

Proposals for revisions to the
Victorian Emergency Minimum
Dataset for 1 July 2009

October 2008

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Melbourne.

Executive Summary

Each year the Department of Human Services (DHS) reviews the data elements and format of the Victorian Emergency Minimum Dataset (VEMD). This review seeks to ensure that the emergency department presentations data collection supports the Department's state and national reporting obligations, assists DHS planning and policy development, and incorporates appropriate feedback from data providers.

In order to be accepted into the VEMD, proposals must demonstrate clear business justification and be fully costed, meaning funding streams will need to be identified and confirmed. Final acceptance of all proposals is by the Executive Directors of the Metropolitan Health and Aged Care Services Division and the Rural and Regional Health and Aged Care Services Division (based upon recommendations by the Data Management Advisory Committee (DMAC)).

The proposed revisions for the Victorian Emergency Minimum Dataset (VEMD) for 1 July 2009 include:

- Implementation of the Standard Australian Classification of Countries, Second edition 2008 for *Country of Birth* and country of residence reporting.
- Introduce new concepts for *Initiation of patient management* and *Time to initiation of patient management*.
- Introduce a new field for *Initiation of patient management date/time*.
- Addition of new code/s to the:
 - *Referred by* codeset for recording referrals to emergency departments by mental health staff.
 - *Referred to on departure* codeset for recording patient referrals to mental health community services.
 - *Departure Status* codeset for recording departures to theatre or procedure room.

Introduction

The VEMD proposals consultation process

This *Proposals* document is being distributed to all Victorian hospitals, to patient management system suppliers known to have Victorian clients, and to a range of industry bodies. It outlines *proposals* for changes to the VEMD at the time of its release in October 2008. This should not be regarded as a complete list of changes to be made for 2009-10. Items in this publication are not guaranteed to change or to change in the form suggested here; nor does the absence of an item from this publication indicate it will not change from 1 July 2009. Confirmed changes will be published in the document *Specification for Revisions to the Victorian Emergency Minimum Dataset for 1 July 2009* scheduled for release in December 2008.

It is expected that release of these proposals will stimulate discussion within the health industry. **Prompt feedback is sought on these proposals.** Hospitals and software suppliers should review this document and assess the feasibility of the proposals. Please provide written feedback to DHS by completing the proforma located at <http://www.health.vic.gov.au/hdss>, and forwarding it to HDSS **by 14 November 2008**.

The proposer or their nominated representative will present their proposal/s at a meeting of the VEMD Technical Reference Group (TRG) on Tuesday 28 October 2008. Minutes of this meeting will be available on the HDSS website following the meeting. There will be further opportunity to comment on these proposals following that meeting.

Queries or concerns regarding the proposals can be discussed with a member of the Health Data Standards and Systems Unit by contacting the HDSS help desk on 9096 8141 or HDSS.helpdesk@dhs.vic.gov.au.

Orientation to this document

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

- New values and definitions relating to existing items are highlighted in orange
- Changes to existing items are highlighted in green
- Redundant values and definitions relating to existing items ~~are struck through~~.
- Comments relating only to the proposal document [*appear in square brackets and italics*].
- Page numbers representing cross-referencing to another section of the VEMD Manual are represented by a hash (#).
- Edits with proposed changes are marked with an asterisk (*) when listed as part of a Data Item.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the Victorian Emergency Minimum Dataset Manual.
 - Specification: details the reporting requirements for the item.
 - Administration: provides additional information including the purpose for the collection of the data item and the source of the code set and definitions.
- Further information such as the background to each proposal is provided.

Abbreviations

DHS	Department of Human Services
DMAC	Data Management Advisory Committee
ED	Emergency Department
EMU	Emergency Medical Unit
MAPU	Medical Assessment and Planning Unit
NHDD	National Health Data Dictionary
NMDS	National Minimum Dataset
SACC	Standard Australian Classification of Countries
SOU	Short Stay Observation Unit
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset

Proposals

Proposal One: Departure to theatre/procedure room

It is proposed to Add an additional option in the codeset for the *Departure Status* data element for departure 'To theatre/procedure room'.

Proposed by Jim Doumtsés
Project Officer
Surgical Services Program
Access & Metropolitan Performance Branch
Department of Human Services

Implementation Date 1 July 2009

Background In April 2008 a sector wide forum 'Victorian Surgical Services Strategic Framework' attended by approximately 70 participants from health services (rural, regional and metropolitan), professional associations and the department identified timely access to emergency surgery as a potential area warranting further investigation and policy development by the department. The workshop articulated the need for the department to 'Develop data systems to support hospital monitoring of emergency and elective surgery demand and service provision'.

The *Departure Status* data element does not allow health services to report where a patient is transferred directly from the emergency department to a theatre or procedure room for surgery.

This data used in combination with the *Departure Date/Time* fields and the proposed Victorian Admitted Episodes Dataset (VAED) field *Start Date/Time of surgery* will provide potential for health services to measure, monitor and analyse timeliness of emergency surgery. It will also allow the department to pursue longer term strategy to balance demand for and provision of planned and unplanned surgery.

Departure Status (*Amended*)

Specification

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

Datatype Alpha/numeric **Form** Code

Field size Two **Layout** N or NN

Reported for Every Emergency Department presentation.

Code set **Select the first appropriate category**

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

Theatre/procedure setting at the Hospital Campus

27	To theatre/procedure room
----	---------------------------

Ward Setting at this Hospital Campus:

15	Intensive Care Unit – this campus
22	Coronary Care Unit – this campus
25	Mental Health Observation/Assessment Unit
3	Short Stay Observation Unit
13	Emergency Medical Unit
14	Medical Assessment and Planning Unit
26	Other Mental Health Bed - this Campus
18	Ward not elsewhere described

Transfers to 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

Returning to usual residence:

23 Mental health residential facility

24 Residential care facility

12 Correctional/Custodial Facility

1 Home

Reporting guide Report 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.

Departure before treatment completed

11 Left at own risk, without treatment

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

- o Without notifying staff,
- o Despite being advised by clinical staff not to leave, or
- o Without receiving advice about alternatives to treatment in the Emergency Department.

Common descriptions include did not wait, DNW, failed to answer, FTA.

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.

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 brought into the ED but there is no intention to resuscitate.

Theatre/procedure setting at this hospital campus

27 To theatre/procedure room

Patient departs the emergency department for an operating or procedure room. Procedure rooms include endoscopy and cardiac catheterisation rooms ('cath labs'), but do not include radiology rooms.

Excludes: Patient undergoing a procedure/investigation in a procedure room or theatre within the emergency department.

Ward Setting at this Hospital Campus

15 Intensive Care Unit – this campus

Patient is transferred to a registered ICU bed at this campus.

Excludes: Coronary Care Unit (use 22).

Refer to: Section 2 *Intensive Care Unit*

22 Coronary Care Unit – this campus

Patient is transferred to a registered CCU bed at this campus.

Excludes Intensive Care Unit (use 15).

Refer to: Section 2 *Coronary Care Unit*

25 Mental Health Observation/Assessment Unit

Includes registered:

- Psychiatric Assessment and Planning Unit (PAPU)
- Mental Health Short Stay Observation Unit

Excludes:

- Other Mental Health Bed at this campus (use 26)
- Short Stay Observation Unit (use 3)
- Emergency Medical Unit (use 13)
- Medical Assessment and Planning Unit (use 14)

3 Short Stay Observation Unit (SOU)

Excludes:

- Emergency Medical Unit (use 13);
- Medical Assessment and Planning Unit (use 14);
- Mental Health Observation/Assessment Unit (use 25)

Refer to: Section 2 *Short Stay Observation Unit*

13 Emergency Medical Unit (EMU)

Excludes:

- Short Stay Observation Unit (use 3);
- Medical Assessment and Planning Unit (use 14);
- Mental Health Observation/Assessment Unit (use 25)

Refer to: Section 2 *Emergency Medical Unit*

14 Medical Assessment and Planning Unit (MAPU)

Excludes:

- Short Stay Observation Unit (use 3);
- Emergency Medical Unit (use 13);
- Mental Health Observation/Assessment Unit

Refer to: Section 2 *Medical Assessment and Planning Unit*

26 Other Mental Health bed – this campus

The bed or ward must be part of an approved mental health program.

Refer to: Section 2 *Mental Health Bed*

18 Ward

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

Excludes patients who:

- Attend the ED from an inpatient ward at the same hospital and then return to a Mental Health bed (use 26).
- 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).
- Depart directly to theatre or procedure room in this hospital campus (report code 27)

Transfers to another Hospital Campus

17 Mental Health bed at another hospital campus

Patient has been transferred to a registered mental health bed at another hospital campus. A *Transfer Destination* must also be reported.

Refer to: Section 2 *Mental Health Bed*

20 Another Hospital Campus - Intensive Care Unit

Patient has been transferred to a registered ICU bed at another hospital campus. A *Transfer Destination* must also be reported.

Refer to: Section 2 *Intensive Care Unit*

21 Another Hospital Campus - Coronary Care Unit.

Patient has been transferred to a registered CCU bed at another hospital campus. A *Transfer Destination* must also be reported.

Refer to: Section 2 *Coronary Care Unit*.

19 Another hospital campus

Patient has been transferred to another hospital campus.

Excludes patients transferred to the following registered bed types at another campus:

- Mental Health bed (use 17)
- ICU bed (use 20)
- CCU bed (use 21)

A *Transfer Destination* must also be reported.

Returning to usual residence

23 Mental health residential facility

Includes psychogeriatric nursing home.

Excludes transfer to hospital Mental health bed:

- At this campus (use 26)
- At another hospital campus (use 17).

24 Residential care facility

Includes:

- Nursing home
- Hostel
- Residential care respite bed
- Nursing home beds located within an acute or sub-acute hospital campus.

Excludes psychogeriatric nursing home (use 23)

12 Correctional / Custodial Facility

The Commonwealth Department of Health and Aged Care does not recognise these facilities as hospitals and therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

Does not require a *Transfer Destination* code.

1 Home

Includes: House,

Unit,

Boarding/rooming house,

Hotel,

Caravan,

Youth hostel accommodation,

Homeless person's shelters

Shelter/refuges

Armed forces hospitals and

No fixed abode.

Patients going to a Rehabilitation In The Home program

Armed Forces Hospitals

The Commonwealth Department of Health and Aged Care does not recognise these facilities as hospitals 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'.

Transit Lounges

Transit lounges/holding areas are not generally considered to be inpatient wards. Thus, emergency patients located in these areas, prior to being admitted to a ward, should be considered to be in the care of the emergency department.

Edits

E142	Dead on Arrival Combination Invalid
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
E367	Unregistered Emergency Medical Unit
E376	Unregistered Medical Assessment and Planning Unit
E377	Unregistered Intensive Care Unit
E378	Unregistered Coronary Care Unit
E382	Unregistered Mental Health Observation/Assessment Unit

Related items

Section 3: *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.

Define patients for performance measures calculation.

Principal data users

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

Collection start	1 July 1995	Version	1	1 July 1995
			2	1 July 2000
			3	1 July 2001
			4	1 July 2002
			5	1 July 2003
			6	1 July 2006
			7	1 July 2008
			8	1 July 2009
Definition source	NHDD	Code set source	DHS	

Proposal Two: Referral of mental health patients to emergency departments

It is proposed to	Add additional options (codes) in the code set for the <i>Referred by</i> data element.
Proposed by	Tracey Burgess Manager Information Analysis and Reporting Mental Health and Drugs Division Department of Human Services
Implementation Date	1 July 2009
Background	<p>The evolving process of referring Mental Health patients to emergency departments means that the current <i>Referred by</i> codeset may benefit from review and/or some alteration.</p> <p>The proposed introduction of a mental health line in late 2008-09 will be a source of referral to emergency departments that will be important to monitor. The state government is likely to invest significantly in a helpline similar to Nurse On Call, but whose focus is mental health. This service may need to refer patients to emergency departments for urgent treatment. A <i>Referred By</i> code that enables sites to capture these referrals will assist in monitoring the effectiveness of this service. It is believed that the commencement of this program could be as soon as April 2009.</p> <p>The existing <i>Referred By</i> value 'Crisis Assessment Team' may also be currently used as a catch-all for other mental health-related referrals such as mental health triage (not to be confused with emergency department triage), so clarification of these options is required.</p>

Referred By (*Amended*)

Specification

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

Datatype Alpha/numeric **Form** Code

Field size Two **Layout** N or NN

Reported for Every Emergency Department presentation.

Code set **Select the first appropriate category**

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

0	Staff from this campus
1	Self, family, friends
2	Local medical officer, includes local GP/Doctor
4	Private specialist
6	Staff from another campus
8	Correctional Officer / Police

9	Crisis Assessment Team
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10	Community Services Staff
----	-------------------------------------

14	Nurse on Call
----	---------------

15	Other Nurse
----	-------------

16	Mental health telephone assessment/advisory line
----	--

17	Other mental health staff
----	---------------------------

18	Other community services staff
----	--------------------------------

19	Other
----	-------

Reporting guide

6 Staff from another campus

Includes: Admitted and non-admitted transfers from another hospital campus.

Excludes: Armed forces hospitals (report code 19)

Prison hospitals (report code 8)

Also record Transfer Source.

8 Correction Officer / Police

Includes prison hospitals. The Commonwealth Department of Health and Aged Care does not recognise these as hospital, therefore admission from, or separation to, such facilities is not an inter-hospital transfer.

14 Nurse on Call

Patient indicated that they had been advised by NURSE-ON-CALL to present to the Emergency Department of the nearest hospital.

Excludes: District Nurse, Nurse Practitioner and Nurses employed within other facilities.

15 Other 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), Nurse on Call, and nurses within this hospital or other acute care facility.

16 Mental Health telephone assessment/advisory line

Includes: Mental health help line
Suicide help line
Mental health area phone triage

17 Other mental health staff

Includes: Psychiatric disability rehabilitation support service (PDRSS)
Crisis assessment team (CAT team)

Excludes: Triage/help line workers

18. Other community services staff

Excludes: Mental Health services staff such as crisis assessment teams (report 17)

Continuing care services.

19 Other

Includes armed forces hospitals. These 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.

Edits

*E130 Referred By Invalid

*E136 Referred By and Transfer Source Combination Invalid

Related items

Section 3: Arrival Transport Mode, Transfer Source

Administration

Purpose

Analysis of referral patterns.

Collection start	1 July 1995	Version	1	1 July 1995
			2	1 July 1997
			3	1 July 2001
			4	1 July 2002
			5	1 July 2003
			6	1 July 2008
			7	1 July 2009
Definition source	DHS	Code set source	DHS	

Proposal Three: Referrals from emergency departments to mental health services

It is proposed to Add additional options (codes) in the code set for the *Referred to on departure* data element.

Proposed by Tracey Burgess
Manager
Information Analysis and Reporting
Mental Health and Drugs Division
Department of Human Services

Implementation Date 1 July 2009

Background The current *Referred to on departure* data item does not allow for explicit identification of referral to a Mental Health community service. The nexus between emergency departments and Mental Health Services is of sufficient public interest for DHS to improve its capacity to monitor this.

It is proposed that this be rectified by modification of the codeset and reporting guide.

Referred to on Departure (*Amended*)

Specification

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

Datatype Alpha/numeric **Form** Code

Field size Two **Layout** N or NN

Reported for Every Emergency Department presentation.

Code set

Code **Descriptor**

1	Review in ED - scheduled
2	Review in ED - as required
3	Outpatients
4	LMO
5	Medical Specialist
6	Other Specialist Health Practitioner
7	Home Nursing Services
8	Specialised Community Service
9	Aged Care Assessment Service
10	Drug and Alcohol Treatment Service
11	Mental Health Community Service
12	Other community service
16	No referral
17	Not known
18	Other
19	Not applicable

Reporting guide Select the first appropriate category.

1 Review in Emergency Department – scheduled

Patient has a planned return date to re-attend the emergency department.

2 Review in Emergency Department – as required

Patient has been advised to return to the emergency department if the problem/s persists and/or further care is required.

3 Outpatients

Patient has been referred to an outpatient clinic for further care,

treatment and/or follow up.

4 Local medical officer (LMO)

Patient has been referred to their local doctor for further care, treatment and/or follow up.

5 Medical specialist

6 Other specialist health practitioner

Includes: Allied health personnel, Dentist.

Excludes: Mental health staff (report code 11 Mental Health community service)

7 Home nursing service

Includes: Royal District Nursing Service (RDNS)

~~**8 Specialised Community Service**~~

~~Used where a patient is referred to a Rape Crisis Centre or Crisis Assessment Team. For referral to Drug and Alcohol Treatment Service use code '10 - Drug and Alcohol Treatment Service'.~~

9 Aged Care Assessment Service (ACAS)

Patient has been 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.

10 Alcohol and Drug Treatment Service

Patient has been referred to an Alcohol and Drug Treatment Service (including Counselling, Residential Withdrawal, Rehabilitation and Supported Accommodation)

11 Mental Health community service

Clinical mental health services are part of larger health services that deliver a range of hospital and community based services. The community-based clinical mental health services to which emergency department patients are most likely to be referred are:

- o Crisis assessment and treatment (CAT) services.

These operate 24 hours a day and provide urgent community-based assessment and short-term treatment interventions to people in psychiatric crisis. CAT services have a key role in deciding the most appropriate treatment option and in screening all potential inpatient admissions. CAT services provide intensive community treatment and support, often in the person's own home, during the acute phase of illness as an alternative to hospitalisation. CAT services also provide a service to designated hospital emergency departments through an onsite presence.

- o Continuing care services.

These are the largest component of adult community based services. They provide non-urgent assessments, treatment, case management, support and continuing care services to people with a mental illness in the community. The length of time case management services are provided to a person varies according to clinical need. Continuing care services may be involved with people for extended periods of time or may provide more episodic care. Continuing care clinicians frequently liaise with, and refer to, generalist services including general practitioners for ongoing support and provision of services to people with a mental illness.

Excludes: Mental Health service provision in the admitted setting

12 Other community service

Includes: Rape crisis centre

16 No referral

The patient's treatment has been completed and no referral is required.

17 Not known

18 Other

19 Not applicable

Patient has either:

- been transferred to ward (including MAPU, EMU, SOU)
- been transferred to another hospital campus,
- died,
- left at own risk or
- Was dead on arrival.

Edits	E142	Dead on Arrival Combination Invalid
	*E240	Referred to on Departure Invalid
	*E242	Referred to on Departure and Departure Status Combination Invalid

Administration

Purpose To promote and monitor the coordination of patient care.

Principal data users Monash University Accident Research Centre;
Access and Metropolitan Performance Branch, DHS.
Mental Health and Drugs Division, DHS

Collection start	1 July 1995	Version	1	1 July 1995
			2	1 July 1997
			3	1 July 2003
			4	1 July 2004
			5	1 July 2009

Definition source	DHS	Code set source	DHS
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Proposal Four: Implement Standard Australian Classification of Countries Second edition 2008 for *Country of Birth* and *Country of Residence* reporting

It is proposed to To revise the *Country of Birth and Country of Residence* codeset to be consistent with the Standard Australian Classification of Countries (SACC) Second edition 2008.

Proposed by Health Data Standards and System Unit
Funding, Health and Information Policy
Metropolitan Health and Aged Care Services Division
Department of Human Services

Implementation Date 1 July 2009

Background The Australian Bureau of Statistics released the SACC Second edition in May 2008. This edition of the SACC has been incorporated into the National Health Data Dictionary (NHDD) as the classification scheme for the *Country of Birth* data element.

DHS currently uses the SACC for the *Country of Birth* data element, as well as for reporting country of residence for overseas residents in the *Locality* data element.

The following changes are required to align the *Country of Birth and Country of Residence* codeset to the SACC Second Edition 2008.

Changed in name

Code	SACC Second Edition for 1 July 2009	Formerly
2100	United Kingdom, Channel Islands and Isle of Man	United Kingdom
2402	Faroe Islands	Faeroe Islands
5105	Vietnam	Viet Nam
6101	China (Excludes SARS and Taiwan)	China (Excludes SARS and Taiwan Province)
7206	Kyrgyzstan	Kyrgyz Republic

Added to the classification

Code	SACC Second Edition for 1 July 2009	Formerly in or part of
1513	Pitcairn Islands	1599 Polynesia (excludes Hawaii), nec
2107	Guernsey	2101 Channel Islands
2108	Jersey	2101 Channel Islands
2408	Aland Islands	2403 Finland
3216	Kosovo	3215 Serbia
4108	Spanish North Africa	4199 North Africa, nec
8431	St Barthelemy	8413 Guadeloupe
8432	St Martin (French part)	8413 Guadeloupe

Removed from the classification

Code	Name	SACC Second Edition for 1 July 2009
2101	Channel Islands	Separately identified as 2107 Guernsey and 2108 Jersey
4199	North Africa, nec	All parts now in 4108 Spanish North Africa

Proposal Five: *Time to treatment*

- It is proposed to
1. Introduce new concepts *Initiation of patient management* and *Time to initiation of patient management*.
 2. Introduce a new data element *Initiation of patient management date/time*.

Proposed by VEMD Technical Reference Group (TRG)

Implementation Date 1 July 2009

Background The VEMD TRG has been holding discussions regarding the *Time to treatment* definition and its relevance in the current emergency department environment, in particular whether the current definitions reliably reflects the time that ED patients wait for treatment to commence.

TRG membership comprises nominated representatives of Emergency Department (ED) Clinicians, hospital management, ED clerical (data submission) staff, Health Information Managers and other relevant industry bodies including the Australasian College of Emergency Medicine, Ambulance Victoria and the Victorian Injury Surveillance Unit, together with representatives of the DHS.

The TRG has agreed that *Time to initiation of patient management* may be an appropriate measure to ultimately replace *Time to treatment*. Discussions regarding definition of the concepts *Initiation of patient management* and *Time to initiation of patient management* are continuing and this document contains those concepts as they have been agreed to date. DHS and the TRG will take into consideration any feedback received following the release of these proposals. It is intended that the new measure be implemented for the 2009-10 reporting year.

A proposal regarding *Time to treatment* has also been received from the Australasian College of Emergency Medicine (ACEM). The principles behind the ACEM proposal have been incorporated into this proposal.

To enable accurate calculation of *Time to initiation of patient management*, it is proposed to introduce a new data element *Initiation of patient management date/time*. The specification for the proposed new data item will include more detailed information once the concept definition *Initiation of patient management* has been finalised and confirmed by the VEMD TRG.

Initiation of patient management (*New concept*)

Classification Concept

Definition Commencement of investigation, care and/or treatment according to a documented problem-specific clinical pathway, protocol or set of guidelines, excluding observations undertaken as a part of the triage process.

Guide for Use Where a patient is managed according to a documented **problem-specific** clinical pathway, protocol or set of guidelines, initiation of patient management occurs at the start of the occasion of contact between the patient and staff member/s whence this protocol is implemented.

As these pathways are specific to the presenting problem, the action taken to initiate the clinical pathway, protocol or guidelines will differ depending on the presenting problem, and may differ between different health services according to their own protocols.

Patient management may be:

- Initiated by a doctor, nurse, mental health practitioner or other recognised health professional able to commence patient management.
- Commenced at or after triage.

Depending on the clinical pathways in place in different hospitals, examples of initiation of patient management may include:

- Anginine administration according to chest pain management pathway.
- Commencement of ongoing neurological observations for patient presenting with neurological dysfunction.

The process of re-triage is considered to be a continuation of the triage process. Do not report re-triage of the patient as initiation of patient management.

Observations taken to monitor a patient pending a clinical decision regarding implementation of a clinical pathway, protocol or set of guidelines do not represent initiation of patient management, however once a clinical pathway, protocol or set of guidelines has been determined, patient management may be initiated by the taking of observations.

Allocation of a patient to a cubicle and/or routine initial assessment and/or observations by a nurse is not initiation of patient management.

Time to initiation of patient management (*New concept*)

Classification Derived Item

Definition Time to initiation of patient management (in minutes) is the difference between Arrival Date/Time and the Date/Time that the emergency department staff member commenced management of the patient's presenting problem.

Guide for Use Time to initiation of patient management is calculated as: [Initiation of patient management date/time] minus [Arrival Date/Time]

Time to initiation of patient management is weighed against the Triage Category for the episode to determine if the patient was treated within an acceptable timeframe.

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 this calculation.

Initiation of patient management date/time (New)

Specification

Definition The date and time that management of the patient was commenced in the emergency department.

Datatype Date/time **Form** Date/time

Field size Twelve **Layout** DDMMYYYYhhmm

Reported for All presentations except where Departure Status is:

- o 8 – Dead on Arrival
- o 10 – Left after clinical advice regarding treatment options or
- o 11 – Left at own risk, without treatment.

Reporting guide Initiation of patient management date/time must be reported for all patients whose care is managed in the emergency department.

Where a patient is managed according to a documented **problem-specific** clinical pathway, protocol or guidelines, initiation of patient management occurs at the start of the occasion of contact between the patient and staff member/s whence this protocol is implemented.

As these pathways are specific to the presenting problem, the action taken to initiate the clinical pathway, protocol or guidelines will differ depending on the presenting problem, and may differ between different health services according to their own protocols.

Patient management may be:

- o Initiated by a doctor, nurse, mental health practitioner or other recognised health professional able to commence patient management.
- o Commenced at or after triage.

Depending on the clinical pathways in place in different hospitals, examples of initiation of patient management may include:

- o Anginine administration according to chest pain management pathway.
- o Commencement of ongoing neurological observations for patient presenting with neurological dysfunction.

The process of re-triage is considered to be a continuation of the triage process. Do not report re-triage of the patient as initiation of patient management.

Observations taken to monitor a patient pending a clinical decision regarding implementation of a clinical pathway, protocol or set of

guidelines do not represent initiation of patient management, however once a clinical pathway, protocol or set of guidelines has been determined, patient management may be initiated by the taking of observations.

Allocation of a patient to a cubicle by a nurse is not initiation of patient management.

Edits *[Relevant and appropriate business rules will be defined following finalisation of the TRG work.]*

Related items

Administration

Purpose Used in the calculation of various derived items:

- Time to Initiation of patient management: Arrival Date/Time, Triage Date/Time and Initiation of patient management date/time.

Principal data users Access and Metropolitan Performance Branch, DHS.

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Definition source DHS (VEMD Technical Reference Group)

Appendix: Feedback Proforma

Please send your feedback using the form located at www.health.vic.gov.au/hdss.

