

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

(February 2003)

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Executive Summary of Changes

The Specification for the VEMD for 2003—04 comprises the Victorian Emergency Minimum Dataset (VEMD) Manual, Seventh Edition, 1 July 2002 (as amended in HDSS Bulletins), together with the amendments detailed in this document:

New Data Items

- Interpreter Required
- Type of Usual Accommodation

Modified Data Items

- Arrival Transport Mode
- Departure Status
- Human Intent
- Preferred Language
- Referred By
- Referred to on Departure
- Type of Visit

Deleted Data Items

- Ongoing Care Communication

New Business Rules

- Description of Injury
- Dead on Arrival

Modified Business Rules

- Departure Status

New Concept and Derived Data Item Definition

- Date/Time Fields

Modified Concept and Derived Data Item Definition

- Diagnosis

Modified VEMD File Structure

Updated Reference Files and Corresponding Data Items

New, Modified and Deleted Edits

A range of VEMD edits have been either introduced, revised or deleted in accordance with the changes to data items outlined in this document. These edits are detailed in Appendix A.

Two major modifications have been undertaken for the 2003–2004 specification:

- The combination of edits relating to the same data item, where applicable. For instance edits:
 - E050 Campus Code Blank
 - E051 Campus Code Invalid
 - E052 Campus Code Does Not Match File Namehave been amalgamated to:
 - E050 Campus Code Invalid
- Addition of a new Edit Type : NOTIFIABLE (refer to Appendix A for further clarification)

Introduction

The need for VEMD modifications

Since the 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 proposed modifications to the dataset for 2003–2004 were distributed in the *Proposals for Revisions the Victorian Emergency Minimum Dataset (VEMD) for 1 July 2003*.

The Department of Human Services (DHS) and the Emergency Department Information Systems (EDIS) Review Committee have considered comments from hospitals and software suppliers regarding the content of the Proposals document. Where possible these suggestions have been accommodated.

For further reference, please see the minutes of HDSS Forum held on Monday 25 November 2002 and the minutes of the EDIS Review Committee meeting held 22 January 2003.

For 1 July 2003, changes to the VEMD will be necessary to:

- Further refine current terminology and code sets.
- Include and revise applicable edits to promote data integrity.
- Update relevant reference files.

Document Convention

- Additional text for existing data items is underlined;
- Deleted text from existing data items is ~~struck through~~;
- New or amended values in code sets are enclosed in a dotted border.
- New and amended edits are identified by an asterisk (*) appearing on the right hand side of the corresponding edit number and descriptor (within the data definition).

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

Distribution and components of this document

This document outlines new and amended VEMD definitions, fields, business rules, edits, and file structure. It has been distributed to Emergency Directors, VEMD submission officers, software suppliers, a range of industry associations, and is also accessible on the Health Data Standards & Systems Unit (HDSS) website at hdss.health.vic.gov.au

Hospitals should request that suppliers modify their software in accordance with the revised specifications. Information on the method of dealing with patients who are remaining in the Emergency Department at midnight on 30 June 2003 is also included in this document.

The changes noted in this document will be incorporated into the VEMD Manual, Eighth Edition, 1 July 2003 planned for release in May 2003. Until the Eighth Edition is released, Software suppliers and hospitals making modifications for 1 July 2003; are advised to work from:

- this document
- VEMD Manual, Seventh Edition, 1 July 2002
- amendments notified in HDSS Bulletins throughout the 2002–2003 financial year

Test Transmissions

The Department of Human Services recognises that software suppliers can experience difficulties making the 1 July revisions to their programs and that distributing untested programs to clients is unsatisfactory. It can also be difficult for hospitals to resolve problems caused by using untested software. The Department will therefore be making a test submission facility available to software suppliers and encourages all suppliers to test new programs before using them to send live data to VEMD.

After making the necessary programming changes to meet the revised requirements, each software supplier can send a reasonable number of tests, without charge.

Each test can be made by sending (as per usual) to: Submit.VEMD@dhs.vic.gov.au

The transmission must contain a control report file and data file. However, you should clearly mark this **email**, not the data file as 'TEST DATA'.

This will be processed by the Department and returned to you within 3 working days.

Staff at the Department will, if requested, assist in identifying problems. However, there is no approval process for testing 1 July updates. Once the supplier and/or the hospital are satisfied that the new software meets the specifications as defined by the Department, live transmissions can commence.

Abbreviations Used in the Document

CALD	Cultural and Language Diversity
DHS	Department of Human Services, Victoria
ED	Emergency Department
EDIS	Emergency Department Information System
HDMG	Hospital Demand Management Group, Metropolitan Health & Aged Care Services, DHS
HDSS	Health Data Standards & Systems Unit, Metropolitan Health & Aged Care Services, 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
VEMD	Victorian Emergency Minimum Dataset
VISAR	Victorian Injury Surveillance and Applied Research System

Data Definition Structure

The table below provides descriptions of the attributes common to data items specified in this document.

Specification

<i>Definition</i>	A statement that expresses the essential nature of a data item and its differentiation from all other data items.
<i>Datatype</i>	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
<i>Form</i>	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.
<i>Field size</i>	The maximum number of characters that can be used to represent this data item.
<i>Layout</i>	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
<i>Reported for</i>	The presentation types that require this data item to be reported.
<i>Code set</i>	The set of valid values for the data item, according to the form, layout, datatype and field size.
<i>Reporting guide</i>	Additional comments or assistance on interpreting, applying and reporting the data item and code set.
<i>Edits</i>	Edits that relate to this data item.
<i>Related items</i>	Non-exhaustive reference between the data item and related subjects within this collection.

Administration

<i>Purpose</i>	The main reason for the collection of this data item.
<i>Principal data users</i>	The key/primary users of the information collected by this data item.
<i>Collection start</i>	The date the collection of this data item commenced.
<i>Version</i>	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.
<i>Definition source</i>	The source from which the data item was defined.
<i>Code set source</i>	The source from which the data item code set was developed.

New Concept & Derived Items Definitions

Date/Time Fields

Definition With the exception of Date Of Birth, all Date fields in VEMD have a related Time field. Although date and time fields are submitted as two separate fields, they should be viewed as a single "Date/Time" entity. To accommodate this, date and time fields are converted to a single "date/time" value before being edited.

Guide for Use Using date without time or vice versa is problematic.

For instance, calculating a Length of Stay of 1 hour, only using arrival time of 11:00 and departure time of 12:00, will be incorrect if the times fall on different days.

Similarly if a patient commences treatment on 2/5/2004 and ceased on 3/5/2004 it may not be appropriate to say that the duration of treatment was one day if it commenced just before midnight and ceased just after.

If the date and time fields fail the conversion process, they are not a valid date/time. For example submitting a date string of 31092003 with a time string of 1153 will fail to convert to a date/time because there are only 30 days in September. Submitting a date string of 30092003 and no (or a null) time string will also fail the conversion.

When correcting "Date/Time" errors, check both the date and the time fields as the error may occur in either or both.

Modified Concepts & Derived Items

Definitions

Diagnosis

Definition

A Diagnosis is a decision reached, after assessment, of the nature and identity of the disease or condition of a patient.

Guide for Use

When determining the patient's diagnosis consideration should be given not only to the a physical examination but also to the history of the present illness, based on a description of symptoms and signs, a past medical history, a family medical history and a social history.

Reporting 'Dead On Arrival (DOA)' patients:

A patient classified as DOA **must** be allocated a Principal Diagnosis of either:

- R95 – Sudden Infant Death Syndrome (SIDS) or
- R961 - Dead on arrival.

A blank Principal Diagnosis is not be acceptable for DOA patients.

New Data Items

Interpreter Required

Revision Summary

To provide more information about which language groups are the main users of hospital services, and within what geographical regions. This will form the basis for improved hospital and statewide planning and monitoring of the expressed need for, and provision of, interpreter services.

Specification

Definition The patient's need for an interpreter, as perceived by the patient or person consenting for the patient.

Datatype Alpha/Numeric **Form** Code

Field size One **Layout** X

Reported for Every Emergency Department presentation (Mandatory item).

Code set **Code** **Descriptor**

1	Yes
2	No
3	Not Stated

Reporting guide Preferred Language to be asked before Interpreter Required.
If the Preferred language is English, Interpreter Required can be assumed to be '2 – No'.

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 is:

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

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 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 is recorded for the person who is consenting. For example a guardian or someone with enduring power of attorney.

Edits

- E357* Interpreter Required Invalid
- E358* Preferred language Equals English but Interpreter Required
- E359* ATSI identification but language Not Equal to English or ATSI
- E360* Preferred Language is Unspecified
- E361* Preferred Language is Not Stated but Interpreter Status Not Equal to '3 – Not Stated'
- E362* Interpreter Status Equals '3 – Not Stated' but Preferred Language Invalid

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 Clinical Governance Section, DHS

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

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

Type of Usual Accommodation

Revision Summary

To allow the collection of data that can 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

Specification

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

Datatype Alpha/Numeric *Form* Code

Field size Two *Layout* XX

Reported for Every Emergency Department presentation (Mandatory item).

Code Set

Code	Descriptor
1	Private Residence, living alone
2	Private Residence, living with other(s)
3	Residential aged care facility - includes both high care (nursing home) and low care (hostel)
4	Boarding/rooming house/hostel or hostel type accommodation (not including aged care hostel)
5	Community-based residential supported living facility or other supported accommodation (includes group home for people with disabilities, supported residential services, specialised alcohol/other drug treatment residence).
6	Psychiatric Hospital
7	Other Hospital Setting
8	Homeless Person's Shelter
9	Shelter/refuge (not including homeless person's shelter)
10	Public place (homeless)
11	Prison/Remand Centre/ Youth Training centre

- 18 Unknown/unable to determine
- 19 Other accommodation, not elsewhere classified

Reporting guide

'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to presentation.

If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation.

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

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 care (nursing home) and low (hostel) care.

Includes: nursing home beds in acute and sub/acute care hospitals.

5 – Community-based residential supported living facility 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. Support is provided by staff on either a live-in or rostered basis, 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. These facilities provide board and lodging and rostered care workers provide client support services.

The intent of code 5 is to capture accommodation where there is some support available. Where there is no support available i.e. the hostel or other facility provides accommodation only, code 4 should be allocated.

6 - Psychiatric Hospital

Includes alcohol/other drug treatment units in psychiatric hospitals

7 - Other Hospital Setting

Includes respite and palliative care facilities.

Edits

E354* Type of Usual Accommodation Invalid

E355* Type of Usual Accommodation and Age Combination Invalid

E356* Type of Usual Accommodation and Departure Status 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.

Collection start

1 July 2003

Version

1 (Effective 01.07.03)

Definition source

DHS

Code set source

DHS

Modifications to Existing Data Items

Arrival Transport Mode

Revision Summary

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 main type of transport the patient utilised to arrive at the Emergency Department.

Datatype Alpha/Numeric Form Code

Field size Two Layout XX

Reported for

Every Emergency Department presentation (Mandatory item).

Code set

Code	Descriptor
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 —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 (Includes private car, walked)
99

Reporting guide

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

For example:

It is acknowledged that most patient's transported by air require road transportation to and/or from the transferring hospital. Where the air transport involves the greater distance, select code 1 or 2 as appropriate.

Edits

E125* Arrival Transport Mode Invalid
E142* Dead on Arrival 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

Departure Status

Revision Summary

To allow for accurate data and the best utilisation of the codeset.

Specification

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

Datatype Alpha/Numeric **Form** Code

Field size One Two **Layout** XX

Reported for Every Emergency Department presentation (Mandatory item).

Code set

Code Descriptor

0	Departure and transfer to aged care residential facility (includes nursing home and hostel). <u>Residential care facility (includes nursing home, hostel, psychogeriatric nursing home, residential care respite bed)</u>
1	Home (includes return to nursing home, mental health residential facility)
2	Ward (Includes HITH and Medical Assessment and Planning Unit; Excludes registered Short Stay Observation Unit)
3	Short stay observation unit (Includes Chest Pain Evaluation Unit; Excludes Medical Assessment and Planning Unit)
4	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	Mental health residential facility (includes psychogeriatric nursing home and community care unit) <u>(Excludes psychogeriatric nursing home, use 0)</u>

<u>10</u>	<u>Left after clinical advice regarding treatment options</u>
<u>11</u>	<u>Left at own risk, without treatment</u>
<u>12</u>	<u>Correctional/Custodial Facility</u>

Reporting guide

Used to identify the **immediate** destination or departure status of the patient upon departure from the ED. This may not necessarily be to the patient's usual place of residence.

~~**0 – Departure and transfer to aged care residential facility (includes nursing home and hostel)**~~

~~0 - Residential care facility (includes nursing home, hostel, and community care unit).~~

~~Includes: nursing home, hostel, psychogeriatric nursing home, residential care respite bed and nursing home beds which are located within an acute or sub-acute hospital campus~~

1 - Home

~~(includes return to nursing home, mental health residential facility)~~

Includes:

- house,
- unit,
- boarding/rooming house,
- hotel,
- caravan,
- youth hostel accommodation,
- homeless person's shelters
- shelter/refuges
- armed forces hospitals and
- no fixed abode

Excludes: accommodation described in remainder of codeset.

2 –Ward (Includes HI TH and Medical Assessment and Planning Unit; Excludes registered Short Stay Observation Unit)

As Per VEMD Manual

3 –Short stay observation unit (Includes Chest Pain Evaluation Unit; Excludes Medical Assessment and Planning Unit)

As Per VEMD Manual

4 - Another hospital campus (also record Transfer Destination)

excludes armed forces hospitals (use 1 – Home) and correction facility hospital (use 12 – Correctional/Custodial facility).

7 – Died Within ED

Patient died after commencement of ED presentation. Includes where there is an intention to resuscitate but the patient is later pronounced dead.

8 – Dead on Arrival

Patient is pronounced dead by a medical practitioner before (or without) being brought into the ED or where the patient is brought into the ED but there is no intention to resuscitate.

9 –Mental health residential facility (Excludes psychogeriatric nursing home, use 0) ~~(includes psychogeriatric nursing home and community care unit)~~

Does not require a Transfer Destination code.

~~Excludes: Patients returning to the mental health residential facility in which they live. Use code 1 - Home in these instances.~~

10 – Left after clinical advice regarding treatment options

At or subsequent to triage, the patient has received advice about Emergency Department and alternative treatment options. On consideration of this advice, the patient chooses to leave without being seen by a definitive service provider.

11 – Left at own risk, without treatment

Patient departs the Emergency Department before being seen by a clinical service provider:

- Without notifying staff; OR
- Despite being advised by clinical staff NOT to leave; OR
- Without receiving advice about alternatives to treatment in the Emergency Department

Common descriptions include: Did Not Wait, DNW, Failed To Answer, FTA.

Edits	E137	Transfer / Destination Source Equals Campus Code
	E142*	Dead on Arrival Combination Invalid
	E182*	First Seen By Treating Nurse / Doctor Date/Time & Departure Status Combination Invalid
	E230*	Departure Status Invalid
	E232	Transfer Departure Status Code Combination Invalid;
	E233	Unregistered Short Stay Observation Unit
	E242*	Referred to on Departure & Departure Status Combination Invalid
	E260*	Primary Diagnosis Blank
	E320	Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid
	E339	Inpatient Bed Request and Departure Status Combination Invalid
	E342*	Primary Diagnosis recorded when Departure Status is '6' or '8'
	E352*	Arrival Transport Mode '9 – Undertaker' but not DOA
	E353*	Diagnosis Code Equals 'R961 – Dead on Arrival' but patient not DOA
	E356*	Type of Usual Accommodation and Departures Status Combination Invalid

Related items As Per VEMD Manual

Administration

Purpose As per VEMD Manual

Principal data users As Per VEMD Manual

Collection start	1 July 1995	Version	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)

Definition source NHDD

Code set source DHS

Human Intent

Revision Summary

A revision of the codeset to replace the description of 'accident' with 'NON-Intentional 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** XX

Reported for As Per VEMD Manual

Code set

Code	Descriptor
-------------	-------------------

1	Accident <u>NON- Intentional Harm</u>
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 and 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
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Preferred Language

Revision Summary

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

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.

Datatype Alpha/numeric **Form** Code

Field size Two **Layout** XX

Reported for Every Emergency Department presentation (Mandatory item).

Reporting guide 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).

Unaccompanied child, who is too young to identify preferred language.

This question on the form was not completed or completed incorrectly and cannot be verified throughout the admission.

Further reference:

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

<http://www.ethnologue.com/>

Edits

E110*	Preferred Language Invalid
E357*	Interpreter Required Invalid
E358*	Preferred language Equals English but Interpreter Required
E359*	ATSI identification but language Not Equal to English or ATSI
E360*	Preferred Language is Unspecified
E361*	Preferred Language is Not Stated but Interpreter Status Not Equal to '3 – Not Stated'
E362*	Interpreter Status Equals '3 – Not Stated' but Preferred Language Invalid

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, Clinical Governance Section, DHS

Collection start

1 July 1995

Version

1 (Effective 01.07.95)
2 (Effective 01.07.03)

Definition source

NHDD

Code set source

NHDD; ABS mod Aust. Stand. Classification

Referred By

Revision Summary

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.

Individual(s) responsible for referring the patient to this Emergency Department.

Datatype

Alpha/numeric

Form

Code

Field size

Two

Layout

XX

Reported for

Every Emergency Department presentation (Mandatory item).

Code set

Code Descriptor

<u>0</u>	<u>Staff from this hospital</u>
1	Self, family, friends
2	Local medical officer, includes local GP/Doctor/ <u>Dentist</u>
3	Outpatients, from this hospital
4	Private specialist
5	Emergency Department Review from this hospital
6	<u>Staff from another hospital campus</u> (includes both admitted and non-admitted transfers. Also record Transfer Source)
7	Nursing Home
8	Prison / Custodial care Correctional Officer / Police
9	Crisis Assessment Team
10	Other Community Services <u>Staff</u>
11	Hospital In The Home Service, from this hospital
12	Inpatient ward in this hospital campus
<u>13</u>	<u>Nurse (Excluding those in categories 0 to 10)</u>
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 Invalid
 E136* Referred By and Transfer Source Combination Invalid

Related items Arrival Transport Mode, Transfer Source, Type of Visit

Administration

Purpose Analysis of referral patterns.

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)
			3	(Effective 01.07.01)
			4	(Effective 01.07.02)
			5	(Effective 01.07.03)

Definition source	DHS	Code set source	DHS
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Referred to on Departure

Revision Summary

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

Specification

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

Datatype Alpha/numeric **Form** Code

Field size Two **Layout** XX

Reported for Every Emergency Department presentation (Mandatory item).

Code set	Code	Descriptor	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.
	9	<u>Aged Care Assessment Service</u>	<u>Dedicated ACAS teams which are able assess eligibility for community & residential aged care programs</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.

9 – Aged Care Assessment Service (ACAS)

Used where a patient is referred to an ACAS in order to assess eligibility for access to Community Aged Care Packages or residential aged care.

The core objective of ACAS is to comprehensively assess the needs of frail older people and to facilitate access to available services appropriate to their needs. In meeting this objective, ACAS also determine eligibility for Commonwealth subsidised residential aged care (including residential respite), Community Aged Care Packages and some flexible care services, including Extended Aged Care at Home (EACH).

Where a patient is referred to any other aged care specific service the appropriate code should be used (e.g. if a referral is made to a geriatrician then use code 5 medical specialist)

Edits

E142*	Dead on Arrival Combination Invalid
E240*	Referred to on Departure 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)
			3	(Effective 01.07.03)

Definition source	DHS	Code set source	DHS
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Type of Visit

Revision Summary

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 reason the patient presented to the Emergency Department.

Datatype Alpha/numeric **Form** Code

Field size Two **Layout** XX

Reported for Every Emergency Department presentation (Mandatory item).

Code set

Code	Descriptor	Includes
1	Emergency presentation	Presentation due to a new clinical condition, <u>An Unplanned presentation for a continuing condition, or a Privately referred or privately treated patient.</u>
2	Return visit - planned	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 <u>as a result of a care plan initiated at discharge, or Outpatient appointment for a planned presentation.</u>
3	Unplanned attendance for continuing condition	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.
4	Outpatient or Outpatient clinic	An appointment has been made for a planned presentation to either a formal or an informal clinic
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	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 is pronounced dead by a medical practitioner before (or without) being brought into the ED or where the patient is brought into the Ed but there is no intent to resuscitate.</u>

Reporting guide

Select the first appropriate category.

2 – Return Visit – Planned

Includes the following:

Where a return visit has been scheduled (for example where a patient is told to return on a specific date for removal of sutures);

Where a return visit is required as a consequence of test results indicating need for further treatment;

Where a return visit becomes necessary as part of a conditional, documented discharge plan (for example: patient is given specific plaster care advice and returns with numbness in the affected limb);

Excludes:

Where a visit follows a general exhortation to return if feeling unwell, this should not be recorded as a planned visit.

Edits	E140*	Type of Visit Invalid
	E142*	Dead on Arrival 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
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Data Items for Deletion

Ongoing Care Communication

Revision Summary

The removal of an unnecessary data item from the VEMD.
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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 accepts this default. It does not indicate the type of communication or the extent of communication to make it of any value for a central data collection.

New Business Rules

Description of Injury

Description of Injury data field **must** be blank **unless** the patient has presented with a condition, classified as an Injury, Poisoning or as a Certain Other Consequence of External Cause (majority of VEMD Diagnosis codes beginning with S or T).

In order to protect patient and employee privacy, collection staff should be instructed NOT to record identifying details in the Description of Injury field. For example:

- 'Tripped on tree root in back yard. TBSB Dr Collingwood' becomes
 - o 'Tripped on tree root in back yard.'
- 'James presented with third overdose this week' becomes
 - o 'Patient presented with third overdose this week.'

Hospitals and software vendors should contact HDSS if they have any further queries.

Dead On Arrival

'Dead on Arrival' status should only be accorded to an episode where the

- i. patient is pronounced dead by a medical practitioner before (or without) being brought into the Emergency Department or
- ii. patient is brought into the Emergency Department but there is no intention to resuscitate them.

Where there is the intention to resuscitate a patient brought into the ED but they are later pronounced dead, the patient should be recorded as having 'Died in E.D'.

If the patient is dead on arrival then the following fields **MUST** contain these values:

Field	Value
Arrival Transport Mode	Any mode – although majority should be 9
Departure Status	8
Diagnosis	R95 or R961
Referred to on Departure	19
Triage category	6
Type of Visit	10

If the patient is NOT dead on arrival then the following fields **MUST NOT** contain these values:

Field	Value
Arrival Transport Mode	9
Departure Status	8
Diagnosis	R961
Triage Category	6
Type of Visit	10

Modified Business Rules

Departure Status

Departure Status Code:

6 – Left before being seen by doctor (or definitive service provider)

Additional Data Items to be completed:

Data items that are mandatory for every ED presentation

Optional Data Items that may be completed and submitted:

- Activity When injured
- Human Intent
- Injury Cause
- Place Where Injury Occurred

Modified File Structure

Conditional Mandatory Items Key

Key	Descriptor
M	Mandatory item
Ⓐ	Mandatory if Medicare Suffix does not equal C-U, N-E or P-N
§	Mandatory if Referred By = 6
*	Should be reported if Arrival Transport Mode = 1, 2, 3, 10, 11
†	Mandatory if Departure Status = 4
⊛	Primary Diagnosis is a mandatory item, except where Departure Status = 6 - Left before being seen by doctor (or definitive service provider) or 8 - Dead on Arrival . If Diagnosis is an injury, further specified by utilising Injury Surveillance items
⊙	Mandatory if any other Injury Surveillance items are completed, or if an injury code from the Nature of Main Injury & Body Region Matrix is in the Primary Diagnosis item
▼	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 services provider (except where Departure Status = 6 - Left before being seen by definitive service provider)
⊕	Mandatory if Primary Diagnosis code = 'Z099 - Attendance for Follow-up (includes injections) / Review following earlier treatment'.
↗	Mandatory if an inpatient bed request was made, regardless of whether the patient is actually admitted as an inpatient
⌘	Mandatory <u>Optional</u> if Primary Diagnosis item is completed
©	Mandatory if Compensable Status = 2
‡	Optional if Departure Status = 4 - Transfer from this hospital

	Field Name	Maximum Characters	Alpha / Numeric	Format / Values	Excel Position
M	Campus Code	4	A/N	XXXX	A
M	Unique Key	9	A/N	XXXXXXXXXX	B
Patient Biographic					
M	Patient Identifier	10	A/N	XXXXXXXXXX	C
<u>Ω</u>	Medicare Number	11	N	NNNNNNNNNNNN or blank	D
M	Medicare Suffix	3	A/N	XXX	E
©	DVA Number	9	A/N	See detailed specification: VEMD Manual, 3-47	F
M	Sex	1	N	1, 2, 3	G
M	Date of Birth	8	N	DDMMCCYY	H
M	Country of Birth	4	A/N	XXXX	I
M	Indigenous Status	1	A/N	2, 5, 6, 7	J
<u>M</u>	<u>Interpreter Required</u>	<u>1</u>	<u>A/N</u>	<u>1, 2, 3</u>	<u>K</u>
M	Preferred Language	2	A/N	XX	L
M	Locality	22	A/N	XXXXXXXXXXXXXXXXXXXX XXXX	M
M	Postcode	4	N	NNNN	N
<u>M</u>	<u>Type of Usual Accommodation</u>	<u>2</u>	<u>A/N</u>	<u>1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 18, 19</u>	<u>O</u>
Patient Management Data					
M	Arrival Transport Mode	2	A/N	1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 19 , <u>99</u>	P
M	Referred By	2	A/N	<u>0</u> , 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 , 12 , <u>13</u> , 19	Q
§	Transfer Source	4	A/N	XXXX	R
M	Type of Visit	2	A/N	1, 2, 3, 4, 5 , 8, 9, 10	S

M	Compensable Status	1	A/N	1, 2, 3, 4, 5, 6, 7	T
*	Ambulance Case Number	6	A/N	See detailed specification: VEMD Manual, 3-10	U
M	Arrival Date	8	N	DDMMCCYY	V
M	Arrival Time	4	N	HHMM	W
M	Triage Date	8	N	DDMMCCYY	X
M	Triage Time	4	N	HHMM	Y
M	Triage Category	1	A/N	1, 2, 3, 4, 5, 6	Z
▼	First Seen by Treating Nurse Date	8	N	DDMMCCYY or Blank	AA
▼	First Seen by Treating Nurse Time	4	N	HHMM or Blank	AB
❖	First Seen by Treating Doctor Date	8	N	DDMMCCYY or Blank	AC
❖	First Seen by Treating Doctor Time	4	N	HHMM or Blank	AD
⌘	Procedure	89	A/N	XX (x30)	AE
↗	Inpatient Bed Request Date	8	N	DDMMCCYY or Blank	AF
↗	Inpatient Bed Request Time	4	N	HHMM or Blank	AG
M	Departure Date	8	N	DDMMCCYY	AH
M	Departure Time	4	N	HHMM	AI
M	Departure Status	1 <u>2</u>	A/N	0, 1, 2, 3, 4, 5, 6 , 7, 8, 9, <u>10</u> , <u>11</u> , <u>12</u>	AJ
†	Transfer Destination	2	A/N	XXXX	AK
M	Referred to on Departure	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, <u>9</u> , 16, 17, 18, 19	AL
M	Ongoing Care Communication	1	A/N	Y, N	AK
†	Reason for Transfer	1	A/N	1, 2, 3, 4, 5, 6, 7, 9	AM

‡ E	Escort Service	1	A/N	1, 2, 3, 4, 5, 9 or blank	AN
†	Departure Transport Mode	2	A/N	1, 2, 3, 4, 6, 7, 8, 10, 11, 19	AO
⊕	Primary Diagnosis	5	A/N	ICD-10-AM VEMD Code	AP
⊕	Additional Diagnosis 1	5	A/N	ICD-10-AM VEMD Code	AQ
⊕	Additional Diagnosis 2	5	A/N	ICD-10-AM VEMD Code	AR
<u>Injury Surveillance Data</u>					
⊙	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	AS
⊙	Body Region	2	A/N	<u>F1, F2, F3, F4, F5, F6, F7</u> 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22	AT
⊙	Description of Injury Event	250	A/N		AU
⊙	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	AV
⊙	Human Intent	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	AW
⊙	Place Where Injury Occurred	1	A/N	H, I, S, A, R, T, C, Q, F, M, P, O, U	AX
⊙	Activity When Injured	1	A/N	S, L, W, E, C, N, V, O, U	AY

Patients 'Remaining In' on 30 June 2003

The format of the VEMD, Eighth Edition is to be implemented for patients who depart the Emergency Department on or after 1 July 2003. This includes patients who remain in the Emergency Department after midnight on the 30 June 2003.