Specifications for revisions to the Victorian Emergency Minimum Dataset (VEMD) for 1 July 2006

May 2006

Published by the Victorian Government Department of Human Services
Melbourne, Victoria

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Introduction

The need for Victorian Emergency Minimum Dataset (VEMD) modifications

From 1 July 2006, changes to the Victorian Emergency Minimum Dataset are necessary to better inform Victorian health program monitoring, planning and policy development by the Department of Human Services (DHS).

Comments from hospitals and software suppliers regarding the content of the document *Proposals for Revisions the Victorian Emergency Minimum Dataset (VEMD), February 2006* have been taken into account and where possible, suggestions have been accommodated.

Distribution and components of this document

This document has been distributed to all Victorian hospitals, software suppliers known to have Victorian clients, and to a range of industry bodies and DHS staff. It provides information regarding an amended data item and related amended edit.

The *VEMD Manual*, *11th Edition, July 2006* will be distributed at a later date. In the meantime, the *VEMD Manual, 10th Edition* together with this document from the VEMD specification for 2006–07.

Victorian hospitals are required to arrange for their software to be modified in accordance with the revised specifications.

The *VEMD Manual, 10th Edition, July 2005* may be accessed on the Internet at
http://www.health.vic.gov.au/hdss/vemd/2004-05/manual/index.htm

HDSS Bulletins may be accessed on the Internet at
http://www.health.vic.gov.au/hdss/bulletin/index.htm

Any questions related to this document may be directed to the HDSS Help Desk on 9096 8141, or PRS2.Help-Desk@dhs.vic.gov.au

Orientation to this document

As this document provides 'specifications' for revisions, there are a few features that require explanation:

- New values and definitions relating to existing items appear in boxes
- ~~Redundant values and definitions relating to existing items are struck through.~~
- *[Comments relating to the specification document only appear in square brackets and italics.]*

Abbreviations

ACHS	Australian Council of Healthcare Standards
CCU	Coronary Care Unit
DHS	Department of Human Services, Victoria
EMU	Emergency Medical Unit
ICU	Intensive Care Unit
MAPU	Medical Assessment and Planning Unit
NHDD	National Health Data Dictionary
SOU	Short Stay Observation Unit
VEMD	Victorian Emergency Minimum Dataset

Section 2: Concept & Derived Items (Alphabetical Order)

Cardiac/Coronary Care Unit

Classification Concept

Definition A Cardiac/Coronary Care Unit (CCU) is defined as a designated ward of a hospital which is specifically staffed and equipped to provide observation, care and treatment to patients with acute cardiac problems, such as acute myocardial infarction and unstable angina, and who may have undergone interventional procedures from which recovery is possible.

The CCU provides special facilities and utilises the expertise and skills of medical, nursing and other staff trained and experienced in the management of these conditions.

(Ministerial Review of Coronary Care Services in Victoria – December 1996).

Guide for use None.

Intensive Care Unit

Classification Concept

Definition An intensive care unit (ICU) is a designated ward of a hospital that is specially staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems.

Guide for use There are five different types and levels of ICU, details of which are listed below:

Adult intensive care – level 3, level 2, level 1
Paediatric intensive care
Neonatal intensive care – level 3

As defined, ICUs do not include Special Care Nurseries, Coronary Care Units, High Dependency Units, Intensive Nursing Units or Stepdown Units.

All types of ICU must substantially conform to appropriate guidelines of the Australian Council on Healthcare Standards (ACHS).

Adult Intensive Care Unit – Level 3:
Nature of Facility

A level 3 adult ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period. It must be a tertiary referral centre for intensive care patients and have extensive back up laboratory and clinical service facilities to support this tertiary referral role.

Care Process

A level 3 adult ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardio-vascular monitoring for an indefinite period. These types of services are illustrative of the nature of care provided in a level 3 adult ICU but are not exhaustive of the possibilities.

Adult Intensive Care Unit – Level 2:
Nature of Facility

A level 2 adult ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support.

Care Process

A level 2 adult ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardio-vascular monitoring for a period of at least several days. These types of services are illustrative of the nature of care provided in a level 2 adult ICU but are not exhaustive of the possibilities.

Adult Intensive Care Unit – Level 1:
Nature of Facility

A level 1 adult ICU must be a separate and self-contained facility in the hospital capable of providing basic multi-system life support usually for less than a 24-hour period.

Care Process

A level 1 adult ICU must be capable of providing mechanical ventilation and simple invasive cardio-vascular monitoring for a period of at least several hours. These types of services are illustrative of the nature of care provided in a level 1 adult ICU but are not exhaustive of the possibilities.

Paediatric Intensive Care Unit:
Nature of Facility

A paediatric ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period. It must be a tertiary referral centre for children needing intensive care and have extensive backup laboratory and clinical service facilities to support this tertiary role.

Care Process

A paediatric ICU must be capable of providing mechanical ventilation, extra-corporeal renal support services and invasive cardio-vascular monitoring for an indefinite period to infants and children less than 16 years of age. These types of services are illustrative of the nature of care provided in a paediatric ICU but are not exhaustive of the possibilities.

Neonatal Intensive Care Unit – Level 3:
Nature of facility
A level 3 neonatal ICU must be a separate and self-contained facility in the hospital capable of providing complex, multi-system life support for an indefinite period.

Care Process
A neonatal ICU must be capable of providing mechanical ventilation and invasive cardio-vascular monitoring. These types of services are illustrative of the nature of care provided in a neonatal ICU but are not exhaustive of the possibilities.

Length of Treatment

Classification Derived Item

Definition The Length of Treatment is the difference between the time treatment commenced and the time the patient departed the Emergency Department.

Guide for Use The Length of Treatment in minutes is calculated as:
[Departure Date/Time] minus [the earliest of [First Seen by Doctor Date/Time] and [First Seen by Treating Nurse Date/Time] and [First Seen by Mental Health Practitioner Date/Time]]

Mental Health Bed

Classification Concept

Definition A DHS Mental Health Branch approved and funded bed in an Area Mental Health service.

Guide for use None.

Mental Health Practitioner

Classification Concept

Definition A Mental health practitioner is a registered nurse (Division 1 or Division 3), psychologist, social worker, occupational therapist, Medical Officer/Psychiatrist or other suitably qualified staff member who is employed by an approved mental health service or working as part of a mental health program.

Guide for Use None.

Time to Treatment

Classification Derived Item

Definition Time to Treatment in minutes is the difference between Arrival Date/Time and the Date/Time Treatment Commenced.

Guide for Use Time to Treatment is calculated as:
[The earliest of [First Seen by Doctor Date/Time] and [First Seen by Treating Nurse Date/Time] and [First Seen by Mental Health Practitioner Date/Time]] minus [Arrival Date/Time]

Time to treatment is weighed against the Triage Category for the episode to determine if the patient was treated within an acceptable timeframe. The use of the earliest treatment time reflects changes in clinical practice such as the use of clinical pathways and role demarcation of staff within the Emergency Department.
Note:
For reporting purposes patients who leave the ED before treatment commences (Departure Status is '10 - Left after clinical advice regarding treatment options' or '11 – Left at own risk, without treatment') are excluded from the calculation.

Examples of calculation of Time to Treatment:

Arrival Time	First Seen by Doctor Time	First Seen by Mental Health Practitioner	First Seen by Treating Nurse Time	Time to Treatment
15:00	16:00	--:--	15:30	30
15:00	--:--	--:--	15:30	30
15:00	16:00	--:--	--:--	60
15:00	15:30	16:30	16:00	30
15:00	--:--	15:30	--:--	30
15:00	15:30	15:45	16:00	30

Section 3 - Amended Data Definitions

Departure Date

Specification

Definition The date the patient physically leaves the Emergency Department.

Datatype	Date	***Form***	Date
Field size	Eight	***Layout***	DDMMCCYY

Reported for Every Emergency Department presentation.

Reporting guide Report the date the patient:

- Leaves the Emergency Department (Departure Status is 1, 5, 10, 11, 12, 17, 19, 20, 21, 23 and 24) ~~0, 1, 4, 5, 9, 10, 11, 12~~); **OR**
- Leaves the Emergency Department to go to a ward (Departure Status is 3, 13, 14, 15, 16, 18 and 22, ~~2~~), ~~Short Stay Observation unit (Departure Status is 3) or Emergency Medical Unit (Departure Status is 13);~~ **OR**
- Dies within the Emergency Department (Departure Status is 7); **OR**
- Is dead on arrival (Departure Status is 8).

Valid Format:

DDMMCCYY

See Section 2 – Concept and Derived Item Definitions (Date / Time Fields, Length of Stay, Time to Treatment).

Edits

E025	Duplicate Attendance
E210	Departure Date/Time Invalid
E212	Departure Date/Time Before First Seen By Treating Nurse Date/Time
E213	Departure Date/Time Before First Seen By Doctor Date/Time
E217	Departure Date Conflicts with VEMD File Name
E219	Length Of Stay Greater Than 10 Days
E335	Departure Date/Time Before Inpatient Bed Request Date/Time

E340	Departure Date/Time Less Than or Equal To Arrival Date/Time.
E350	Length Of Stay Greater Than 4 and Less Than 10 Days
E374	Departure Date/Time Before First Seen By Mental Health Practitioner Date/Time

Related items Departure Time, Departure Status

Administration

Purpose

Used in the calculation of various derived items:

- Length of Stay: Arrival Date/Time and Departure Date/Time
- Length of Treatment: Departure Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time or First Seen by Mental Health Practitioner Date/Time.

Principal data users Monash University Accident Research Centre; Statewide Emergency Program, DHS.

Collection start 1 July 1995

Version

1 (Effective 01.07.95)

2 (Effective 01.07.02)

3 (Effective 01.07.06)

Definition source NHDD

Departure Status

Revision Summary	Add new codes to the codeset and discontinue codes where the meaning has substantially altered.

Specification

Definition The Patient's destination or status on departure from the Emergency Department.
(Use first appropriate code)

Datatype	Alpha/Numeric	***Form***	Code
Field size	Two	***Layout***	N or NN

Reported for Every Emergency Department presentation.

Code set	**Code**	**Descriptor**
Departure Before Treatment Completed:		
	11	Left at own risk, without treatment
	10	Left after clinical advice regarding treatment options
	5	Left at own risk, after treatment started
	7	Died within ED
	8	Dead on arrival
Ward Setting at this Hospital Campus:		
	16	Mental Health bed – this campus
	15	Intensive Care Unit – this campus
	22	Coronary Care Unit – this campus
	3	Short Stay Observation Unit
	13	Emergency Medical Unit
	14	Medical Assessment and Planning Unit
	~~2~~ 18	Ward not elsewhere described (excludes SOU, EMU, MAPU, ICU, CCU and Mental Health Bed)
Transfers to another Hospital Campus (also report Transfer Destination):		
	17	Mental Health bed at another Hospital campus
	20	Another Hospital Campus - Intensive Care Unit
	21	Another Hospital Campus - Coronary Care Unit
	~~4~~ 19	Another hospital campus (excludes for Mental Health and ICU or CCU transfer)
Returning to usual residence:		
	~~9~~ 23	Mental health residential facility or psychogeriatric nursing home.

~~0~~ 24 Residential care facility (includes nursing home, hostel, ~~psychogeriatric nursing home,~~ residential care respite bed)

12 Correctional/Custodial Facility

1 Home

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.

For all Transfer Departure Statuses please refer to Section 4 Business Rules "Transfer to Another Hospital Campus"

1 - Home

Includes:

- house;
- unit;
- boarding/rooming house;
- hotel;
- caravan;
- youth hostel accommodation;
- homeless person's shelters;
- shelter/refuges;
- armed forces hospitals;
- no fixed abode; and
- patients going to a Rehabilitation In The Home programme.

Excludes:

- accommodation described in remainder of codeset.

3 – Short Stay Observation Unit ~~(Excludes Emergency Medical Unit and Medical Assessment and Planning Unit)~~

Excludes:

- Emergency Medical Unit (use 13);
- Medical Assessment and Planning Unit (use 14).

See also Section 2 – Concept and Derived Item Definitions.

5 – Left at own risk, after treatment started

Patient departs the Emergency Department after being seen by a definitive service provider despite being advised by clinical staff NOT to leave. ~~The appropriate hospital forms must be completed and signed by the patient.~~

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 bought into

the ED but there is no intention to resuscitate.

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 without being seen by a definitive 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.

12 – Correctional / Custodial Facility

Does not require a Transfer Destination code. Refer to comments below.

13 – Emergency Medical Unit ~~(Excludes Medical Assessment and Planning Unit and Short Stay Observation Unit)~~

Excludes:

- Short Stay Observation Unit (use 3);
- Medical Assessment and Planning Unit (use 14);

See also Section 2 – Concept and Derived Item Definitions.

14 – Medical Assessment and Planning Unit

Excludes:·

- Short Stay Observation Unit (use 3);
- Emergency Medical Unit (use 13).

See also Section 2 – Concept and Derived Item Definitions.

15 – Intensive Care Unit

See also Section 2 – Concept and Derived Item Definitions.

16 – Mental Health bed at this hospital

The bed or ward must be part of an approved mental health programme. See also Section 2 – Concept and Derived Item Definitions.

17 – Mental Health bed at a different hospital

Excludes:

- armed forces hospitals (use 1);
- correction facility hospital (use 12).

The bed must be an approved bed. Transfer destination must also be reported.

See also Section 2 – Concept and Derived Item Definitions.

18 – Ward ~~(includes HITH, RITH and Medical Assessment and Planning Unit; Excludes Emergency Medical Unit, and Short Stay Observation Unit)~~

Includes patients who:

- go to the ward after attending the ED at the same hospital;
- go to HITH;
- attend the ED from an inpatient ward at the same hospital and then return to the ward (except as noted below.)

Excludes patients who:

- attend the ED from an inpatient ward at the same hospital and then return to a Mental Health bed (use 16);
- return home to RITH (RITH is no longer considered an admitted patient service - use 1.)
- depart to a Short Stay Observation Unit (use 3);
- depart to an Emergency Medical Unit (use 13);
- depart to a Medical Assessment and Planning Unit (use 14);
- depart to an Intensive Care Unit (use 15).

~~Includes patients who are admitted to the ward after attending the ED at the same hospital (includes HITH and RITH), and those patients who attend the ED from an inpatient ward at the same hospital and then return to the ward.~~

See also Section 2 – Concept and Derived Item Definitions.

Any change in 'Campus code' in multi-campus transfers is considered a transfer and requires a 'Transfer Destination' code.

19 - Another hospital campus

Excludes:

- armed forces hospitals (use 1);
- correction facility hospital (use 12);
- Patients being transferred to a Mental Health, ICU or CCU bed at another hospital campus (use 17).

Transfer Destination must also be reported.

20 – Intensive Care Unit bed at a different hospital

Excludes:

- armed forces hospitals (use 1);
- correction facility hospital (use 12).

The bed must be in a registered ICU. Transfer destination must also be reported.

See also Section 2 – Concept and Derived Item Definitions.

21 – Another Hospital Campus - Coronary Care Unit.

Excludes:

- armed forces hospitals (use 1);
- correction facility hospital (use 12).

The bed must be in a registered CCU. Transfer destination must also be reported.

See also Section 2 – Concept and Derived Item Definitions.

22 – Coronary Care Unit – this campus

The bed must be in a registered CCU.

See also Section 2 – Concept and Derived Item Definitions.

~~9~~ 23 - Mental health residential facility ~~(Excludes psychogeriatric nursing home, use 0)~~

Does not require a Transfer Destination code.

Includes:

- Psychogeriatric nursing home

Excludes:

- ~~psychogeriatric nursing home (use 0);~~

transfer to inpatient Mental health bed (use 16 or 17).

~~0~~ 24- Residential care facility (includes nursing home, hostel, ~~psychogeriatric nursing home~~, residential care respite bed)

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.

Excludes: psychogeriatric nursing home (use 23)

Armed Forces and Prison Hospitals:

These are not generally recognised as hospitals 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 from the ED to an Armed Forces hospital, Departure Status equals '1 - Home'.
If a patient is transferred from the ED to a Prison hospital, Departure Status equals '12 - Correctional/Custodial Facility'.

Edits

E142	Dead on Arrival Combination Invalid
E181	First Seen By Treating Nurse Date/Time Before Triage Date/Time
E182	First Seen By Treating Clinician Date/Time and 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 and Departure Status Combination Invalid
E260	Primary Diagnosis Blank
E339	Inpatient Bed Request Date/Time and Departure Status Combination Invalid
E342	Primary Diagnosis Recorded When Departure Status Is '10', '11' OR '8'.
E356	Type of Usual Accommodation and Departure Status Combination Invalid
E366	Departure Status and Triage Category Combination Invalid
E376	Unregistered Medical Assessment and Planning Unit
E377	Unregistered Intensive Care Unit
E378	Unregistered Coronary Care Unit

Related items Escort Source, Transfer Destination, Referred to on Departure, Reason for Transfer, Departure Transport Mode.

Administration

Purpose To identify and monitor the status and location of patients on departure from the ED. It is also used to define patients for whom performance measures, including admission block, are calculated.

Principal data users Monash University Accident Research Centre; Statewide Emergency Services Program, DHS.

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)
6	(Effective 01.07.06)

Definition source NHDD

Code set source DHS

Departure Time

Specification

Definition The time the patient physically leaves the Emergency Department.

Datatype Time ***Form*** Quantitative Value

Field size Four ***Layout*** HHMM

Reported for Every Emergency Department presentation.

Reporting guide

Report the time the patient:

- Leaves the Emergency Department (Departure Status is 1, 5, 10, 11, 12, 17, 19, 20, 21, 23 and 24) ~~0, 1, 4, 5, 9, 10, 11, 12~~)
- Leaves the Emergency Department to go to a ward (Departure Status is 3, 13, 14, 15, 16, 18 and 22, ~~2~~), ~~Short Stay Observation unit (Departure Status is 3) or Emergency Medical Unit (Departure Status is 13);~~ **OR**
- Dies within the Emergency Department (Departure Status is 7); **OR**
- Is dead on arrival (Departure Status is 8).

Valid Format: HHMM (Must be in 24-hour format) between 0001 and 2359

Following international convention midnight is reported as either 2359 of preceding date or 0001 of the following date.

See Section 2 – Concept and Derived Item Definitions (Date / Time Fields, Length of Stay, Time to Treatment).

Edits

E025	Duplicate Attendance
E210	Departure Date/Time Invalid
E212	Departure Date/Time Before First Seen By Treating Nurse Date/Time
E213	Departure Date/Time Before First Seen By Doctor Date/Time
E217	Departure Date Conflicts with VEMD File Name
E219	Length Of Stay Greater Than 10 Days
E335	Departure Date/Time Before Inpatient Bed Request Date/Time
E340	Departure Date/Time Less Than or Equal To Arrival Date/Time.

	E350	Length Of Stay Greater Than 4 and Less Than 10 Days
	E374	Departure Date/Time Before First Seen By Mental Health Practitioner Date/Time

Related items Departure Date.

Administration

Purpose

Used in the calculation of various derived items:

- Length of Stay: Arrival Date/Time and Departure Date/Time
- Length of Treatment: Departure Date/Time and First Seen by Doctor Date/Time or First Seen by Treating Nurse Date/Time and Departure Date.

Principal data users Monash University Accident Research Centre; Statewide Emergency Program, DHS.

Collection start	1 July 1995	***Version***	1	(Effective 01.07.95)
			2	(Effective 01.07.02)

Definition source DHS

Departure Transport Mode

Specification

Definition

The type of transport used to transfer the patient from the Emergency Department to another hospital.

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

Field size Two ***Layout*** N or NN

Reported for

Presentations where Departure Status code is 17, 19, 20 and 21 ~~4 – Another hospital campus~~.
Must remain blank if Departure Status code is **not** 17, 19, 20 and 21 ~~4 – Another hospital campus~~ (Conditional mandatory).

Code set

Code	***Descriptor***
1	Air ambulance - fixed wing aircraft other than helicopter (code 2)
2	Helicopter
3	Ambulance Service – MICA
4	Ambulance Service - road car
6	Community / philanthropic services (e.g. hospital volunteer drivers)
7	Private car
8	Police vehicle
10	Ambulance Service - private ambulance car - MAS / RAV contracted
11	Ambulance Service - private ambulance car - hospital contracted
19	Other

Reporting guide

Item should be blank if patient has not been transferred to another hospital.
For journeys involving more than one transport mode, select the mode of transport in which the greater distance of the journey was undertaken.

Edits

E232 Transfer Departure Status Code Combination Invalid
E255 Departure Transport Mode Invalid

Related items

Departure Status, Transfer Destination, Reason for Transfer, Escort Source.

Administration

Purpose	Analysis of transport utilisation.		
Principal data users	Monash University Accident Research Centre; Statewide Emergency Program, DHS.		
Collection start	1 July 1995	***Version***	1 (Effective 01.07.95) 2 (Effective 01.07.97) 3 (Effective 01.07.00) 4 (Effective 01.07.02)
Definition source	DHS	***Code set source***	DHS

Escort Source

Specification

Definition

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

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

Field size One ***Layout*** N

Reported for

Departure Status is 17, 19, 20 and 21 ~~4 – Another hospital campus~~. (Optional).

Code set

Code	***Descriptor***
1	Emergency Department
2	ICU/CCU
3	Ward
4	Retrieval Service
5	Nil (no medical or nursing escort)
9	Other medical or nursing escort

Reporting guide

Item should be left blank if Departure Status is not one of 17, 19, 20 and 21 ~~equal to 4~~.

Report the first appropriate code, which best explains the escort source.

Edits

E250 Escort Source Code Invalid

Related items

Departure Status, Transfer Destination, Reason for Transfer, Departure Transport Mode.

Administration

Purpose

To monitor medical or nursing staff resource consumption for patient transfers.

Principal data users

Monash University Accident Research Centre; Statewide Emergency Program, DHS.

Collection start	1 July 1995	***Version***	1 (Effective 01.07.95) 2 (Effective 01.07.97) 3 (Effective 01.07.01)
Definition source	DHS	***Code set source***	DHS

First Seen By Mental Health Practitioner Date

Specification

Definition	The date the patient was first attended to by a Mental Health Practitioner.		
Datatype	Date	***Form***	Date
Field size	Eight	***Layout***	DDMMCCYY or blank

Reported for All presentations where the patient is seen by a mental health practitioner. (Conditional mandatory.)

Reporting guide Where the Mental Health practitioner is the definitive service provider First Seen By Doctor Date/Time and First Seen By Treating Nurse Date/Time may be left blank.

Where Departure Status is '10 – Left after clinical advice, regarding treatment options', or '11 – Left at own risk, without treatment' first Seen By Mental Health Practitioner Date/Time, First Seen By Doctor Date/Time, First Seen By Treating Nurse Date/Time and First Seen By Mental Health Practitioner should be left blank.

Where a valid date has been reported in First Seen By Mental Health Practitioner Date, a valid time must be reported in First Seen By Mental Health Practitioner Time.

Edits

E182	First Seen By Treating Clinician Date/Time and Departure Status Comb Invalid
E373	First Seen By Mental Health Practitioner Date/Time Before Arrival Date/Time
E374	Departure Date/Time Before First Seen By Mental Health Practitioner Date/Time
E375	First Seen By Mental Health Practitioner Date/Time Invalid

Related items First Seen by Mental Health Practitioner Time

Administration:

Purpose To facilitate service planning for and monitoring of access and service provision to emergency department patients in need of mental health

treatment or assessment.

Principal data users	Statewide Emergency Program; Mental Health Branch, DHS.		
Collection start	1 July 2006	***Version***	1 (Effective 01.07.06)
Definition source	DHS	***Code set source***	DHS

First Seen By Mental Health Practitioner Time

Specification

Definition The time the patient was first attended to by a Mental Health Practitioner.

Datatype	Time	***Form***	Quantitative Value
Field size	Four	***Layout***	HHMM or blank

Reported for All presentations where the patient is seen by a Mental Health Practitioner. (Conditional mandatory.)

Reporting guide

Where a valid date has been entered in First Seen By Mental Health Practitioner Date, a valid time must be entered in First Seen By Mental Health Practitioner Time.

The date/time must be between arrival date/time and departure date/time.

Valid Format: HHMM (Must be in 24-hour format) between 0001 and 2359

Following international convention midnight is reported as either 2359 of preceding date or 0001 of the following date.

See Section 2 – Concept and Derived Item Definitions.

Edits

E182	First Seen By Treating Clinician Date/Time and Departure Status Comb Invalid
E373	First Seen By Mental Health Practitioner Date/Time Before Arrival Date/Time
E374	Departure Date/Time Before First Seen By Mental Health Practitioner Date/Time
E375	First Seen By Mental Health Practitioner Date/Time Invalid

Related items First Seen By Mental Health Practitioner Date.

Administration

Purpose To facilitate service planning for and monitoring of access and service

	provision to emergency department patients in need of mental health treatment or assessment.		
Principal data users	Statewide Emergency Program; Mental Health Branch, DHS.		
Collection start	1 July 2006	***Version***	1 (Effective 01.07.06)
Definition source	DHS	***Code set source***	DHS

Reason for Transfer

Specification

Definition	Reason for transfer of a patient to another hospital or health service.		
Datatype	Alpha/numeric	***Form***	Code
Field size	One	***Layout***	N

Reported for Presentations with Departure Status of 17, 19, 20 or 21 ~~4 – Another hospital campus~~ (Conditional mandatory).

Code set

Code	***Descriptor***
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

Reporting guide Select the first appropriate category.

Edits

E232 Transfer Departure Status Code Combination Invalid

E245 Reason for Transfer Code Invalid

Related items Transfer Destination, Escort Source, Departure Status, Departure Transport Mode.

Administration

Purpose To monitor the reasons for patient transfer between hospitals.

Principal data users ~~Critical Care Inter Hospital Transfer program~~; Monash University Accident Research Centre; Statewide Emergency Program, DHS.

Collection start	1 July 1995	***Version***	1	(Effective 01.07.95)
			2	(Effective 01.07.97)
Definition source	DHS	***Code set source***	DHS	

Transfer Destination

Specification

Definition

The ~~acute health care facility (hospital or campus)~~ hospital campus to which the patient was transferred.

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

Field size Four ***Layout*** NNNN

Reported for

Presentations where Departure Status is 17, 19, 20 or 21 ~~4 – Another hospital campus~~ irrespective of whether they were admitted or not admitted at the sending hospital (Conditional mandatory).

Reporting guide

Victorian hospital

If a patient is transferred to a Victorian hospital, report a valid campus code. The Campus Code Table is located on the internet at http://www.health.vic.gov.au/hdss/reffiles/index.htm. This table is updated as required throughout the year.

Interstate/overseas hospital

If a patient is transferred interstate or overseas, report a destination following the 'Guide to interstate / overseas hospital codes. The codes can be located in Section 8-6 of the VEMD Manual.

Item should be left blank if patient has not been transferred or if transfer is to a Nursing Home.

Prison Hospitals and Armed Forces Hospitals:

These are not generally recognised as hospitals by the Commonwealth Department of Health and Aged Care and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

Reporting guide (Cont)

Multiple-campus hospital transfers:

The VEMD is a 'campus' based collection.
Where the patient transfers to another campus of the same hospital (different campus code):

- Departure Status is 17, 19, 20 and 21 ~~4 – Another hospital campus~~
- Transfer Destination is the receiving site's Campus Code.

~~Where the patient moves between wards of the same campus (same~~

~~site identifier):~~

- ~~Departure Status is '2 - Ward (including HITH and MAPU)'~~
- ~~Departure Status is '3 – SOU'~~
- ~~Departure Status is '13 – EMU'.~~

Unknown Transfer Destination:

It is expected that the sending hospital is aware of the specific receiving hospital to which the patient is being transferred. Transfer Destination of 9999 ("unknown") will result in a rejection.

See Section 3 – Data Definitions (Campus Code, Transfer Source)

Edits

E137	Transfer Destination / Source Equals Campus Code
E232	Transfer Departure Status Code Combination Invalid
E235	Transfer Destination Code Invalid

Related items Departure status.

Administration

Purpose Analysis of patient transfer patterns.

Principal data users Monash University Accident Research Centre; Statewide Emergency Program, DHS.

Collection start 1 July 1995

Version
1 (Effective 01.07.95)
2 (Effective 01.07.97)
3 (Effective 01.07.99)

Definition source DHS

Code set source DHS

Section 4 – Business Rules

Departure Status and Referred to on Departure

Valid combinations of the Departure Status and Referred to on Departure data items:

If Departure Status is:		Referred to on Departure must be:
Departure Before Treatment Completed:		
11	Left at own risk, without treatment	19
10	Left after clinical advice regarding treatment options	1 – 18
5	Left at own risk, after treatment started	19
7	Died within ED	19
8	Dead on arrival	19
Ward Setting at this Hospital Campus:		
16	Mental Health bed – this campus	19
15	Intensive Care Unit – this campus	19
22	Coronary Care Unit – this campus	19
3	Short Stay Observation Unit	19
13	Emergency Medical Unit	19
14	Medical Assessment and Planning Unit	19
18	Ward not elsewhere described (excludes SOU, EMU, MAPU, ICU, CCU and Mental Health Bed)	19
Transfers to another Hospital Campus (also report Transfer Destination):		
17	Mental Health bed at another Hospital campus	19
20	Another Hospital Campus - Intensive Care Unit	19
21	Another Hospital Campus - Coronary Care Unit	19
19	Another hospital campus (excludes for Mental Health and ICU or CCU transfer)	19
Returning to usual residence:		
23	Mental health residential facility or psychogeriatric nursing home.	1 – 18
24	Residential care facility (includes nursing home, hostel, residential care respite bed)	1 – 18
12	Correctional/Custodial Facility	1 – 18
1	Home	1 – 18

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~~ 17 - Mental Health bed at another Hospital campus 20 - Another Hospital Campus - Intensive Care Unit 21 - Another Hospital Campus - Coronary Care Unit 19 - Another hospital campus (excludes for Mental Health and ICU or CCU transfer)
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 (completion of this field is optional)	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

Section 5 – Compilation and Submission

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
†	Mandatory if Departure Status is ~~= '4 – Another Hospital Campus'~~
	17 - Mental Health bed at another Hospital campus
	20 - Another Hospital Campus - Intensive Care Unit
	21 - Another Hospital Campus - Coronary Care Unit
	19 - Another hospital campus (excludes for Mental Health and ICU or CCU transfer)
✪	Primary Diagnosis is a mandatory item, for all Departure Status codes other than '10 – Left after clinical advice, regarding treatment options' and '11 – Left at own risk, without treatment'. For Departure Status codes 10 and 11 Primary Diagnosis must not be recorded. If Diagnosis is an injury, complete all the Injury Surveillance data fields
◎	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
♓	Optional for Departure Status '10 – Left after Clinical Advice regarding Treatment Option', OR '11- Left at Own Risk, Without Treatment'.
▼	Mandatory if the Nurse is the definitive service provider (except where Departure Status = '10 – Left after clinical advice, regarding treatment options' or '11 – Left at own risk, without treatment').
△	Mandatory if the Mental Health Practitioner is the definitive service provider Blank where Departure Status = '10 – Left after clinical advice, regarding treatment options' or '11 – Left at own risk, without treatment'.
❖	Mandatory if the Doctor is the definitive service provider (except where Departure Status = '10 – Left after clinical advice, regarding treatment options' or '11 – Left at own risk, without treatment').
♋	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 moved to an inpatient bed.
⌘	Optional if Primary Diagnosis item is completed
©	Mandatory if Compensable Status = 2

‡	Optional if Departure Status is ~~= '4 – Another Hospital Campus'~~ 17 - Mental Health bed at another Hospital campus 20 - Another Hospital Campus - Intensive Care Unit 21 - Another Hospital Campus - Coronary Care Unit 19 - Another hospital campus (excludes for Mental Health and ICU or CCU transfer)

	Field Name	Max Chars	Alpha / Numeric	Format / Values (trailing spaces are not required)
M	Campus Code	4	A/N	XXXX
M	Unique Key	9	A/N	XXXXXXXXX
Patient Biographic				
M	Patient Identifier	10	A/N	XXXXXXXXXX
♎	Medicare Number	11	N	NNNNNNNNNNN or blank
M	Medicare Suffix	3	A/N	XXX
©	DVA Number	9	A/N	See detailed specification: VEMD Manual, 3-47
M	Sex	1	A/N	1, 2, 3, 4
M	Date of Birth	8	N	DDMMCCYY
M	Country of Birth	4	A/N	XXXX
M	Indigenous Status	1	A/N	2, 5, 6, 7, 8, 9
M	Interpreter Required	1	A/N	1, 2, 3
M	Preferred Language	2	A/N	XX
M	Locality	22	A/N	XXXXXXXXXXXXXXXXXXXXXX
M	Postcode	4	N	NNNN
M	Type of usual Accommodation	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 18, 19
Patient Management Data				
M	Arrival Transport Mode	2	A/N	1, 2, 3, 6, 8, 9, 10, 11, 99
M	Referred By	2	A/N	0, 1, 2, 4, 6, 8, 9, 10, 13, 19
§	Transfer Source	4	A/N	XXXX
M	Type of Visit	2	A/N	1, 2, 8, 9, 10
M	Compensable Status	1	A/N	1, 2, 3, 4, 5, 6, 7
*	Ambulance Case Number	4	A/N	See detailed specification: VEMD Manual, Section 3.
M	Arrival Date	8	N	DDMMCCYY
M	Arrival Time	4	N	HHMM
M	Triage Date	8	N	DDMMCCYY
M	Triage Time	4	N	HHMM
M	Triage Category	1	A/N	1, 2, 3, 4, 5, 6
▼	First Seen by Treating Nurse Date	8	N	DDMMCCYY or Blank
▼	First Seen by Treating Nurse Time	4	N	HHMM or Blank
❖	First Seen by Treating Doctor Date	8	N	DDMMCCYY or Blank
❖	First Seen by Treating Doctor Time	4	N	HHMM or Blank
△	First Seen by Mental Health Practitioner Date	8	N	DDMMCCYY or Blank

△	First Seen by Mental Health Practitioner Time	4	N	HHMM or Blank
⌘	Procedure	89	A/N	XX (x30)
♐	Inpatient Bed Request Date	8	N	DDMMCCYY or Blank
♐	Inpatient Bed Request Time	4	N	HHMM or Blank
M	Departure Date	8	N	DDMMCCYY
M	Departure Time	4	N	HHMM
M	Departure Status	2	A/N	1, 3, 5, 7, 8, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24
†	Transfer Destination	4	A/N	XXXX
M	Referred to on Departure	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 16, 17, 18, 19
†	Reason for Transfer	1	A/N	1, 2, 3, 4, 5, 6, 7, 9
‡	Escort Service	1	A/N	1, 2, 3, 4, 5, 9 or blank
†	Departure Transport Mode	2	A/N	1, 2, 3, 4, 6, 7, 8, 10, 11, 19
✪	Primary Diagnosis	5	A/N	ICD-10-AM VEMD Code
♋	Additional Diagnosis 1	5	A/N	ICD-10-AM VEMD Code
	Additional Diagnosis 2	5	A/N	ICD-10-AM VEMD Code
Injury Surveillance Data				
◎♓	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, 26
◎♓	Body Region	2	A/N	F1, F2, F3, F4, F5, F6, F7 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22
◎♓	Description of Injury Event	250	A/N	
◎♓	Injury Cause	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30
◎♓	Human Intent	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11
◎♓	Place Where Injury Occurred	1	A/N	H, I, S, A, R, T, C, Q, F, M, P, O, U
◎♓	Activity When Injured	1	A/N	S, L, W, E, C, N, V, O, U

File Naming Convention

Every file submitted to the VEMD must be named as follows:

File Naming Convention: AAAABnna.txt

Where:	AAAA	=	Campus Code (for example: 1010)
	B	=	Version of the dataset (2006-07 is version 11. Code "1" will be used)
	nn	=	Month of Transmission
	a	=	Data Submission Indicator (1st submission 07a, 2nd 07b)

Example: 1010107a.txt (*please **zip** the file using **128 bit encryption** before submission via e-mail* **1010107a.zip**)

File Security

Data files transmitted by VEMD reporting hospitals via electronic mail should be password encrypted using WinZip 128 bit encryption to deter unauthorised access. Passwords are allocated by the Department and are required to open VEMD data files attached to e-mail messages.

Please contact the HDSS Help Desk if you have not received a password, see Section 1 – Introduction (Contact Details).

Section 7 – New Edits

E373 First Seen By Mental Health Practitioner Date/Time Before Arrival Date/Time

Effect REJECTION

Problem The First Seen By Mental Health Practitioner Date/Time reported is earlier than the Arrival Date/Time. Either or both date/times may be incorrect.

Remedy The First Seen By Mental Health Practitioner Date/Time must be equal to or greater than the Arrival Date/Time.

Note:

First Seen by Mental Health Practitioner Date/Time must be blank where the Departure Status equals '10 – Left after clinical advice regarding treatment' or '11 – Left at own risk, without treatment'

~~i. First Seen by Mental Health Practitioner Date/Time can be blank where:~~

- ~~First Seen by Doctor Date/Time has been reported.~~

Check dates and times for

- First Seen By Mental Health Practitioner, and
- Arrival

Correct as appropriate and re-submit the transaction.

See:		
	Section 2,	Date/Time Fields;
	Section 3,	Departure Status;
		First Seen By Doctor Date;
		First Seen By Doctor Time;
		First Seen By Treating Nurse Date;
		First Seen by Treating Nurse Time;
		Arrival Date;
		Arrival Time;
	Section 4,	Dead on Arrival;
		Left without Treatment;
		Transfer to Another Hospital.

E374 Departure Date/Time Before First Seen By Mental Health Practitioner Date/Time

Effect REJECTION

Problem The Departure Date/Time reported in this record is earlier than the First Seen By Mental Health Practitioner Date/Time. Either or both date/times may be incorrect.

Remedy Check date/time of First Seen By Mental Health Practitioner and Departure, correct as appropriate and re-submit the transaction.

See:	Section 2,	Date/Time Fields; Length of Treatment;
	Section 3,	Departure Date; Departure Time; First Seen by Mental Health Practitioner Date; First Seen by Mental Health Practitioner Time.

E375 First Seen By Mental Health Practitioner Date/Time Invalid

Effect REJECTION

Problem The First Seen by Mental Health Practitioner Date/Time reported in this record is not valid.

Remedy Correct First Seen by Mental Health Practitioner Date/Time and re-submit the transaction.

See:	Section 2,	Date/Time Fields;
	Section 3,	First Seen By Mental Health Practitioner Date;
	Section 4,	First Seen by Mental Health Practitioner Time; Left without Treatment.

E376 Unregistered Medical Assessment and Planning Unit

Effect REJECTION

Problem The Departure Status is reported as 14 - Medical Assessment and Planning Unit, but the Campus Code entered does not have a registered MAPU with DHS.

Remedy Check the Departure Status, correct as appropriate and re-submit.
Contact DHS, Statewide Emergency Program (see Section 1 – Contact Details) for registration of the unit.

See:	Section 2	Medical Assessment and Planning Unit;
		Campus;
	Section 3	Campus Code;
		Departure Status;
	Section 8	Medical Assessment and Planning Unit:
		Approved;
	HDSS Website	Hospital Code Tables.

E377 Unregistered Intensive Care Unit

Effect REJECTION

Problem The Departure Status is reported as '15 – Intensive Care Unit', but the campus does not have an ICU approved by DHS.

Remedy Check the Departure Status, correct as appropriate and re-submit the transaction.
Contact DHS, Statewide Emergency Program, see Section 1 – Introduction (Contact Details) for registration of the unit.

See:	Section 2,	Intensive Care Unit;
		Campus;
	Section 3,	Campus Code;
		Departure Status;
	Section 8,	Intensive Care Unit: Approved.

E378 Unregistered Coronary Care Unit

Effect REJECTION

Problem The Departure Status is reported as '13 – Coronary Care Unit, but the campus does not have a CCU approved by DHS.

Remedy Check the Departure Status, correct as appropriate and re-submit the transaction.
Contact DHS, Statewide Emergency Program, see Section 1 – Introduction (Contact Details) for registration of the unit.

See:	Section 2,	Coronary Care Unit;
		Campus;
	Section 3,	Campus Code;
		Departure Status;
	Section 8,	Coronary Unit: Approved.

Section 7 - Amended Edits

E102 Unusual Country of Birth

Effect ~~NOTIFIABLE~~ WARNING

Problem One of the following unusual Country of Birth codes has been reported:

- 0001 Born at Sea
- 0002 Country of Birth, not elsewhere classified
- 1700 Antarctica, not further defined
- 1701 to 1707 Antarctica territories
- 2206 Vatican City; Holy See

Remedy Check the patient's Country of Birth, correct and re-submit the transaction.

If you have used '0002 Country of Birth not elsewhere classified' because there is no code for the country, contact the HDSS Helpdesk.

~~If correct, notify the VEMD Helpdesk of the accuracy of the record, providing detailed explanation. If the information is validated DHS will accept the record into the VEMD.~~

See: Section 3, Country of Birth.
Section 8, Country of Birth Codes.

E137 Transfer Destination / Source Equals Campus Code

Effect REJECTION

Problem The Transfer Source code and/or the Transfer Destination code specified in this record are the same as the Campus Code of this hospital.

Remedy Check and correct the Transfer Source code and/or Transfer Destination code and re-submit the transaction.

If this attendance ended in the patient being admitted to this hospital, the Departure Status code should be '3, 13, 14, 15, 16, 18 OR 22 ~~Admission to ward (including HITH) / Return to ward', '3 – Registered Short Stay Observation Unit' or '13 – Registered Emergency Medical Unit'~~, and the Transfer Destination code should be blank.

See:	Section 3,	Campus Code;
		Transfer Destination;
		Transfer Source;
	Section 4,	Transfer to Another Hospital;
	HDSS Website,	Hospital Code Tables.

E182 First Seen By Treating Clinician Date/Time and Departure Status Comb Invalid

Effect REJECTION

Problem Note:

Treating Clinician refers to Nurse, Doctor or Mental Health Practitioner as described in Section 3

- Departure Status equals 10 or 11 and at least one of the following fields has been reported:
  - First Seen by Treating Nurse Date/Time
  - First Seen by Doctor Date/Time
  - First Seen by Mental Health Practitioner Date/Time
- Departure Status does not equal 10 or 11 and all of the following fields are blank:
  - First Seen by Treating Nurse Date/Time,
  - First Seen by Doctor Date/Time or
  - First Seen by Mental Health Practitioner Date/Time.

Remedy If the patient did see a clinician ~~definitive service provider~~, correct the Departure Status as appropriate and re-submit.

If the patient did not see a clinician ~~definitive service provider~~, correct the First Seen By Treating Nurse Date/Time and/or First Seen By Doctor Date/Time and/or First Seen by Mental Health Practitioner Date/Time as appropriate and re-submit the transaction.

See:	Section 2,	Date/Time Fields;
	Section 3,	Departure Status;
		First Seen By Doctor Date;
		First Seen by Doctor Time;
		First Seen By Treating Nurse Date;
		First Seen by Treating Nurse Time;
		First Seen By Mental Health Practitioner Date;
		First Seen by Mental Health Practitioner Time;
	Section 4,	
		Dead on Arrival;
		Departure Status;
		Left without Treatment;
		Primary Diagnosis;
		Transfer to Another Hospital.

E207 Procedure Code Format Invalid

Effect REJECTION

Problem

- The Procedure code reported does not exist in the Procedure Reference Table,
- The Procedure code format is not valid, eg. Procedure codes have been separated by more than one curly bracket {{, or include a space
- Procedure code sequence is not valid, eg. there is a blank first Procedure followed by a valid Procedure code.
- There is a trailing curly bracket.

Remedy Check code and formatting and re-submit transaction.

See: Section 3, Procedures;
Section 4, Left without Treatment;
Section 8, Procedure Codes.

E232 Transfer Departure Status Code Combination Invalid

Effect REJECTION

Problem

- Departure Status ~~equals~~ is one of 17, 19 20 or 21 ~~'4 - Another hospital campus'~~, but at least one of Transfer Destination, Reason for Transfer and Departure Transport Mode is null.

- Departure Status is not one of 17, 19, 20 or 21 ~~equals 0, 1, 2, 3, 5, 7, 8, 9, 10, 11, 12 or 13~~ but at least one of Transfer Destination, Reason for Transfer and Departure Transport Mode is not null.

Remedy

If the Departure Status is one of 17, 19 20 or 21 ~~equals '4'~~, Transfer Destination, Reason for Transfer and Departure Transport Mode items must be completed;
If Departure Status is not one of 17, 19, 20 or 21 ~~equals 0, 1, 2, 3, 5, 7, 8, 9, 10, 11, 12 or 13~~ then Transfer Destination, Reason for Transfer and Departure transport Mode must be null.
Correct as appropriate and re-submit transaction.

See: Section 3, Departure Status;
Departure Transport Mode;
Reason for Transfer;
Transfer Destination;
Section 4, Transfer to Another Hospital.

E242 Referred to on Departure and Departure Status Combination Invalid

Effect REJECTION

Problem

- Referred to on Departure equals '19 - Not Applicable', but Departure Status is 1, 10, 12, 23 OR 24 ~~0, 1, 9, 10 or 12~~; **OR**
- Referred to on Departure does not equal '19 - Not applicable', but Departure Status is not one of 1, 10, 12, 23 OR 24 ~~2, 3, 4, 5, 7, 8, 11 or 13.~~

Remedy

Check the Departure Status and Referred to on Departure items, correct as appropriate and re-submit the transaction.
See: Section 3, Departure Status;
Referred to on Departure.

E339 Inpatient Bed Request Date/Time and Departure Status Comb Invalid

Effect NOTIFIABLE

Problem Departure Status is 14, 15, 16, 18 or 22 ~~'2 - Admission to ward (including HITH) / return to ward'~~ but no Inpatient Bed Request Date/Time has been recorded.
It is rare for a patient to go to a ward without a request for an inpatient bed being performed (unless patient is returning to the inpatient ward).

Remedy Check Departure Status and Inpatient Bed Request items, correct as appropriate and re-submit the transaction.
If correct, notify the VEMD Helpdesk of the accuracy of the record, providing detailed explanation. If the information is validated DHS will accept the record into the VEMD.

See: Section 2, Date/Time Fields;
Section 3, Departure Status;
Inpatient Bed Request Date;
Inpatient Bed Request Time;
Section 4, Departure Status.

E351 Potentially Excessive Wait For Treatment

Effect NOTIFIABLE

Problem The Time to Treatment exceeds the value for the corresponding Triage category in the following table:

Triage Category	Time to Treatment
1 – Resuscitation	1 minute
2 – Emergency	120 minutes
3 – Urgent	360 minutes
4 – Semi Urgent	720 minutes
5 – Non Urgent	720 minutes
6 – Dead on Arrival	360 minutes

Remedy Check documentation to determine whether the calculation of Time to Treatment is correct.

The following fields require investigation and possible corrective action:

- Arrival Date/Time,
- First Seen by Doctor Date/Time,
- First Seen by Treating Nurse Date/Time,
- First Seen by Mental Health Practitioner Date/Time,
- Triage Category,
- Departure Status.

Note: The Date/Times and Triage Category reported must be substantiated by the hospital's medico-legal documentation.

For the purpose of this edit, if a patient's episode of care concludes with the allocation of a Departure Status of '10 – Left against clinical advice regarding treatment options' or '11 – Left at own risk, without treatment', the Time to Treatment is calculated as the difference between Departure Date/Time and Arrival Date/Time.

If correct, notify the VEMD Helpdesk to confirm the accuracy of the record, providing a detailed explanation. If the information is validated DHS will accept the record into the VEMD.

See: Section 2, Date/Time Fields;
Time to Treatment;
Section 3, Arrival Date;
Arrival Time;
First Seen by Doctor Date;
First Seen by Doctor Time;
First Seen by Treating Nurse Date;
First Seen by Treating Nurse Time;
Triage Category,
First Seen by Mental Health Practitioner Date;
First Seen by Mental Health Practitioner Time;

E356 Type of Usual Accomm and Departure Status Comb Invalid

Effect WARNING

Problem The record's Type of Usual Accommodation is '11 – Prison/Remand Centre/Youth Training Centre' but the Departure Status is not 3, 5, 7, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, or 22

~~2~~ ~~Admission to ward; **OR**~~
~~3~~ ~~Admission to registered short stay observation unit; **OR**~~
~~4~~ ~~Transfer from this hospital campus to another hospital campus; **OR**~~
~~7~~ ~~Died within ED; **OR**~~
~~12~~ ~~Custodial/Correctional Facility.~~

Remedy It is unlikely that a patient with an identified Type of Usual Accommodation of 11 would have a discharge status other than one indicating the patient remains in custodial care.
Correct as appropriate and re-transmit.

See: Section 3, Departure Status;
Type of usual Accommodation.

E366 Departure Status and Triage Category Combination Invalid

Effect NOTIFIABLE

Problem The Departure Status is '10 – Left after clinical advice regarding treatment options' or '11 – Left at own risk, without treatment' but the patient has a Triage Category of '1 – Resuscitation'.

Remedy Check Departure Status and Triage Category ~~and First Seen by Treating Nurse or Doctor Date/Time~~, amend as appropriate if necessary, and re-transmit.

If correct, notify the VEMD Helpdesk of the accuracy of the record, providing detailed explanation. If the information is validated DHS will accept the record into the VEMD.

See: Section 3, Departure Status;
~~First Seen by Doctor Date;~~
~~First Seen by Doctor Time;~~
~~First Seen by Treating Nurse Date;~~
~~First Seen by Treating Nurse Time~~;
Triage Category;
Section 4, Left without Treatment.

Section 8 Supplementary Code Lists

Revision Summary	New list consolidating commonly used features of VEMD Hospital Campuses.

Campus	Short name	MAPU	SOU	EMU	ICU	CCU
1010	Alfred	1	1	0	1	1
1021	Bendigo	0	0	0	1	1
1031	ARMC Austin	1	1	1	1	1
1040	Bairnsdale	0	0	0	0	0
1050	Box Hill	1	1	0	1	1
1071	Hamilton	0	0	0	1	1
1121	Shepparton	0	0	1	1	1
1150	Wangaratta	0	0	0	1	1
1160	Mercy Hosp Women	0	0	0	0	0
1170	MMC Clayton	1	1	1	1	1
1180	Western	1	1	0	1	1
1191	RCH	0	1	0	1	1
1210	Maroondah	0	1	1	1	1
1230	Royal Womens	0	0	0	0	0
1240	RVEEH	0	0	0	0	0
1250	Rosebud	0	0	0	0	0
1280	Northern	0	1	0	1	1
2111	Dandenong	1	1	1	1	1
1320	Mercy Werribee	0	0	0	0	1
1334	RMH	1	1	0	1	1
1360	Sandringham	0	0	0	0	1
1390	Sunshine	1	1	0	0	0
1450	St Vincents	1	1	1	1	1
1460	Williamstown	0	0	0	0	1
1491	Swan Hill	0	0	0	0	0
1580	West Gippsland	0	0	0	0	0
1590	Angliss	0	1	0	1	1
1660	Wodonga	0	0	0	0	0
2010	Ballarat Base	1	0	0	1	1
2050	Geelong	0	1	1	1	1
2060	Sale	0	0	0	1	1
2160	Warrnambool	0	0	0	1	1
2170	Horsham	0	0	0	1	1
2180	Echuca	0	0	0	0	0
2220	Frankston	0	1	1	1	1
2320	Mildura	0	0	0	1	1
2440	Latrobe Regional	0	1	0	1	1
3660	Casey Hospital	0	0	0	0	0

Note: For a current list of the above data, please refer to:
http://www.health.vic.gov.au/hdss/reffiles/index.htm