NN

**Reported for** As Per VEMD Manual

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>
	1	<del>Accident</del> Misadventure / NON- Intentional Self Harm
	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

**Reporting guide** As per VEMD Manual

**Edits**  
 E300 : Human Intent Code Invalid  
 E301 : Human Intent Blank  
 E302 : Human Intent Code & Age Incompatible

**Related items** Primary Diagnosis, Nature of Main Injury, Body Region, Description of Injury Event, Injury Cause, Place Where Injury Occurred, Activity When Injured

## Administration

**Purpose** To facilitate injury / poisoning research.

**Principal data users** Monash University Accident Research Centre; Emergency Demand Co-ordination Group, DHS

**Collection start** 1 July 1995                      **Version** 1 (Effective 01.07.95)  
 2 (Effective 01.07.03)

**Definition source** NHDD                      **Code set source** NHDD, modified

## Proposal #6

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### Type of Visit

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**Proposed by:**

Health Data Standards and Systems, DHS.

**Reason for Proposal:**

To clarify the VEMD codeset for this data item and as a result simplify the mapping that will be required between the VEMD and the National Minimum Dataset.

### Specification

<b>Definition</b>	The reason the patient presented to the Emergency Department.		
<b>Datatype</b>	Alpha/numeric	<b>Form</b>	Code
<b>Field size</b>	Two	<b>Layout</b>	NN
<b>Reported for</b>	Every Emergency Department presentation (Mandatory item).		

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	<b>Includes</b>
	1	Emergency presentation	<ul style="list-style-type: none"> <li>• Presentation due to a new clinical condition or one that has not been recently treated within the past week by a hospital (inpatient or ED),</li> <li>• An Unplanned presentation for a continuing condition or a</li> <li>• Private referred or privately treated patient</li> </ul>
	2	Return visit - planned	<ul style="list-style-type: none"> <li>• Planned return to the ED as a result of a previous ED presentation or return visit. The return visit may be for planned follow-up treatment or as a consequence of test results indicating need for further treatment or an</li> <li>• Outpatient appointment for a planned presentation</li> </ul>
	3	<del>Unplanned attendance for continuing condition</del>	<del>Previously attended the ED, treatment completed, and no further attendance were planned for the known/existing condition. The attendance may be following a previous admitted patient episode.</del>
	4	<del>Outpatient or Outpatient clinic</del>	<del>An appointment has been made for a planned presentation to either a formal or an informal clinic</del>
	5	<del>Privately referred and privately treated</del>	<del>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</del>
	8	Pre-arranged admission - clerical, nursing, clinical	Presentation at the ED for 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	<u>Patient who is dead on arrival at the Emergency Department</u>

**Reporting guide** Select the first appropriate category.

**Edits**

E132 : Referred By and Type of Visit Combination Invalid  
E140 : Type of Visit Blank  
E141 : Type of Visit Code Invalid  
E142 : Type of Visit Combination Invalid

## Administration

**Purpose** Analysis of service utilisation.

**Principal data users** Monash University Accident Research Centre; Emergency Demand Co-ordination Group, DHS

**Collection start** 1 July 1995

**Version** 1 (Effective 01.07.95)  
2 (Effective 01.07.03)

**Definition source** NHDD

**Code set source** DHS; NHDD, modified

## Proposal #7

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# Arrival Transport Mode

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### Proposed by:

Health Data Standards and Systems, Department of Human Services

Australasian College for Emergency Medicine, Victoria Faculty

Contact: Harry Karipis, Telephone: 9764 6249

### Reason for Proposal:

To clarify the VEMD codeset for this data item and as a result simplify the mapping that will be required between the VEMD and the National Minimum Dataset.

## Specification

**Definition** The type of transport the patient utilised to arrive at the Emergency Department.

**Datatype** Alpha/numeric      **Form** Code

**Field size** Two      **Layout** NN

**Reported for** Every Emergency Department presentation (Mandatory item).

<b>Code set</b>	Code	<b>Descriptor</b>
	1	Air ambulance - fixed wing aircraft for all or any part of journey. Excludes helicopter (Code equals 2)
	2	Helicopter
	3	<u>Road</u> Ambulance service <del>MICA</del>
	4	<del>Ambulance service</del> <del>road car</del>
	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 99 Other (Includes private care, walked)

**Reporting guide**

For journeys involving more than one transport mode, select the first appropriate category, mode in which the greater distance of the journey was undertaken.

For example:

It is acknowledged that all patient transport by air requires road transportation to and from either the transferring hospital or accident site. Because the air transport will most likely involve the greater distance, select code 1 or 2 as appropriate.

**Edits**

- E125 : Arrival Transport Mode Blank
- E126 : Arrival Transport Mode Invalid
- E142 : Type of Visit Combination Invalid
- E151 : Ambulance Case Number & Arrival Transport Mode Combination Invalid

**Related items**

Ambulance Case Number

**Administration**

**Purpose**

Analysis of transport service utilisation and co-ordination.

**Principal data users**

Metropolitan Ambulance Service; Rural Ambulance Victoria; Monash University Accident Research Centre; Emergency Demand Co-ordination Group, DHS

**Collection start**

1 July 1995

**Version**

- 1 (Effective 01.07.95)
- 2 (Effective 01.07.97)
- 3 (Effective 01.07.99)
- 4 (Effective 01.07.03)

**Definition source**

DHS

**Code set source**

DHS

## Proposal #8

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### Departure Status

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#### **Proposed by:**

Hospital Demand Management Section, DHS.  
Contact : David Gardner, Telephone: 9616 7798

#### **Reason for Proposal:**

The Hospital Demand Management Section has determined that a number of Emergency Departments are in the process of introducing initiatives whereby patients are diverted from traditional forms of emergency care. This may be to primary care providers, or to self-care. Using current datasets often results in these presentations being coded as left before being seen therefore the proposed amendment would allow EDs to accurately code these presentations.

The revision of code '0' and '9' is justified by analysis of VEMD data from 2001–2002 which identified that only 390 (0.04%) patients across the state had Departure Status of '9 - Transfer to mental health residential care facility' recorded, whilst Departure Status '0 - Transfer to aged care residential facility' was used in only 630 (0.07%) presentations. The combination of these two codes under the description of 'Transfer to residential care facility (includes nursing home, hostel, mental health residential facility and community care unit)' will allow for accurate data and the best utilisation of the codeset. The data will be used for the assessment of effectiveness and take up rate of new initiatives.

## Specification

**Definition** Patient status and/or destination on departure from the Emergency Department.

**Datatype** Alpha/numeric **Form** Code

**Field size** One **Layout** N

**Reported for** Every Emergency Department presentation (Mandatory item).

<b>Code set</b>	Code	Descriptor
	0	<del>Departure and transfer to aged care residential facility (includes nursing home and hostel).</del> <u>Transfer to residential care facility (includes nursing home, hostel, mental health residential facility and community care unit)</u>
	1	Discharge to home (includes return to nursing home, mental health residential facility)
	2	Admission to ward (Includes HITH and Medical Assessment and Planning Unit; Excludes registered Short Stay Observation Unit)
	3	Admission to registered short stay observation unit (Includes Chest Pain Evaluation Unit; Excludes Medical Assessment and Planning Unit)
	4	Transfer from this hospital campus to another hospital campus (also record Transfer Destination)
	5	Left at own risk, after treatment started
	6	Left before being seen by doctor (or definitive service provider)
	7	Died within ED
	8	Dead on arrival
	9	<del>Departure and transfer to mental health residential facility (includes psychogeriatric nursing home and community care unit)</del>
	<u>10</u>	<u>Left after Advice, at triage, may include recommendation to see other providers.</u>

<b>Reporting guide</b>	<p><del>0 – Departure and transfer to aged care residential facility (includes nursing home and hostel)</del></p> <p><b><u>0 - Transfer to residential care facility (includes nursing home, hostel, mental health residential facility and community care unit).</u></b></p> <p><u>Excludes: Patients returning to the aged care residential facility in which they live. Use code 1 – Home in these instances.</u></p> <p><b>2 – Admission to ward (Includes HITH and Medical Assessment and Planning Unit; Excludes registered Short Stay Observation Unit)</b></p> <p>As Per VEMD Manual</p> <p><b>3 – Admission to short stay observation unit (Includes Chest Pain Evaluation Unit; Excludes Medical Assessment and Planning Unit)</b></p> <p>As Per VEMD Manual</p> <p><del>9 – Departure and transfer to mental health residential facility (includes psychogeriatric nursing home and community care unit)</del></p> <p>Departure and transfer to mental health residential facility (includes psychogeriatric nursing home and community care unit). Does not require a Transfer Destination code.</p> <p><del>Excludes: Patients returning to the mental health residential facility in which they live. Use code 1 – Home in these instances.</del></p> <p><b>Armed Forces and Prison Hospitals:</b></p> <p>As Per VEMD Manual</p>
<b>Edits</b>	As Per VEMD Manual
<b>Related items</b>	As Per VEMD Manual

## Administration

<b>Purpose</b>	As per VEMD Manual		
<b>Principal data users</b>	As Per VEMD Manual		
<b>Collection start</b>	1 July 1995	<b>Version</b>	1 (Effective 01.07.95) 2 (Effective 01.07.00) 3 (Effective 01.07.01) 4 (Effective 01.07.02) 5 (Effective 01.07.03)
<b>Definition source</b>	NHDD	<b>Code set source</b>	DHS

## Proposal #9

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### Referred to on Departure

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#### Proposed by:

Coordinated & Home Care Unit of Aged Care Branch, DHS.

Contact: Viki Perre, Telephone: 9616 7095

#### Reason for Proposal:

To identify the number and proportion of ED patients referred on departure to the Aged Care Assessment Service (ACAS).

#### Specification

**Definition** The primary agency the patient was referred to for continuing care.

**Datatype** Alpha/numeric      **Form** Code

**Field size** Two      **Layout** NN

**Reported for** Every Emergency Department presentation (Mandatory item).

<b>Code set</b>	<b>Code</b>	<b>Descriptor</b>	<b>Includes</b>
	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	Detox Centre, Rape Crisis

	Service	Centre, Crisis Assessment Team, etc.
9	<u>Aged Care Assessment Service</u>	<u>ACAS</u>
16	No referral	Treatment complete
17	Not known	
18	Other	
19	Not applicable	Admission to inpatient bed, Short Stay Observation unit, Transferred, Died, Dead on Arrival, Left at own risk. Can include: Left before seen by definitive service provider

**Reporting guide** Select the first appropriate category.

**Edits**  
E142 : Type of Visit Combination Invalid  
E240 : Referred to on Departure Blank  
E241 : Referred to on Departure Code Invalid  
E242 : Referred to on Departure & Departure Status Combination Invalid

**Related items** Ongoing Care Communication

## Administration

**Purpose** To promote and monitor the coordination of patient care.

**Principal data users** Monash University Accident Research Centre; Emergency Demand Co-ordination Group, DHS

**Collection start** 1 July 1995      **Version** 1 (Effective 01.07.95)  
2 (Effective 01.07.97)

**Definition source** DHS      **Code set source** DHS

# ***Proposed Data Items for Deletion***

## **Proposal #10**

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### **~~Ongoing Care Communication~~**

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#### **Proposed by:**

Australasian College for Emergency Medicine, Victoria Faculty  
Contact: Harry Karipis, Telephone: 9764 6249

#### **Reason for Deletion:**

The data currently collected in this field is unreliable and inaccurate. In many systems it defaults to “Yes” and the data entry person simply accept this default. It does not indicate the type of communication or the extent of communication to make it of any value.

The removal of this data item should help to simplify the VEMD.

# ***Proposed New Edits***

## **Proposal #11**

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### Type of Usual Accommodation Blank

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**Proposed by:**

Result of new data item proposed by Hospital Demand Management Section.

**Reason for Proposal:**

New data item

Effect	REJECTION
Problem	No Type of Usual Accommodation has been recorded.
Remedy	A Type of Usual Accommodation is a mandatory data item for all emergency attendances. Allocate an appropriate Type of Usual Accommodation and resubmit the transaction.

## Proposal #12

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### Type of Usual Accommodation Invalid

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**Proposed by:**

Result of new data item proposed by Hospital Demand Management Section.

**Reason for Proposal:**

New data item

Effect	REJECTION
Problem	The Type of Usual Accommodation format is not valid.
Remedy	Correct the Type of Usual Accommodation, and resubmit the transaction.

## Proposal #13

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### Interpreter Required Blank

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**Proposed by:**

Result of new data item proposed by Performance Unit.

**Reason for Proposal:**

New data item

Effect	REJECTION
Problem	No Interpreter Required code has been recorded.
Remedy	An Interpreter Required is a mandatory data item for all emergency attendances. Allocate an appropriate Interpreter Required code and resubmit the transaction.

## Proposal #14

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### Interpreter Required Invalid

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**Proposed by:**

Result of new data item proposed by Performance Unit.

**Reason for Proposal:**

New data item

Effect	REJECTION
Problem	The Interpreter Required field format is not valid.
Remedy	Correct the Interpreter Required, and resubmit the transaction.

# ***Proposed Deletions to Existing Edits***

## **Proposal #15**

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### **~~E243~~ ~~Ongoing Care Communication Blank~~**

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***Effect*** REJECTION

***Problem*** The Ongoing Care Communication code has not been specified in this record.  
Ongoing Care Communication is a mandatory data item for all emergency attendances.  
See: ~~Page 3~~ 80, Ongoing Care Communication.

***Remedy*** ~~Correct Ongoing Care Communication code and resubmit the transaction.~~

## **Proposal #16**

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### **~~E244~~ ~~Ongoing Care Communication Invalid~~**

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**~~1~~** REJECTION

***Problem*** The Ongoing Care Communication code specified in this record is not a valid code. It does not exist in the Ongoing Care Communication reference table.  
See: ~~Page 3~~ 80, Ongoing Care Communication.

***Remedy*** ~~Correct Ongoing Care Communication code and resubmit the transaction.~~

## ***Abbreviations Used in the Document***

DHS	Department of Human Services Victoria
ED	Emergency Department
EDCG	Emergency Demand Co-ordination Group
EDIS	Emergency Department Information System
HDSS	Health Data Standards & Systems Unit, Acute Health Division, DHS
IAU	Information Analysis Unit, Acute Health Division, DHS
ICD-10-AM	Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
MUARC	Monash University Accident Research Centre
NHDD	National Health Data Dictionary
NLI	National Localities Index
PRS/2	Patient Reporting System Version 2: Computer system by which hospitals transmit admitted patient data to Department of Human Services
VEMD	Victorian Emergency Minimum Dataset
VISAR	Victorian Injury Surveillance and Applied Research System
VISS	Victorian Injury Surveillance System