

Section 4— Business Rules

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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 within 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
First Seen By Doctor Date/Time	Time patient was certified DOA

All other mandatory fields should also be completed.

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

Departure Status and Referred to on Departure

The valid combinations of the Departure Status and Referred to on Departure data items.

If Departure Status is	Referred to on Department must be
0 - Residential care facility	1 – 18
1 - Home	1 – 18
2 – Ward (admitted, HITH, MAPU)	19
3 – Short Stay Observation Unit (SOU)	19
4 - Another hospital campus	19
5 - Left at own risk, after treatment started	19
7 - Died within ED	19
8 – Dead on Arrival	19
9 - Mental health residential facility	1 – 18
10 - Left after clinical advice regarding treatment options	1 – 18
11 - Left at own risk, without treatment	19
12 - Correctional/Custodial Facility	1 – 18
13 - Emergency Medical Unit (EMU)	19

Injury Surveillance

If a patient presents with an injury and receives treatment all of the following data items must be reported:

- Activity when Injured.
- Body Region.
- Description of Main Injury Event.
- Human Intent.
- Injury Cause.
- Nature of Main Injury.
- Place where Injury occurred.
- Primary Diagnosis code beginning with an S or T

If a patient presents with an injury, but leave without treatment then report:

- As many Injury Surveillance fields as were collected prior to the patient's departure.
- Departure Status of 10 or 11.
- No Diagnosis codes

Injury surveillance fields (including Description of Injury Event) are not permitted with any diagnosis that is not an injury code (starting with either 'S' or 'T').

An illustration of how the Injury Surveillance fields should be utilised is detailed below. Each of the three scenarios has been allocated an appropriate code or data item in the table below.

Examples:

1. Poisoning as child ingested 8 paracetamol tablets (cardboard packet of brand X) found in bathroom cabinet while playing in the bathroom at home.
2. Crush injury to foot, wooden pallet dropped onto foot whilst working at a construction site, wearing safety boots with steel capped toes at the time.
3. Shop assistant received contusion to cheek, punched in face by angry customer at the local shopping centre.

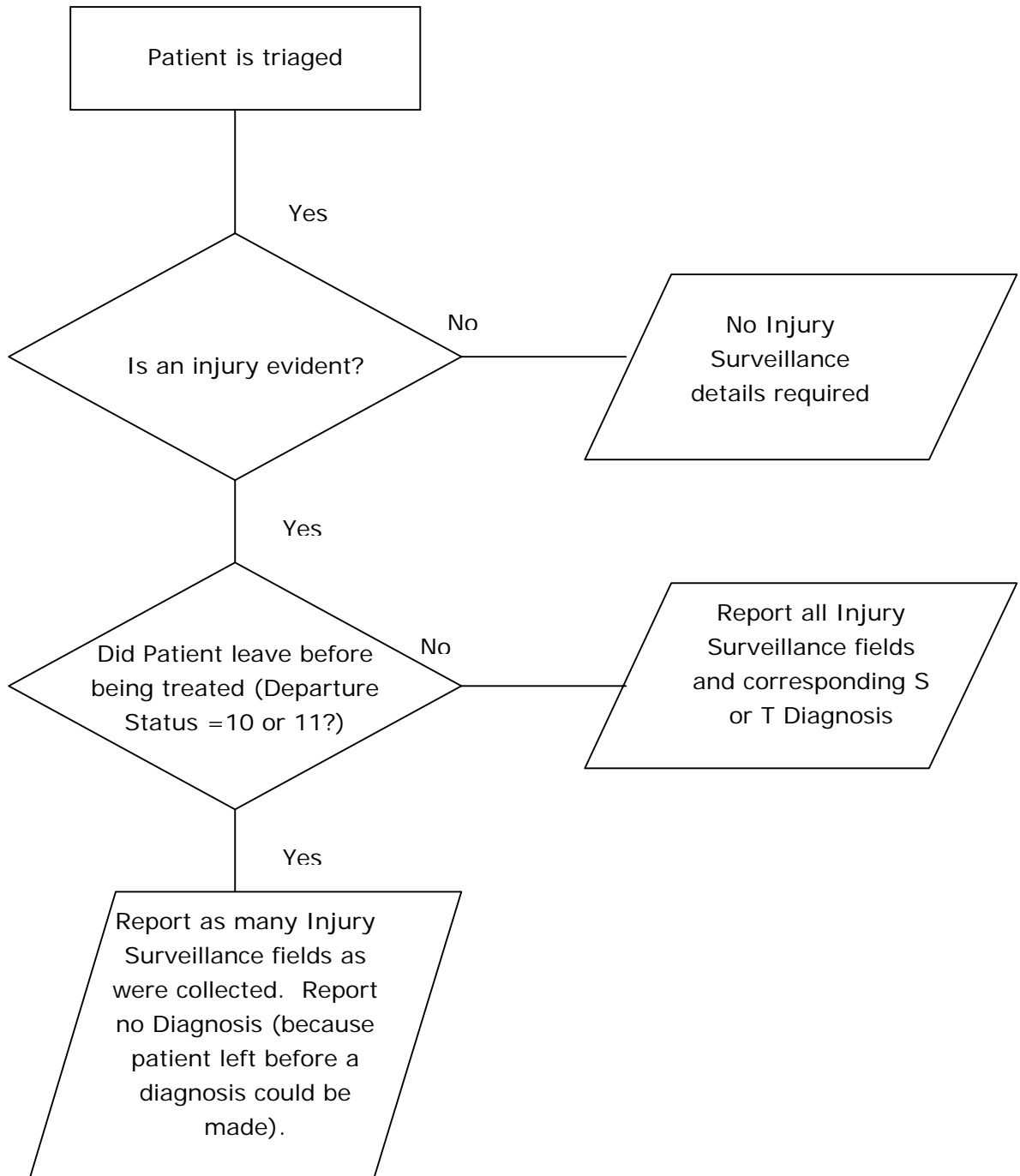
	Example 1	Example 2	Example 3
Primary Diagnosis	[Use code T391] Poisoning, paracetamol	[Use code S978] Crush injury of foot	[Use code S0080] Contusion of cheek
Nature of Main Injury	[Use code 20] Poisoning, toxic effect	[Use code 9] Crushing injury	[Use code 1] Superficial
Body Region	[Use code 22] Body Region not applicable	[Use code 19] Foot	[Use code 2] Face
Description of Injury Event	Poisoning as child ingested 8 paracetamol tablets (cardboard packet of brand X) found in bathroom cabinet while playing at home	Crush injury to foot, wooden pallet dropped onto foot whilst working at a construction site, safety boots with steel capped toes	Shop assistant received contusion to cheek, punched in face by angry customer at the local shopping centre
Injury Cause	[Use code 17] Poisoning - other or unspecified substance	[Use code 24] Struck by or collision with object	[Use code 23] Struck by or collision with person
Human Intent	[Use code 1] Accident	[Use code 1] Accident	[Use code 7] Assault not otherwise specified
Place Where Injury Occurred	[Use code H] Own home, bathroom	[Use code C] Construction site	[Use code T] Shopping centre
Activity When Injured	[Use code L] Leisure	[Use code W] Working for income	[Use code W] Working for income

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 Jacob' becomes 'Tripped on tree root in back yard.'
- 'James presented with third overdose this week' becomes 'Patient presented with third overdose this week.'

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

Injury Surveillance Collection Schema



Interpreter Required and Preferred Language

Valid combinations. Only fields that cannot contain the full code set are listed.

If Interpreter Required is	Preferred Language must be
1 Yes	00 - 18, 20 - 95, 97
2 No	00 - 95, 97
3 Not Stated	96, 98

If Preferred Language is	Interpreter Required must be
00 - 18 Refer Section 8 <i>Preferred Language</i>	1, 2
19 English	2
20 - 95 Refer Section 8 <i>Preferred Language</i>	1, 2
96 Inadequately described	3
97 Non verbal, so described (including sign languages eg: Auslan, Makaton)	1, 2
98 Not stated	3

Left Without Treatment

A patient who is triaged upon presentation at the Emergency Department but departs before receiving treatment should have the data field values indicated below:

Field	Value
Departure Date / Time	Date and Time the patient left the ED
Departure Status	'10 – Left after Clinical Advice regarding Treatment Option', OR '11- Left at Own Risk, Without Treatment'
Departure Transport Mode	Blank
Diagnosis – Primary	Blank
First Seen By Doctor Date	Blank
First Seen By Doctor Time	Blank
First Seen By Treating Nurse	Blank
First Seen By Treating Nurse	Blank
Procedure	Blank
Referred To On Departure	If Departure Status = 10 <ul style="list-style-type: none"> Any code excluding '19 – Not Applicable' If Departure Status = 11 <ul style="list-style-type: none"> '19 – Not Applicable'
Injury Surveillance Fields (all pertinent edits and business rules still applied).	
All or any of the Injury Surveillance fields can be submitted for any episode where the Departure Status equals either 10 – Left after Clinical Advice regarding Treatment Option, OR 11- Left at Own Risk, Without Treatment.	
Activity When Injured	Optional
Body Region	
Description of Main Injury	
Human Intent	
Injury Cause	
Nature of Main Injury	
Place Where Injury occurred	

Locality / Postcode

There are two categories of Postcode/Locality errors:

1. Invalid combination of Postcode and Locality based on the Postcode/Locality reference file

The following editing on the Postcode and Locality data items apply:

- The validity of the Locality and Postcode combination is checked against the reference file:

Accepted if Postcode and Locality are a valid combination as per the Postcode/Locality reference file, including:

- Locality is blank and the Postcode is 1000 or 9988.
- Postcode is 8888 and Locality is a valid country code from the Postcode/Locality reference file.

Reject (edit 115) if there is not an exact match for both Locality and Postcode.

- The Locality is blank and the Postcode is not 1000 or 9988.
- The Locality is not blank and the Postcode is 1000 or 9988.
- Postcode is 8888 and Locality is between 0000 and 1203.

2. Format Error in the layout of either the Locality or Postcode, as summarised blow:

- The correct Postcode includes a zero (numeric) but the hospital has entered this as an O (alpha).
- The Locality name has been entered with one or more spaces in front of the name or between the words in a name: check on the Control Report the alignment of Locality name with the Locality name of records that have been accepted.

Nature of Main Injury and Body Region

Nature of Main Injury	Body Region
1 - 12, 21, 23 - 24, 26	1 - 21
13, 15 - 20	22
14	F1 - F7
22	1 - 22

Primary Diagnosis

A Primary Diagnosis is MANDATORY unless

Departure Status equals:

- 10 – Left after clinical advice regarding treatment options; OR
- 11 – Left at own risk, without treatment

Transfer to Another Hospital Campus

If a patient is transferred to another hospital campus for continuing treatment the following fields **MUST** contain these values (all other fields should be completed as appropriate):

Field	Value
Departure Date / Departure Time	Date and Time the patient left the ED
Departure Status	4 – Another Hospital Campus
Departure Transport Mode	Select the appropriate Mode of Transport: 1 – Air Ambulance 2 – Helicopter 3 – Ambulance Service – MICA 4 – Ambulance Service – Road Car 6 – Community / Philanthropic Service 7 – Private Car 8 – Police Vehicle 10 – Ambulance Service – MAS/RAV 11 – Ambulance Service – hospital contracted 19 – Other
Escort Source	Select the appropriate Escort Source: 1 – Emergency Department 2 – ICU / CCU 3 – Ward 4 – Retrieval Service 5 – Nil 9 – Other medical or nurse source
Reason for Transfer	Select the appropriate 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
Referred to on Departure	19 – Not Applicable
Transfer Destination	Hospital code of destination hospital