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| Victorian Emergency Minimum Dataset (VEMD) manual 2022-2023 |
| 27th edition |
| OFFICIAL |

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# Section 1: Introduction

The Victorian Emergency Minimum Dataset (VEMD) contains de-identified demographic, administrative and clinical data detailing Emergency Department presentations at Victorian public hospitals, and others as directed by the Department of Health (the department).

The Data Collections Unit (DCU) manages VEMD operations.

## Purpose

The VEMD manual provides contributors and users with a complete dataset resource including:

* definitions of data items
* how to compile and submit data
* information for contributors and data users
* code lists and links to reference files
* contact details for support services.

This manual together with subsequent HDSS Bulletins forms the data submission specifications for each financial year.

The manual is available on the [HDSS website](https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd) <https://www.health.vic.gov.au/data-reporting/victorian-emergency-minimum-dataset-vemd>

## Contact details

For advice and assistance with data submission, reported data items or the contents of this manual, contact the [HDSS Helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <HDSS.Helpdesk@health.vic.gov.au>.

# Data quality statement

This is a summary of what the department does to ensure consistent capturing and reporting of data quality across data sets and over time.

## Accuracy

The department publishes the VEMD manual on the HDSS website to provide clarity on reporting requirements for health services and information for data users. There are lists of valid codes in the manual and reference files on the HDSS website.

Data submitted by health services is subject to a validation process, checking for valid values and compliance with VEMD business rules.

The department performs monthly data quality checks:

* ED only admits
* overlapping ED presentation times and admission times
* VEMD length of stay (LOS) > 24 hours

Where anomalies are detected, health services are required to correct the data.

The VEMD is subject to audits. The audit program is managed by Health Data Integrity Unit in the Victorian Agency for Health Information (VAHI).

## Validity

The VEMD validation process provides reports for the health service to check the total number of records submitted, the number of rejections and warnings, and make appropriate corrections and re-submissions until they have a clean (zero rejection) submission by the ‘clean’ date.

## Completeness

The department monitors completeness through distribution of a monthly compliance report and regular analyses of the VEMD. Compliance emails are routinely sent to health services when a reporting deadline is missed, or rejections are outstanding.

Monthly extracts are sent to health services for review and reconciliation.

## Coherence

Each year the department reviews the VEMD to ensure the data collection:

* supports the department's state and national reporting obligations
* assists planning and policy development
* reflects changes in hospital funding and service provision arrangements for the coming financial year
* incorporates appropriate feedback from data providers on improvements
* ensures definitions for common data items are consistent across data collections.

## Interpretability

The VEMD manual provides definitions of concepts, data items, reporting guides and business rules relating to more than one data item.

Changes to the data collection during the year are published in the HDSS Bulletin.

The department provides data reporting advice and support to health services via the HDSS Helpdesk.

## Timeliness

The VEMD is updated daily from data held in the VEMD processing database.

Health services must submit data to the VEMD at least daily.

Data reporting for the financial year must be completed by the annual consolidation date published in the Department of Health policy and funding guidelines.

## Accessibility

The department provides a suite of reports that allows health services to verify that all relevant data has been submitted.

The VAHI Data Request Hub website provides information regarding data available, data release and confidentiality, and the application process.

The Victorian Health Services Performance website provides statistical information on Victoria’s public hospitals and health services. Activity and performance data are updated quarterly, with an aim to provide greater transparency and a better understanding of Victoria's public health and ambulance services.

# Communications and useful links

## HDSS Bulletin

The HDSS Bulletin, published by the department provides advice on several data collections including the VEMD.

It is available at the [HDSS Bulletins webpage](https://www.health.vic.gov.au/data-reporting/health-data-standards-and-systems) <https://www.health.vic.gov.au/data-reporting/health-data-standards-and-systems>

To subscribe to or update the mailing list, use the online form on the HDSS website or contact the HDSS help desk by emailing [HDSS Helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au>

## Health Records Act

Privacy and confidentiality access and regulations on disposal and retention of health records are available at [health records act](https://www.health.vic.gov.au/legislation/health-records-act) <https://www.health.vic.gov.au/legislation/health-records-act>

## Reference files

Reference files including the postcode and locality file are available at [VEMD reference files](https://www.health.vic.gov.au/data-reporting/reference-files) <https://www.health.vic.gov.au/data-reporting/reference-files>

The VEMD Library File and VEMD Editing Matrix is available from the HDSS Helpdesk. Please email the [HDSS Helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au>.

## Victorian health policy and funding guidelines

The Victorian Health Policy and Funding Guidelines is published annually on the department’s [policy and funding guidelines webpage](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>

## Victorian health services performance monitoring framework

The Victorian Health Services Performance Monitoring Framework is published annually on the department’s [performance monitoring webpage](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework) <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework>

The framework outlines the Government’s approach to overseeing the performance of Victorian health services.

# History and development of the VEMD

The VEMD commenced in 1995 as an initiative of the Department of Health in collaboration with the Victorian Emergency Departments Association, the Australasian College for Emergency Medicine Victorian Faculty, the Emergency Nurses Association, and Monash University Accident Research Centre (MUARC).

Significant changes have been made to the dataset since 1995 in order to:

* meet national reporting requirements
* meet the increased need for information by providers and users of health services and other bodies
* simplify and streamline the dataset.

2022-23

* Amend compensable status and associated validations for private hospitals
* Amend reporting guide for Sex
* Add a new validation for ambulance handover date/times

2021-22

Add emergency use codes to Referred by, Referred to on Departure, Service Type and Type of Visit existing VEMD data items.

2020-21

* Amend the Telehealth concept to include patient physically present in correctional facility

Amended during 2020-21:

* End date Type of Visit code to identify activity at COVID-19 assessment clinics

2019-20

New data items:

* Add Service Type for all presentations.
* Add Patient Location for Telehealth presentations.

Amendments to existing data items:

* Amend the Departure Status code set to include departures:
  + to Mental Health and AOD Hub Short Stay Unit
  + for Telehealth presentations.
* Amend Human Intent code set to include intentional self-harm with no intent to die and suicide attempt.
* Amend reporting guide for Advance Care Directive Alert.
* Amend existing and add new validations for Telehealth presentations and admissions to Mental Health and AOD Hub Short Stay Unit.
* Amend existing and add new concepts for Telehealth presentations.

Updated reference files:

* VEMD Library File and Editing Matrix for 2019-20.

Introduced during 2019-20:

* Add two new Service Type codes to identify COVID-19 testing
* Add one new Type of Visit code to identify activity at COVID-19 assessment clinics

2018-19

Amendments to existing data items

* Amend Advance Care Plan Alert data element name to Advance Care Directive Alert, amend definition and reporting guide.
* Add Referred By codes 21 Apprehended by police/PSO under Mental Health Act and 22 Correctional Officer / Other to replace deleted code 8 Correction Officer / Police.
* Amend Type of Usual Accommodation code descriptors to clarify reporting of residential aged care
* Add Type of Visit examples of emergency presentation and return visit – planned.

Amendments to validations

* Add new ambulance transfer validation

E407 Ambulance at Destination date/time and Departure date/time invalid combination

* Removal of notifiable validations E262 Diagnosis Code and Sex incompatible and E263 Diagnosis Code and Age incompatible

2017-18

New data items:

* Add Given Name and Family Name for DVA presentations
* Add Advance Care Plan Alert for all presentations

Amendments to existing data items

* Amend reporting guide for date/time fields to allow reporting of time 0000
* Amend definition, reporting guide, code descriptor for Sex to include code for Other
* Amend reporting guides for Seen by fields to clarify mandatory reporting
* Amend reporting guide to mandate reporting for all patients Seen by a Mental Health Practitioner
* Extend reporting of Ambulance at Destination date/time and Ambulance Handover Complete date/time to include all ambulance services, not just emergency
* Amend Ambulance Case number, increasing field to 10 characters and extend reporting to include all ambulances, (previously hospital contracted ambulances were excluded)
* Amend existing and add new validations for ambulance transfer data

Updated reference files

* Updated country of birth and country of residence code set
* Updated preferred language code set
* VEMD Library File and Editing Matrix for 2017-18
* VEMD editor for 2017-18

2016-17

Amendments to existing data items

* Amendment to Human Intent code set to include additional codes for family violence
  + New codes

12 Sexual assault by current or former intimate partner

13 Sexual assault by other family member (excluding intimate partner)

14 Sexual assault by other/unknown

15 Neglect, maltreatment, assault by current or former intimate partner

16 Neglect, maltreatment, assault by other family member (excluding intimate partner)

17 Neglect, maltreatment, assault by other/unknown

* + Removed codes

3 Sexual assault

4 Child neglect, maltreatment by parent, guardian

5 Maltreatment, assault by domestic partner

7 Assault not otherwise specified

10 Other specified intent

11 Intent not specified

* Amendments to definitions and reporting guides for Arrival Date and Arrival Time to align with national reporting requirements and clarify reporting of arrival time
* Removal of Procedures
* Removal of Type of Visit code 9 Patient in transit
* Amendment to reporting of patient dead on arrival at ED
* VEMD library and editing matrix updated, removing duplicates and updating diagnosis code for death

2015-16

* Library file updated to ICD-10-AM 9th edition code set
* Addition of new validation 401 Ambulance Handover complete date/time and Arrival Transport Mode combination invalid
* Modification of validation 397 Ambulance at Destination date/time and Arrival Transport Mode combination invalid to discontinue validation against arrival transport mode 10 and 11

2014-15

* Addition of new data fields: Ambulance at Destination date/time & Ambulance Handover Complete date/time
* Removal of data field: Inpatient Bed Request date/time and addition of data field: Clinical Decision to Admit date/time
* Library file updated to ICD-10-AM 8th edition code set

2013-14

* Addition of new notifiable edit E389 for patients reported as Triage Category 1 and the Time to Treatment (in minutes) exceeds 1 minute
* Change to business rules for Departure Status and Diagnosis to allow an optional diagnosis in the primary diagnosis field when Departure status is ‘10’ or ‘30’
* Removal of the field Escort Source

2012-13

* Primary diagnosis definition changed to ‘The diagnosis established at the conclusion of the patient’s attendance in an emergency department to be mainly responsible for occasioning the attendance following consideration of clinical assessment’
* Edit E351 Potentially Excessive Time to Initiation of Patient Management was changed from a Notifiable to a warning
* Updated Reference Files for Preferred Language and Country of Birth
* Updated library file to align with ICD-10-AM 7th edition

2011-12

* The Specification of Ambulance Case Number was modified to align with AV numbers
* The Departure Status code set was modified to include: 30 Left after clinical advice regarding treatment options – GP Co-Located Clinic

2010-11

The Departure Status code set was modified to remove: 13 Emergency Medical Unit

2009-10

* The Departure Status code set was modified to include codes: 27 for Cardiac catheter laboratory and Other procedure room/theatre
* Data fields First Seen by Treating Nurse date/time were replaced by Nurse Initiation of Patient Management date/time
* New derived item Time to initiation of patient management – the difference between Arrival date/time and the date/time that the emergency department staff member commenced management of the patient’s presenting problem
* Country of Birth and Country of Residence code set changed to align with the Standard Australian Classification of Countries Second edition 2008
* The Referred By code set modified to include codes: 16 Mental health telephone assessment/advisory line, 17 Telephone advisory line not otherwise specified, 18 Other mental health staff, and 20 Other community services staff. Two codes were deleted from the existing code set: 9 Crisis assessment team & 10 Community services staff

2008-09

* Introduction of a new data item Date of Birth Accuracy Code
* Referred By code set modified to include two new data items: 14 Nurse on Call & 15 Other Nurse. Code 13 – Nurse was removed
* The Departure Status code set was modified to include codes: 25 Mental Health Observation/Assessment Unit & 26 Other Mental Health Bed - this Campus. The following code was removed:16 Mental Health Bed- this Campus
* Indigenous Status code set descriptions modified to include Torres Strait Islander
* Interpreter required code set modified. 3 Not stated changed to 9 Not Stated / Inadequately Described
* VEMD Library File updated to align with ICD-10-AM Sixth edition

2007-08

* The ASCCSS Country code set was replaced with SACC Country code set for Country of Residence reported in the Locality data element, and Country of Birth data
* The existing Preferred Language code set was replaced with the Australian Standard Classification of Languages (ASCL) Preferred Language code set

2006-07

* Departure Status code set modified to expand Ward setting at this hospital campus and Transfers to another hospital campus
* Introduction of a new data items: First Seen by Mental Health Practitioner date/time

2005-06

New Indigenous status codes 8 Question unable to be answered & 9 Patient refused to answer

2004-05

* Referred to on Departure code set modified to include Alcohol and Drug Treatment Service
* New code for Sex: 4 Intersex
* Postcode/Locality reference file revised and overseas and interstate codes amended

2003-04

* New data fields: Interpreter Required and Type of Usual Accommodation
* Removed data field Ongoing Care Communication
* The Departure Status code set was modified to include new codes: 10 Left after clinical advice regarding treatment options, 11 Left at own risk, without treatment and 12 Correctional/Custodial Facility. Code 6 Left before being seen by doctor was removed
* Referred By code set was modified to include new codes: 0 Staff from this hospital, 13 Nurse (Excluding those in categories 0 to 10) Codes removed: 11 Hospital In The Home Service, from this hospital, 12 Inpatient ward in this hospital campus
* Referred to on departure code set amended - new code: 9 Aged Care Assessment Service

2002-03

* Removed data field Inpatient Bed Request. Inpatient bed request data/time fields still valid.
* New rule implemented to mandate an additional diagnosis if the primary diagnosis code is Z099 – Attendance for Follow-Up, to identify the condition under review

2001-02

* The Departure Status code set was modified to include new code 3 Admission to registered short stay observation unit
* The mandatory collection of Escort Source was discontinued
* The mandatory collection of Procedure if Primary Diagnosis is recorded was discontinued

2000-01

* New data fields: Ongoing Care Communication and DVA Number
* The Departure Status code set was modified to include new codes: 9 Departure and transfer to mental health residential facility & 0 Departure and transfer to aged care residential facility
* The Departure Transport Mode code set was modified to include new codes 10 Ambulance Service - private ambulance care - MAS / RAV contracted and 11 -Ambulance Service private ambulance care hospital contracted’ and remove codes: 5 Ambulance Service - private ambulance car

1999-00

* New data fields: Inpatient bed request date, Inpatient bed request time and Medicare Suffix
* Indigenous status code set modified to include: 5 = Indigenous - Aboriginal but not Torres Strait Islander origin, 6 = Indigenous - Torres Strait Islander but not Aboriginal origin and 7 = Indigenous - Aboriginal and Torres Strait Islander origin and removed 1 = Aboriginal or Torres Strait Islander
* The Arrival Transport Mode code set was modified to include new codes: 10= Ambulance service - private ambulance car - MAS / RAV contracted & 11= Ambulance service - private ambulance car - Hospital contracted’ and remove codes: 5 = Ambulance service - private ambulance car
* The following codes were removed from Type of Visit: 6 Pre-arranged admission - clerical only & ‘7 Pre-arranged admission - nursing and clerical
* The following code was removed from Departure Status: ‘3 = Admission within ED’

# Section 2: Concepts and derived item definitions

This section provides definitions of the concepts underlying the VEMD and the items derived from the data collected by the department.

The definitions contained in this section are based wherever possible on the National Health Data Dictionary (NHDD).

## Age

|  |  |
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| **Classification** | Derived item |
| **Definition** | The patient’s age on presentation at the Emergency Department |
| **Guide for Use** | Age can be measured in years, months or days and is calculated as:  [Arrival Date] minus [Date of Birth] |

## Ambulance at Destination

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| **Classification** | Concept |
| **Definition** | Time of ambulance arrival at the hospital and immediately prior to the paramedic turning the engine off and/or getting out of the vehicle (generated by ambulance paramedics). |
| **Guide for Use** | This time is generated by ambulance paramedics activating the arrival button on their mobile data terminal (MDT) or RavNet radio when they arrive at the ambulance bay at the hospital. The MDT/ RavNet radio ‘at destination time’ is entered by the paramedic into the Victorian Ambulance Clinical Information System (VACIS).  ‘Ambulance at destination time’ will be provided by the ambulance paramedics to hospital staff at triage or reception when the patient is taken into the emergency department (ED). The time is then entered into the ED information system by hospital staff.  Data is entered for ED patients arriving by ambulance. Includes non-emergency patient transport vehicles. |

## Ambulance Handover Complete

|  |  |
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| **Classification** | Concept |
| **Definition** | Time when:   * clinical information has been given to the ED clinician; and * the patient has been moved from the ambulance stretcher to the hospital bed, care area or waiting room. |
| **Guide for Use** | Handover may be provided to ED clinicians (including a nurse or doctor) when the patient is transferred to a hospital bed, care area or waiting room. Paramedics may need to retrieve some ambulance equipment prior to completion of handover.  ‘Ambulance handover complete’ is recorded as the actual time that has been confirmed by the ED clinician and ambulance paramedics.   * ‘Ambulance handover complete’ time does not include: * Paramedics watching how a patient is managed in the ED subsequent to handover * Cleaning of equipment and re-stocking of ambulance vehicle * Completion of VACIS following ambulance handover complete. * ED staff are responsible for entering the time into the ED information system. Paramedics are responsible for entering the time into Victorian Ambulance Clinical Information System (VACIS).   Data is entered for ED patients arriving by ambulance. Includes non-emergency patient transport vehicles.  Refer to the following case studies: |

Ambulance handover complete - case studies

Case study 1

An ambulance patient arrives at ED, is registered, triaged and allocated to an ED cubicle. The ED clinician receives the patient’s clinical information from the ambulance paramedics. The patient is moved onto a hospital bed but is still attached to the ambulance cardiac monitor.

Ambulance handover is not complete until ambulance equipment has been retrieved, including the ambulance cardiac monitor, at which point the ‘ambulance handover complete’ time should be agreed by the ED clinician and ambulance paramedics.

The ‘ambulance handover complete time’ is recorded by the ED clinician in the ED information system and by ambulance paramedics in the VACIS.

Case study 2

An ambulance patient arrives at ED and is transferred to a hospital bed. Ambulance equipment is returned to ambulance paramedics. The ED clinician has not been available to receive the patient’s clinical information. ‘Ambulance handover’ is not complete until all clinical information has been provided to the ED clinician.

## Campus

|  |  |
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| **Classification** | Concept |
| **Definition** | A physically distinct site owned or occupied by a health service/hospital, where treatment and/or care is regularly provided to patients. |
| **Guide for Use** | For the purposes of reporting to the VEMD:  A single campus hospital provides emergency and admitted patient services at one location, through a combination of emergency, overnight stay beds and day stay facilities.  A multi–campus hospital has two or more locations providing emergency and admitted services, where the locations:   * are separated by land (other than public road) not owned, leased, or used by that hospital * has the same management at the health service/hospital level * each has overnight stay facilities – a separate location (see first dot point) providing day only services, such as a satellite dialysis unit, is considered to be part of a campus * are not private homes. Private homes, where Hospital in the Home services are provided, are considered to be part of a campus.   The department holds that, as a general principle, VEMD reporting should identify activity at each campus. Any multi–campus hospital not currently reporting on this basis, or a hospital intending to change from a single to multi–campus or vice versa, should discuss this with the department. |

## 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.  **Source**: (Ministerial Review of Coronary Care Services in Victoria – December 1996). |
| **Guide for Use** | None |

## Date/time fields

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | Except for Date of Birth, all date fields in VEMD have a related time field. Although date and time fields are submitted as two separate fields, they should be viewed as a single date/time entity. To accommodate this, date and time fields are converted to a single date/time value before being validated. |
| **Guide for use** | Time data in the VEMD is currently reported with a precision of minutes. To avoid ambiguity and ensure a consistent approach between different sites, where the data entry system captures seconds, these are to be rounded down to the previous minute for VEMD reporting. |

## Death – Verification and Certification

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | **Verification of Death** refers to establishing that death has occurred after clinical assessment of a body. This process is not restricted to registered medical practitioners as the law does not prevent other health professionals with relevant training such as registered nurses, midwives or paramedics (as defined by the Health Practitioner Regulation National Law (Victoria) Act 2009) from undertaking this role.  Refer to guidance note for the [verification of death](https://www.health.vic.gov.au/publications/guidance-note-for-the-verification-of-death) <https://www.health.vic.gov.au/publications/guidance-note-for-the-verification-of-death > |

## Diagnosis

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | The diagnosis established at the conclusion of the patient’s attendance in an emergency department to be mainly responsible for occasioning the attendance following consideration of clinical assessment. |
| **Guide for use** | When determining the patient’s diagnosis consideration should be given not only to the physical examination but also to the history of the present illness, based on a description of symptoms and signs, a past medical history, a family medical history and a social history.  It is acknowledged that diagnosis in an emergency setting is based on the best information available at the conclusion of the patient’s emergency presentation and therefore may be a provisional rather than a definitive diagnosis. |

## Emergency Department

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | A dedicated area in a hospital that is organised and administered to provide emergency care (including reception, triage, initial assessment, and management) to people who perceive the need for, or are in need of, acute or urgent care.  An Emergency Department reporting to the VEMD must be staffed on a 24-hour basis by hospital medical staff (includes staff on shift or on-call).  All hospitals previously receiving Non-Admitted Emergency Services Grant funding are deemed to have an Emergency Department whose activity should be reported to VEMD. |
| **Guide for use** | Where the range of care is limited (for example, to specialties such as women’s health, paediatrics) pre-hospital and other policies should be in place to ensure appropriate presentation |

## Emergency Department Presentation

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | An Emergency Department Presentation is the reporting unit of the VEMD. All presentations assessed to the extent that they are allocated a Triage Category should be reported.  This includes presentations to the Emergency Department via an audio-visual link (refer to Telehealth below) where the patient is physically present with a nurse or doctor at a public urgent care centre, other public emergency department or a Victorian government or non-government residential aged care service. |
| **Guide for use** | Some form of formal or informal triage event logically precedes the act of receiving treatment in the Emergency Department. For instance, a patient may be so critically ill that they by-pass the formal triage process to receive resuscitative intervention. However, the act of prioritising access to care according to the level of need has still occurred.  For Telehealth presentations, a patient will be triaged into the Emergency Department workload via electronic referral and telephone discussion between nurse or doctor at the patient location.  An Emergency Department Presentation should be reported even if the patient leaves the Emergency Department before the treatment has commenced or if the registration was commenced but not completed (use the appropriate Departure Status code).  If a patient attends the Emergency Department for the treatment of two or more conditions concurrently, only one presentation should be reported to the VEMD.  Health Services are advised to use the description in the Observation Medicine Guidelines 2009 and the definitions in this manual to select the code that best represents the model of observation medicine that they deliver. |

## Emergency Department (ED) Short Stay Unit

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | An approved Emergency Department (ED) Short Stay Unit (SSU) is a designated unit that is specifically staffed and equipped to provide observation, care and treatment for emergency patients who have an expected length of stay between 4 and 24 hours. The facility may be adjacent to, within, or remote from the Emergency Department. |

## Hospital

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | A health care facility established under Commonwealth, State or Territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients. |
| **Guide for use** | A hospital may be located at one physical site or may be a multi-campus hospital.  For the purposes of these definitions, ‘hospital’ includes satellite units managed and staffed by the hospital and private homes used for service provision under the Hospital in the Home program.  Definition:  Public hospitals, denominational hospitals, public health services, and privately operated (public) hospitals as defined in the Health Services Act 1988, as amended.  Private hospitals and day procedure centres registered under the Victorian Health Services Act 1988, as amended. Private Hospitals are required to maintain separate registrations for each site.  Nursing homes and hostels, which are now approved under the Aged Care Act 1997 (Commonwealth), are excluded from the definition, as are supported residential services registered under the Health Services Act 1988, as amended. |
| **Refer to** | Section 2 Campus  Section 3 Campus Code |

## Injury Surveillance

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | A set of data items generally collected at triage when an injury has occurred. These are mandatory items for presentations related to injuries. |
| **Guide for use** | Injury Surveillance will ordinarily be accompanied by an injury diagnosis (a Diagnosis code starting with an ‘S’ or ‘T’ – excluding those ‘S’ and ‘T’ codes where completion of Injury Surveillance fields is optional – refer to the VEMD Editing Matrix). However, in circumstances where a patient leaves before assessment or treatment by a definitive care provider Injury Surveillance can be reported with no accompanying Diagnosis code.  The following Injury Surveillance data items must be completed:   * Activity When Injured * Body Region * Description of Injury Event * Human Intent * Injury Cause * Nature of Main Injury * Place Where Injury Occurred. |
| **Refer to** | Section 2 Campus  Section 3 Campus Code |

## Initiation of Patient Management

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | Commencement of investigation, care and/or treatment according to an established clinical pathway, protocol or set of guidelines. |
| **Guide for use** | Where a patient’s care is managed according to an established standard clinical pathway, protocol, set of guidelines, or accepted clinical practice, initiation of patient management occurs at the start of the occasion of contact between the patient and staff member/s when this protocol is implemented.  Established clinical pathways, protocols, guidelines or accepted clinical practice are not necessarily documented but are agreed procedures of the emergency department.  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.   Observations taken to monitor a patient leading to a clinical decision regarding commencement of a clinical pathway, protocol, set of guidelines or accepted clinical practice do not represent initiation of patient management, however once a clinical pathway, protocol, set of guidelines or clinical practice has been determined, patient management may be initiated by the taking of observations.  Placement of a patient in a cubicle and/or routine initial assessment and/or observations by a nurse does not, on its own, constitute initiation of patient management.  The process of re-triage is considered a continuation of the triage process and does not constitute initiation of patient management.  Refer to following case studies: |

Initiation of Patient Management Case Studies (1–7)

Case Study 1

Patient presents at ED with mild asthma. At triage, the patient is categorised as category 3 and returns to waiting area.

Patient has more severe asthma attack in waiting area, is re–triaged to category 2 and shown to cubicle where standard observations are taken.

Nurse comes to cubicle and commences treatment based on an acknowledged clinical pathway of the health service. At this point: Patient Management has been initiated.

Case Study 2

Patient presents at ED in an agitated, delusional state. At triage, the patient is categorised as category 2 and placed in a cubicle and the Mental Health practitioner notified.

Observations are taken and nursing staff continue to observe the patient.

Mental Health practitioner arrives, assesses patient and develops management plan. At this point: Patient Management has been initiated.

Case Study 3

Patient presents at ED with an ankle injury from football. At triage, the patient is categorised as category 4 and moved to ‘fast track area’.

Physiotherapist attends, examines the patient, making an assessment (including diagnostic imaging requirements) and determines a treatment plan. At this point: Patient Management has been initiated.

Case Study 4

Patient presents at ED with a sore arm, following a fall, with limited arm movement possible.

Patient is categorised as category 3 at triage and placed in a cubicle.

Nurse provides analgesia and assesses patient including ordering diagnostic imaging. At this point: Patient Management has been initiated.

Case Study 5

Patient presents at ED feeling vague and having been generally unwell for a day or two, patient has a slight cough. At triage, patient is categorised as category 3.

Patient is placed in cubicle, observations are taken, respiration is 26 BPM, BP is 90/60 and patient is hypoxic, patient is given oxygen and the treating clinician attends and provides instruction regarding patient care. At this point: Patient Management has been initiated.

Case Study 6

Patient presents at ED with chest pain. Triage category 2 is allocated. Patient is placed in cubicle and nurse gives oxygen and Anginine, takes bloods and an ECG. ECG is reviewed. At this point: Patient Management has been initiated.

Doctor subsequently arrives and patient is transferred to catheter lab after examination.

Case Study 7

ED is notified by ambulance that a patient is being transported having severe behavioural problems.

The patient is taken to an appropriate ED cubicle and restrained.

Clinician administers sedation and requests attendance of mental health practitioner. At this point: Patient Management has been initiated.

## 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 different types of ICU, listed below:   * Adult intensive care * Paediatric intensive care * Neonatal intensive care   Note: ICUs do not include Special Care Nurseries, Coronary Care Units, High Dependency Units, Intensive Nursing Units or Step-down Units. |

## Length of Stay

|  |  |
| --- | --- |
| **Classification** | Derived Item |
| **Definition** | The Length of Stay (LOS) is the total time for each Emergency Department presentation. |
| **Guide for use** | The LOS in minutes is calculated as:  [Departure date/time] minus [Arrival date/time]. |

## 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 [Nurse Initiation of Patient Management date/time] and [First Seen by Mental Health Practitioner date/time]] |

## Medical Assessment and Planning Unit

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | A Medical Assessment and Planning Unit (MAPU) is a designated ward, which concentrates admissions for general medical conditions in one geographical area to streamline the care planning processes. Planned length of stay in MAPU may be up to 48 hours prior to transfer to another ward, or discharge home. |
| **Context** | Institutional health care: MAPU patients are admitted patients, provided a criterion for admission outlined in the admission policy is met. |

## Medicare Eligibility Status

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | The patient’s eligibility for Medicare as specified under the Commonwealth Health Insurance Act 1973 |
| **Guide for use** | An eligible person includes a person who resides in Australia and is:   * An Australian citizen * A permanent resident * A New Zealand citizen * A temporary resident who has applied for a permanent visa and who has either   + An authority to work in Australia or   + can prove relationship to an Australian citizen (other requirements may apply)   Other persons who are eligible for Medicare in certain circumstances include:  Visitors to Australia from a country that has a Reciprocal Health Care Agreement  In practice, the primary method for ascertaining Medicare eligibility status is sighting the patient’s Medicare card.  **Newborns**  A newborn will usually take the Medicare eligibility status of the mother. However, the eligibility status of the father will be applied to the newborn if the baby is not eligible solely by virtue of the eligibility status of the mother. For example, if the mother of a newborn is an ineligible person but the father is eligible for Medicare, then the newborn will be eligible for Medicare.  For further information regarding eligibility to Medicare refer to: [Medicare card webpage](http://www.humanservices.gov.au/customer/enablers/medicare/medicare-card/eligibility-for-medicare-card) <http://www.humanservices.gov.au/customer/enablers/medicare/medicare-card/eligibility-for-medicare-card> |

## Mental Health and AOD Hub Short Stay Unit

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | An approved Mental Health and AOD Hub Short Stay Unit is a separate short stay facility for the treatment of patients with mental health and drug and alcohol problems. The facility may be adjacent to, within, or remote from the Emergency Department. |

## Mental Health Bed

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | A Department of Health Mental Health and Drugs Division approved and funded bed in an Area Mental Health service. |

## 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. |

## Metropolitan Health Service

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | Metropolitan health service is a term used in the Health Services Act 1988 to refer to a public hospital, which is listed in Schedule 5 of the Act. A metropolitan health service may consist of several campuses. |
| **Guide for use** | Refer to the department’s public hospitals in [Victoria webpage](https://www.health.vic.gov.au/hospitals-and-health-services/public-hospitals-in-victoria) <https://www.health.vic.gov.au/hospitals-and-health-services/public-hospitals-in-victoria> |

## Patient

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | A patient is a person for whom a hospital accepts responsibility for treatment and/or care. |

## Registration

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | The recording of complete patient particulars including the reason for presentation, details of relatives and relevant healthcare providers, authorised in person by the patient or their representative, and undertaken when the health service is responding to a patient request to receive emergency medical attention. |
| **Guide for use** | Except for Telehealth presentations remote provision of patient particulars such as by telephone or electronic data entry either by a medical practitioner or a patient does not constitute registration. |

## Statistical Local Area (SLA)

|  |  |
| --- | --- |
| **Classification** | Derived Item |
| **Definition** | The Statistical Local Area (SLA) of the patient’s usual residence. |
| **Guide for use** | The department utilises a file to validate both the Postcode and Locality and then using both of these fields derives a SLA using a lookup table. Non–residential postcodes are excluded. |

## Telehealth

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | Telehealth consultations are provided by an ED clinician to a patient when there is a need to deliver a consultation remotely i.e., assessment, evaluation, and treatment. |
| **Guide for use** | The patient must be physically present with a nurse or doctor at a public urgent care centre, another public emergency department or a Victorian government or non-government RACS or a correctional facility.  The Telehealth consultation must be equivalent to a face-to-face consultation. This means both the remote ED clinician and the patient must interact in a mutually responsive manner, utilising an audio-visual link. The patient’s presenting condition/injury must be visible to the remote ED clinician.  The patient’s presentation must be of an unplanned nature.  Refer to the department’s about [telehealth webpage](https://www.health.vic.gov.au/rural-health/telehealth) <https://www.health.vic.gov.au/rural-health/telehealth> |

## Time to Initiation of Patient Management

|  |  |
| --- | --- |
| **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:  [The earliest of [First seen by doctor date/time] and [Seen by mental health practitioner date/time] and [Nurse initiation of patient management date/time]] minus [Arrival date/time].  For reporting purposes, patients who are dead on arrival (Departure Status 8) or who leave the emergency department before treatment commences (Departure Status 10, 11, 30 and T1) are excluded from this measure.  Refer to Initiation of Patient Management, Case Studies (1–7). |

## Treatment

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | The medical and/or surgical care provided to a patient with a view to stabilisation, diagnosis, and alleviation of their condition(s). |
| **Guide for Use** | It is acknowledged that treatment can commence prior to the patient’s arrival at the hospital.  Hospital treatment starts when a qualified clinical staff member commences treatment. |

## Triage

|  |  |
| --- | --- |
| **Classification** | Concept |
| **Definition** | Triage is the structured screening of a patient upon presentation at the Emergency Department to determine the urgency of their presenting complaint (Triage Category) and thereby assist in determining their priority of care |
| **Guide for Use** | The Triage Category is used to determine the urgency with which patients are investigated or treated by the ED staff.  Triage relies on expertise in the following:  1. Assessment (of)   * Characteristics and severity of the presenting condition * Brief physical assessment * Patient’s history * Presenting signs and symptoms * Vital signs * Overall appearance.   2. Knowledge (of)   * Physiology and pathology * Resources * Department capabilities   3. Intuition   * Skill * Sensitivity * Surveillance.   It is acknowledged that treatment can commence before, during or after triage. Information obtained during triage should be sufficient to determine the needs and urgency of emergency department treatment. This does not exclude the instigation of more detailed investigation or recommendations by the triage staff.  At or after triage, the patient may receive advice about Emergency Department and alternative treatment options. On consideration of this advice, the patient may choose to leave the Emergency Department without being treated. |

# Section 3: Data Definitions

This section provides the specifications for each VEMD data item. Sites and software vendors should be aware that this manual describes the data as submitted to the department, not as stored internally in a site’s system. Sites should map from their internally stored values to the values specified for VEMD.

## Data Definition Structure

Information about each data item is presented in the following structured format:

Specification

|  |  |
| --- | --- |
| **Definition** | A statement that expresses the essential nature of a data item and its differentiation from all other data items. |
| **Reported by** | Criteria for reporting data item. |
| **Reported for** | The specified circumstances when this data item must be reported |
| **Code set** | The set of valid values for the data item |
| **Reporting guide** | Additional comments or assistance on interpreting, applying and reporting the data item and code set. |
| **Validations** | A list of validations (numbers and titles) that relate to this data item. |

Administration

|  |  |
| --- | --- |
| **Purpose** | The main reason/s for the collection of this data item. |
| **Principal data users** | Identifies the key/primary users of this information. |
| **Collection start** | The year the collection of this data item commenced. |
| **Version** | Provides information regarding modifications made to the data item. Listed are a version number, beginning with 1 and incremented by 1 for each subsequent revision as well as an effective date, describing the date the modification came into effect. |
| **Definition source** | Identifies the authority that defined this data item. |
| **Code set source** | Identifies the authority that developed the code set for this data item. |

## Data Items

## Activity When Injured

Specification

|  |  |
| --- | --- |
| **Definition** | The type of activity being undertaken by the person, at the moment the injury occurred. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | All presentations where an injury code (S or T code) is in the Primary Diagnosis field unless completion of injury surveillance data elements is flagged as optional for that particular S or T code (refer to the VEMD Editing Matrix). |
| **Code set** | **Code Descriptor**  **S** **Sports** (sport as means of leisure or income)  *Includes*  Physical exercise with a described functional element such as: golf, riding, jogging, skiing, school athletics, swimming, trekking, water skiing  *Excludes*  Leisure (L)  **L** **Leisure**  *Includes*  Hobby activities; leisure time activities with an entertainment element such as being at a cinema, a dance or party; participating in activities of a voluntary organisation  *Excludes*  Sports (S)  **W** **Working for income**  *Includes*  Paid work for salary (manual) (professional), bonus and other types of income; transportation (time) to and from such activities  *Excludes*  Voluntary work (L) Sports (S)  **E** **Education**  *Includes*  Formal education, learning activities, such as: attending school session or lesson, university, undergoing education  **C** **Other work**  *Includes*  Unpaid domestic duties such as: caring for children and relatives, cleaning, gardening, household maintenance, cooking. Other duties for which income is not gained, such as: unpaid work in family business  *Excludes*  Voluntary work (L)  **N** **Being nursed**, cared for  *Includes*  Care of infant by parent, patient by nurse  **V** **Vital activity,** resting, sleeping, eating  *Includes*  Personal hygiene, other personal activity  **O** **Other** specified activity  **U** **Unspecified** activity |
| **Reporting guide** | Report the first appropriate code listed in the table which best characterises the type of activity being undertaken by the person at the time when the injury occurred, on the basis of the information available at the time the information is recorded. |
| **Refer to** | Refer to Section 4 Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised. |
| **Validations** | E310 Activity When Injured Code invalid  E391 The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements |
| **Related items** | Section 3 Body Region  Description of Injury Event  Human Intent  Injury Cause  Nature of Main Injury  Place where Injury Occurred  Section 4 Primary Diagnosis  Injury Surveillance |

Administration

|  |  |
| --- | --- |
| **Purpose** | To facilitate injury research |
| **Principal data users** | Monash University Accident Research Centre; Department of Health (DH) |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Advance Care Directive Alert

Specification

|  |  |
| --- | --- |
| **Definition** | An alert, flag or similar that is obvious to any treating team across the health service that indicates:   * an advance care directive is on file, and/or * medical treatment decision maker has been recorded. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation except Triage Category 6 Dead on arrival. |
| **Code set** | **Code Descriptor**  1 No advance care directive alert  2 Presence of an advance care directive alert  3 Presence of a medical treatment decision maker alert  4 Presence of both an advance care directive alert and a medical treatment decision maker |
| **Reporting guide** | An advance care directive alert will be identified by an alert identifying any of the following:   * A completed Refusal of Treatment Certificate, completed prior to 12 March 2018 * An advance care directive * Other advance care planning documentation (documentation of a person’s future wishes such as a written letter, use of varying forms, or advance care planning discussion record) * Advance Statement under the Mental Health Act (Vic) 2014 * A medical treatment decision maker alert will be identified by an alert, flag or similar identifying any of the following: * Medical treatment decision maker appointment * Guardian appointed by VCAT with powers to consent to medical treatment * Identification of the medical treatment decision maker as per ‘the medical treatment decision maker hierarchy’ * Enduring power of attorney (medical treatment) appointed prior to 12 March 2018   Advance care planning: have the conversation: A strategy for Victorian health services 2014-2018 ([the Strategy](http://www.health.vic.gov.au/acp)) <www.health.vic.gov.au/acp>. |
| **Validations** | E406 Advance Care Directive Alert invalid |

Administration

|  |  |
| --- | --- |
| **Purpose** | To enable monitoring of advance care planning uptake. |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 2017 |
| **Version** | Version Effective date  1 1 July 2017 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Ambulance at Destination Date

Specification

|  |  |
| --- | --- |
| **Definition** | The date of ambulance arrival at the hospital and immediately prior to the paramedic turning the engine off and/or getting out of the vehicle (generated by ambulance paramedics). |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | All ED patients arriving by ambulance. Non-Emergency Patient Transport vehicles arriving at the ED are included. |
| **Reporting guide** | A valid date  This date is generated by ambulance paramedics activating the arrival button on their mobile data terminal (MDT) or RavNet radio when they arrive at the ambulance bay at the hospital. The MDT/ RavNet radio ‘at destination time’ is entered by the paramedic into the VACIS.  ‘Ambulance at destination date’ will be provided by the ambulance paramedics to hospital staff at triage or reception when the patient is taken into the emergency department (ED). The time is then entered into the ED information system by hospital staff. |
| **Validations** | E397 Ambulance at Destination Date/time and Arrival Transport Mode invalid  E398 Ambulance at Destination Date/time invalid  E400 Triage Date/time before Ambulance at Destination Date/time  E407 Ambulance at Destination Date/time and Departure Date/time invalid Combination |
| **Related Items** | Section 2 Ambulance at Destination  Date/time fields  Section 3 Ambulance at Destination Time  Ambulance Case Number  Ambulance Handover Complete Date  Ambulance Handover Complete Time |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis of reception of patients via ambulance into the ED. |
| **Principal data users** | Ambulance Victoria; Department of Health. |
| **Collection start** | 1 July 2014 |
| **Version** | Version Effective date  1 1 July 2014  2 1 July 2017 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Ambulance at Destination Time

Specification

|  |  |
| --- | --- |
| **Definition** | The time of ambulance arrival at the hospital and immediately prior to the paramedic turning the engine off and/or getting out of the vehicle (generated by ambulance paramedics). |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | All ED patients arriving by ambulance. Non-Emergency Patient Transport vehicles arriving at the ED are included. |
| **Reporting guide** | A valid 24-hour time (0000 to 2359)  This time is generated by ambulance paramedics activating the arrival button on their mobile data terminal (MDT) or RavNet radio when they arrive at the ambulance bay at the hospital. The MDT/ RavNet radio ‘at destination time’ is entered by the paramedic into the VACIS.  ‘Ambulance at destination time’ will be provided by the ambulance paramedics to hospital staff at triage or reception when the patient is taken into the emergency department (ED). The time is then entered into the ED information system by hospital staff. |
| **Validations** | E397 Ambulance at Destination Date/time and Arrival Transport Mode invalid  E398 Ambulance at Destination Date/time invalid  E400 Triage Date/time before Ambulance at Destination Date/time  E407 Ambulance at Destination Date/time and Departure Date/time invalid Combination |
| **Related Items** | Section 2 Ambulance at Destination Date/time fields  Section 3 Ambulance at Destination Date  Ambulance Case Number  Ambulance Handover Complete Date  Ambulance Handover Complete Time |
| **Definition** | The time of ambulance arrival at the hospital and immediately prior to the paramedic turning the engine off and/or getting out of the vehicle (generated by ambulance paramedics). |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | All ED patients arriving by ambulance. Non-Emergency Patient Transport vehicles arriving at the ED are included. |
| **Reporting guide** | A valid 24-hour time (0000 to 2359)  This time is generated by ambulance paramedics activating the arrival button on their mobile data terminal (MDT) or RavNet radio when they arrive at the ambulance bay at the hospital. The MDT/ RavNet radio ‘at destination time’ is entered by the paramedic into the VACIS.  ‘Ambulance at destination time’ will be provided by the ambulance paramedics to hospital staff at triage or reception when the patient is taken into the emergency department (ED). The time is then entered into the ED information system by hospital staff. |
| **Validations** | E397 Ambulance at Destination Date/time and Arrival Transport Mode invalid  E398 Ambulance at Destination date/time invalid  E400 Triage date/time before Ambulance at Destination date/time  E407 Ambulance at Destination date/time and Departure date/time invalid Combination |
| **Related Items** | Section 2 Ambulance at Destination date/time fields  Section 3 Ambulance at Destination Date  Ambulance Case Number  Ambulance Handover Complete Date  Ambulance Handover Complete Time |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis of reception of patients via ambulance into the ED. |
| **Principal data users** | Ambulance Victoria; Department of Health. |
| **Collection start** | 1 July 2014 |
| **Version** | Version Effective date  1 1 July 2014  2 1 July 2017 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Ambulance Case Number

Specification

|  |  |
| --- | --- |
| **Definition** | Unique identifier issued by Ambulance Victoria (AV) for each ambulance transport occasion |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | All ED patients arriving by ambulance. |
| **Code set** | A valid Ambulance Case Number  Alternate Codes  Ambulance Case Number not available due to:   * B - Industrial action (for example: bans, strikes) * U - Not provided by Ambulance Officer   If the patient arrives via an interstate ambulance service, Ambulance Case Number should be either:  ACT, NSW, NT, QLD, SA, TAS or WA |
| **Validations** | E392 invalid Ambulance Case Number |
| **Related Items** | Section 2 Ambulance at Destination date/time fields  Section 3 Ambulance at Destination Date  Ambulance Case Number  Ambulance Handover Complete Date  Ambulance Handover Complete Time |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis of ambulance service delivery. |
| **Principal data users** | Ambulance Victoria; Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2002  3 1 July 2003  4 1 July 2004  5 1 July 2007  6 1 July 2011  7 1 July 2012  8 1 July 2013  9 1July 2017 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Ambulance Handover Complete Date

Specification

|  |  |
| --- | --- |
| **Definition** | The date when:   * clinical information has been given to the ED clinician; and * the patient has been moved from the ambulance stretcher to the hospital bed, care area or waiting room. |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | All ED patients arriving by ambulance. Non-Emergency Patient Transport vehicles arriving at the ED are included |
| **Reporting guide** | Handover may be provided to ED clinicians (including a nurse or doctor) when the patient is transferred to a hospital bed, care area or waiting room.  Paramedics may need to retrieve some ambulance equipment prior to completion of handover.  ‘Ambulance handover complete’ is recorded as the actual time that has been confirmed by the ED clinician and ambulance paramedics.  ‘Ambulance handover complete’ time does not include:   * Paramedics watching how a patient is managed in the ED subsequent to handover * Cleaning of equipment and re-stocking of ambulance vehicle. * Completion of VACIS following ambulance handover complete.   ED staff are responsible for entering the time into the ED information system. Paramedics are responsible for entering the time into VACIS. |
| **Validations** | E399 Ambulance Handover Complete date/time invalid  E413 Ambulance Handover Completed date/time and Departure date/time invalid |
| **Related Items** | Section 2 Ambulance Handover Complete date/time fields  Section 3 Ambulance at Destination Date  Ambulance at Destination Time  Ambulance Case Number  Ambulance Handover Complete Time |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis of handover of patients from Ambulance Victoria to ED. |
| **Principal data users** | Ambulance Victoria; Department of Health. |
| **Collection start** | 1 July 2014 |
| **Version** | Version Effective date  1 1 July 2014  2 1 July 2017  3 1 July 2022 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Ambulance Handover Complete Time

Specification

|  |  |
| --- | --- |
| **Definition** | The time when:   * clinical information has been given to the ED clinician; and * the patient has been moved from the ambulance stretcher to the hospital bed, care area or waiting room. |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | All ED patients arriving by ambulance. Non-Emergency Patient Transport vehicles arriving at the ED are included. |
| **Reporting guide** | A valid 24-hour time (0000 to 2359)  Handover may be provided to ED clinicians (including a nurse or doctor) when the patient is transferred to a hospital bed, care area or waiting room.  Paramedics may need to retrieve some ambulance equipment prior to completion of handover.  ‘Ambulance handover complete’ is recorded as the actual time that has been confirmed by the ED clinician and ambulance paramedics.  ‘Ambulance handover complete’ time does not include:   * Paramedics watching how a patient is managed in the ED subsequent to handover * Cleaning of equipment and re-stocking of ambulance vehicle. * Completion of VACIS following ambulance handover complete.   ED staff are responsible for entering the time into the ED information system. Paramedics are responsible for entering the time into VACIS. |
| **Validations** | E399 Ambulance Handover Complete date/time invalid  E413 Ambulance Handover date/time and Departure date/time invalid |
| **Related Items** | Section 2 Ambulance Handover Complete date/time fields  Section 3 Ambulance at Destination Date  Ambulance at Destination Time  Ambulance Case Number  Ambulance Handover Complete Date |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis of handover of patients from Ambulance Victoria to ED. |
| **Principal data users** | Ambulance Victoria; Department of Health |
| **Collection start** | 1 July 2014 |
| **Version** | Version Effective date  1 1 July 2014  2 1 July 2017  3 1 July 2022 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Arrival Date

Specification

|  |  |
| --- | --- |
| **Definition** | The date on which the patient/client presents for delivery of an Emergency Department service. |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation |
| **Reporting guide** | The date of patient presentation at the emergency department is the date of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process whichever happens first.  For Telehealth presentations the arrival date is the date the patient was first registered by clerical officer or triage process commences by a triage nurse or doctor (whichever comes first) in the Emergency Department. |
| **Validations** | E025 Duplicate Attendance  E086 Medicare IRN and Date of Birth combination invalid  E089 Medicare IRN and Date of Birth combination invalid  E093 Sex Indeterminate and Age Less Than 90 Days  E095 Date of Birth invalid  E103 Invalid combination of Date of Birth, Arrival Date and Country Of Birth  E155 Arrival date/time invalid  E167 Triage date/time Before Arrival date/time  E219 Length Of Stay Greater Than 10 Days  E340 Departure date/time Less Than or Equal To Arrival date/time  E350 Length Of Stay Greater Than 4 and Less Than 10 Days  E351 Potentially Excessive Time to Initiation of Patient Management  E389 Triage Category 1 patient – Excessive Time to Initiation of Patient Management  E395 Clinical Decision to Admit date/time Before Arrival date/time |
| **Related Items** | Section 2 Length of Stay  Registration  Time to Initiation of Patient Management  Section 3 Arrival Time |

Administration

|  |  |
| --- | --- |
| **Purpose** | Used in the calculation of various derived items, including Age at admission, Length of Stay, Time to Initiation of Patient Management |
| **Principal data users** | Monash University Accident Research Centre; Department of Health. |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2002  3 1 July 2016  4 1 July 2018  5 1 July 2019 |
| **Definition source** | Department of Health |

## Arrival Time

Specification

|  |  |
| --- | --- |
| **Definition** | The time at which the patient presents for delivery of an Emergency Department service |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation |
| **Reporting guide** | A valid 24-hour time (0000 to 2359)  The time of patient presentation at the emergency department is the time of first recorded contact with an emergency department staff member. The first recorded contact can be the commencement of the clerical registration or triage process whichever happens first.  For Telehealth the arrival time is the time the patient was first registered by clerical officer or triaged by a triage nurse or doctor (whichever comes first) in the Emergency Department. |
| **Validations** | E095 Date of Birth invalid  E103 Invalid combination of Date of Birth, Arrival Date and Country Of Birth  E155 Arrival date/time invalid  E167 Triage date/time Before Arrival date/time  E219 Length of Stay Greater Than 10 Days  E340 Departure date/time Less Than or Equal to Arrival date/time  E350 Length of Stay Greater Than 4 and Less Than 10 Days  E351 Potentially Excessive Time to Initiation of Patient Management  E372 Age invalid  E389 Triage Category 1 patient – Excessive Time to Initiation of Patient Management  E395 Clinical Decision to Admit date/time Before Arrival date/time |
| **Related Items** | Section 2 Length of Stay  Registration  Time to Initiation of Patient Management  Section 3 Arrival Date |

Administration

|  |  |
| --- | --- |
| **Purpose** | Used in the calculation of various derived items, including Age at admission, Length of Stay, Time to Initiation of Patient Management |
| **Principal data users** | Monash University Accident Research Centre; Department of Health. |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2002  3 1July 2016  4 1 July 2018  5 1 July 2019 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Arrival Transport Mode

|  |  |
| --- | --- |
| **Definition** | The type of transport the patient used to arrive at the Emergency Department |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation except Service Type 2 - Telehealth |
| **Code set** | **Code Descriptor**  1 Air ambulance - fixed wing aircraft (excludes helicopter)  2 Helicopter  3 Road Ambulance service  6 Community/public transport (includes council / philanthropic services)  8 Police vehicle  9 Undertaker  10 Ambulance service - private ambulance car - AV contracted  11 Ambulance service - private ambulance car - hospital contracted  99 Other |
| **Reporting guide** | For journeys involving more than one transport mode, select the mode of transport in which the greater distance of the journey was undertaken.  Code 1 - Air ambulance – fixed wing aircraft; excludes helicopter. Use code 2.  For example: Most patients transported by air require road transportation to and/or from the transferring hospital. Where the air transport involves the greater distance, select code 1 or 2 as appropriate. |
| **Validations** | E125 Arrival Transport Mode invalid  E142 Dead on Arrival combination invalid  E397 Ambulance at Destination date/time and Arrival Transport Mode invalid |
| **Related Items** | Section 2 Telehealth  Ambulance at Destination  Ambulance Handover Complete  Section 3 Ambulance at Destination Date  Ambulance at Destination Time  Ambulance Handover Complete Date  Ambulance Handover Complete Time |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis of transport service utilisation and coordination. |
| **Principal data users** | Ambulance Victoria; Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1997  3 1 July 1999  4 1 July 2003  5 1 July 2019 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Body Region

Specification

|  |  |
| --- | --- |
| **Definition** | The region of the body where the injury was sustained |
| **Reported by** | Public hospitals  Private hospital, optional |
| **Reported for** | All presentations where an injury code (S or T code) is in the Primary Diagnosis field unless completion of injury surveillance data elements is flagged as optional for that particular S or T code (refer to the VEMD Editing Matrix).  There are two sets of Body Region codes based on whether or not the Nature of Main Injury code indicates that the injury is due to a foreign body.  **Foreign body** - ‘any object or substance found in an organ or tissue in which it does not belong under normal circumstances, such as a bolus of food in the trachea or a particle of dust in the eye’ (Mosby’s Medical, Nursing & Allied Health Dictionary, 6th Edition, Mosby Inc, 2002, p. 699) |
| **Code set 1** | **Body Region – Foreign body injury**  **Code Descriptor**  F1 Eye  F2 Ear  F3 Nose  F4 Respiratory tract (excludes nose)  F5 Digestive tract  F6 Genitourinary tract  F7 Soft tissue |
| **Reporting guide** | Must be reported if Nature of Main Injury is ’**14 Foreign Body**’.  Code F4 – Respiratory tract; excludes nose. Use code F3 – Nose.  Select the first appropriate category  Excludes:  Non-foreign body injury (refer to Body Region-Non foreign body injury.) |
| **Code set 2** | **Body Region – Non-Foreign body injury**  **Code Descriptor**  1 Head (includes ear, excludes face)  2 Face (excludes eye)  3 Neck  4 Thorax  5 Abdomen  6 Lower back (includes loin)  7 Pelvis (includes anogenital and perineum)  8 Shoulder  9 Upper arm  10 Elbow  11 Forearm  12 Wrist  13 Hand (includes fingers)  14 Hip  15 Thigh  16 Knee  17 Lower leg  18 Ankle  19 Foot (includes toes)  20 Unspecified body region  21 Multiple injuries involving more than one body region  22 Body Region not applicable |
| **Reporting guide** | Must be reported if Nature of Main Injury **is** **not ‘14 - Foreign Body’**.  Code 1 - Head includes ear, excludes face. Use code 2  Code 2 - Face, excludes eye. Use Code 22  Select the first appropriate category.  Excludes:  Foreign Body injury (refer to Body Region-Foreign body injury).  Each injury code in the Primary Diagnosis field is matched in the Nature of Main Injury and Body Region matrix. For valid combinations refer to the VEMD Editing Matrix available on request from the HDSS Helpdesk. |
| **Validations** | E286 Body Region Code invalid.  E320 Nature of Main Injury, Body Region and Primary Diagnosis Combination invalid.  E391 The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements |
| **Related items** | Section 3 Activity When Injured  Description of Injury Event  Human Intent  Injury Cause  Nature of Main Injury  Place Where Injury Occurred  Primary Diagnosis  Section 4 Injury Surveillance  Nature of Main Injury and Body Region |

Administration

|  |  |
| --- | --- |
| **Purpose** | To facilitate injury research. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1997 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health National Health Data Dictionary (NHDD) modified |

## Campus Code

Specification

|  |  |
| --- | --- |
| **Definition** | Indicates the hospital campus at which the Emergency Department presentation occurred |
| **Reported by** | All Victorian hospitals (public and private) |
| **Reported for** | Every Emergency Department Presentation.  The Campus Code table is located at: [Reference files](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files)  <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files>  This table is updated as required throughout the year.  The codes contained in the Campus Code Table will be amended occasionally as new hospitals open and others close. These changes will be documented in the HDSS Bulletin. |
| **Validations** | E010 Non VEMD Hospital  E050 Campus Code invalid  E137 Transfer Destination / Source Equals Campus Code  E233 Unregistered Short Stay Observation Unit |
| **Related items** | Section 3 Transfer Destination  Transfer Source |

Administration

|  |  |
| --- | --- |
| **Purpose** | To identify the reporting hospital. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1997  3 1 July 1999 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Clinical Decision to Admit Date

Specification

|  |  |
| --- | --- |
| **Definition** | Date of clinical decision to admit the patient to a bed in this campus |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Presentations where a clinician has decided that a patient is to be admitted to this campus. |
| **Reporting guide** | A valid date.  See Section 2 Date / Time Fields |
| **Validations** | E393 Clinical Decision to Admit date/time and Departure Status Combination invalid  E394 Departure date/time Before Clinical Decision to Admit date/time  E395 Clinical Decision to Admit date/time Before Arrival date/time  E396 Clinical Decision to Admit date/time invalid |
| **Related items** | Section 2 Date/time fields  Section 3 Arrival date/time  Clinical Decision to Time  Departure date/time  Departure Status |

Administration

|  |  |
| --- | --- |
| **Purpose** | To record the date/time of the clinical decision to admit the patient and support compliance with the National Health Reform Agreement. |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 2014 |
| **Version** | Version Effective date  1 1 July 2014 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Clinical Decision to Admit Time

Specification

|  |  |
| --- | --- |
| **Definition** | Time of clinical decision to admit the patient to a bed at this campus |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Presentations where a clinician has decided that a patient is to be admitted to this campus. |
| **Reporting guide** | A valid 24-hour time (0000 to 2359) |
| **Validations** | E393 Clinical Decision to Admit date/time and Departure Status Combination invalid  E394 Departure date/time Before Clinical Decision to Admit date/time  E395 Clinical Decision to Admit date/time Before Arrival date/time  E396 Clinical Decision to Admit date/time invalid |
| **Related items** | Section 2 Date/time fields  Section 3 Arrival date/time  Clinical Decision to Time  Departure date/time  Departure Status |

Administration

|  |  |
| --- | --- |
| **Purpose** | To record the date/time of the clinical decision to admit the patient and support compliance with the National Health Reform Agreement. |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 2014 |
| **Version** | Version Effective date  1 1 July 2014 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Compensable Status

Specification

|  |  |
| --- | --- |
| **Definition** | Whether or not a patient is a compensable patient. |
| **Reported by** | All Victorian hospitals (public and private) |
| **Reported for** | Every Emergency Department Presentation. |
| **Code set** | **Code Descriptor**  1 Transport Accident Commission  2 Department of Veterans' Affairs  3 Work Safe  4 Common Law, Public liability, Other compensable, Service personnel  5 Ineligible not compensable  6 Medicare patient/Overseas eligible/Ineligible hospital exempt  7 Compensable status unknown |
| **Reporting guide** | Select the first appropriate category. |
| **Validations** | E079 Compensable Status and DVA Number combination invalid  E145 Compensable Status invalid  E404 Compensable Status and Given Name combination invalid  E405 Compensable Status and Family Name combination invalid |
| **Replated items** | Section 3 DVA Number  Family Name  Given Name  Medicare Number  Medicare Suffix |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis and monitoring. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health; Department of Veterans’ Affairs; Work Safe; Transport Accident Commission; Medicare. |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2022 |
| **Definition source** | Department of Health NHDD, METeOR ID 623179 |
| **Code set source** | Department of Health |

## Country of Birth

Specification

|  |  |
| --- | --- |
| **Definition** | The country in which the patient was born. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department Presentation. |
| **Code set** | Country of Birth code set is at: [Reference files](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files)  <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files> |
| **Reporting guide** | Select the code which describes the patient’s Country of Birth as precisely as possible. |
| **Validations** | E100 Country of Birth invalid  E102 Unusual Country of Birth  E103 Invalid combination of Date of Birth, Arrival Date and Country of Birth  E107 Aboriginal or Torres Strait Islander Origin but Not Australian Born |

Administration

|  |  |
| --- | --- |
| **Purpose** | Country of Birth is important in the study of access to services by different population sub-groups. This item is required for analysis of service utilisation, need for services and epidemiological studies |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2007  3 1 July 2009  4 1 July 2012  5 1 July 2017 |
| **Definition source** | NHDD |
| **Code set source** | ABS Standard Australian Classification of Countries (SACC), 2016, Department of Health modified |

## Date of Birth

Specification

|  |  |
| --- | --- |
| **Definition** | Patient's date of birth |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department Presentation. |
| **Reporting guide** | Unknown Date of Birth:  If the patient’s date of birth is unknown, this should be estimated. If the patient’s approximate age is known, then the Date of Birth should be estimated using the approximate age to calculate an estimated year of birth. Sentinel dates should not be used. |
| **Validations** | E086 Medicare IRN and Date of Birth combination invalid  E089 Medicare IRN and Date of Birth combination invalid  E092 Sex Indeterminate with Age Greater Than or Equal To 90 Days  E093 Sex Indeterminate and Age Less Than 90 Days  E095 Date of Birth invalid  E103 Invalid combination of Date of Birth, Arrival Date and Country of Birth  E265 Diagnosis Code and Age — Check  E297 Injury Cause Code and Age incompatible  E302 Human Intent Code and Age incompatible  E355 Type of Usual Accommodation and Age combination invalid  E372 Age invalid |
| **Related items** | Section 2 Age  Section 3 Date of Birth Accuracy Code |

Administration

|  |  |
| --- | --- |
| **Purpose** | Used in the calculation of derived items. |
| **Principal data users** | Monash University Accident Research Centre, Department of Health. |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995 |
| **Definition source** | NHDD |
| **Code set source** | Department of Health |

## Date of Birth Accuracy Code

Specification

|  |  |
| --- | --- |
| **Definition** | A code representing the accuracy of the components of a date:   * day * month * year |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department Presentation |
| **Value domain** | Value domain consists of a combination of three codes, each of which denotes the accuracy of one date component: |
| **Code set** | **Code Descriptor**  A The referred date component is accurate  E The referred date component is not known but is estimated  U The referred date component is not known and not estimated  This data element contains three positional components (DMY) that reflect the order of the date components in the format (DDMMYYYY) of the reported Date of Birth.  **Component Descriptor**  1st – D Refers to the accuracy of the day component  2nd – M Refers to the accuracy of the month component  3rd – Y Refers to the accuracy of the year component |
| **Reporting guide** | Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.  Where possible, report the accuracy of each date component. However, where software systems allow the collection of a binary value for Date of Birth Accuracy (that is the system has an ‘Estimated Date of Birth’ check box or similar) values such as ‘AAA’ and ‘EEE’ will be acceptable.  It is understood that the Date of Birth Accuracy Code will be reported as ‘AAA’ unless the date has been flagged as an estimated date. It is not necessary to validate the Date of Birth provided by every patient unless there is a reasonable suspicion that the date provided is not correct. Where there is a question over the date provided, or where the patient is unable or unwilling to provide their date of birth, the date should be estimated and flagged as such.  If the date of birth is provided by a reliable source (for example the patient or close relative) and is known as accurate then the date accuracy indicator should be reported as ‘AAA’.  If the patient’s approximate age is known, then the Date of Birth should be estimated using the approximate age to calculate an estimated year of birth. Sentinel dates should not be used. The Date of Birth Accuracy code would be reported as ‘UUE’, that is the day and month are ‘unknown’ and the year is ‘estimated’.  A Year component value of U – Unknown is not acceptable.  Where the date part is accurate or estimated, the date part cannot be ‘00’. Where the date part is unknown, the date part may be ‘00’ or ‘NN’.  Examples:  Valid combinations include:  DOB Accuracy = ‘AAA’, DOB=‘03/11/1956’  DOB Accuracy = ‘EEE’, DOB=‘03/11/1956’  DOB Accuracy = ‘UUE’, DOB=‘00/00/1945’  DOB Accuracy = ‘UUE’, DOB=‘01/01/1945’  Invalid combinations include:  DOB Accuracy = ‘AAA’, DOB=‘00/00/1956’  DOB Accuracy = ‘AAA’, DOB=‘00/06/1956’  DOB Accuracy = ‘EEE’, DOB=‘00/00/1956’  DOB Accuracy = ‘UUE’, DOB=‘00/00/0000’  DOB Accuracy = ‘UEE’, DOB=‘00/00/1956’ |
| **Validations** | E383 Invalid Date of Birth Accuracy Code |

Administration

|  |  |
| --- | --- |
| **Purpose** | Required to derive age for demographic analyses and for analysis by age at a point of time. |
| **Principal data users** | Multiple internal and external research users. |
| **Collection start** | 1 July 2008 |
| **Version** | Version Effective date  1 1 July 2008 |
| **Definition source** | NHDD (Department of Health modified) |
| **Code set source** | NHDD, METeOR ID 294429 |

## Departure Date

Specification

|  |  |
| --- | --- |
| **Definition** | The date the patient leaves the clinical area of the Emergency Department. |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department Presentation. |
| **Reporting guide** | * If Departure Status is This Campus (Departure Status codes 3, 14, 15, 18, 22, 25, 26, 27, 28 and 31) then record the date the patient physically leaves the emergency department to go to the ward or procedure room. * If Departure Status is Returning to usual residence (Departure Status codes 1, 12, 23, and 24) then record the date the patient physically leaves the clinical area of the emergency department. **Note** Waiting rooms are not considered part of the clinical area. * If Departure Status is Transfer to another hospital campus (Departure Status codes 17, 19, 20, and 21) then record the date the patient physically leaves the emergency department. * If the Departure Status is Left at own risk or Left after clinical advice (Departure Status codes 5, 10, 11, and 30) then record the date the patient physically leaves the emergency department or was first noticed as having left. * If the Departure Status is Died within ED (Departure Status code 7) then record the date the body was removed from the emergency department. * If the Departure Status is Dead on arrival (Departure Status code 8) then record the date the body was removed from the emergency department. However if the emergency clinician certifies the patient’s death outside the emergency department record the date of certification of death. * If the Departure Status is Telehealth (Departure Status codes T1, T2, T3, T4, T5, T6 and T7) then record the date when the ED clinician completes the final consultation and the audio-visual link ends. For example, some Telehealth presentations may require the patient to stay at the urgent care centre for observation. In this case there may be several Telehealth consultations via audio visual links between the ED and the urgent care centre. The departure date will be when the final Telehealth consultation is completed and the visual audio link ends. |
| **Validations** | E025 Duplicate Attendance  E210 Departure date/time invalid  E212 Departure date/time Before Nurse Initiation of Patient  Management 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  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  E394 Departure date/time Before Clinical Decision to Admit  date/time  E407 Ambulance at Destination date/time and Departure date/time invalid combination  E413 Ambulance Handover date/time and Departure date/time invalid |
| **Related items** | Section 2 Date/time fields  Length of Stay  Verification/Certification of death  Section 3 Departure Time  Departure Status. |

Administration

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| --- | --- |
| **Purpose** | Included in the calculation of various derived items:   * Length of Stay * Length of Treatment |
| **Principal data users** | Monash University Accident Research Centre; Department of Health for calculation of National Emergency Access Target (NEAT). Note: Departure Status 30 is the excluded for the NEAT calculation. |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2002  3 1 July 2006  4 1 July 2012  5 1 July 2019 |
| **Definition source** | NHDD (Department of Health modified) 684489 |
| **Code set source** | Department of Health |

## Departure Status

Specification

|  |  |
| --- | --- |
| **Definition** | Patient destination or status on departure from the Emergency Department |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **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  30 Left after clinical advice regarding treatment options - GP Co- Located Clinic  5 Left at own risk, after treatment started  7 Died within ED  8 Dead on arrival  ***This campus:***  27 Cardiac catheter laboratory  28 Other operating theatre/procedure room  15 Intensive Care Unit - this campus  22 Coronary Care Unit - this campus  25 Mental Health Observation/Assessment Unit  3 Emergency Department (ED) Short Stay Unit  14 Medical Assessment and Planning Unit  26 Other Mental Health Bed - this Campus  18 Ward not elsewhere described  31 Mental Health and AOD Hub Short Stay Unit  ***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  ***Telehealth:***  T1 Left at own risk without consultation  T2 Left at own risk after consultation started  T3 Referred to GP  T4 Discharged to usual residence  T5 Transferred to ward setting  T6 Transferred to another health service  T7 Recommended for transfer to Telehealth Emergency Department campus |
| **Reporting guide** | **Departure before treatment completed**  11 Left at own risk, without treatment  Patient departs the Emergency Department before 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) and 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.  30 Left after clinical advice regarding treatment options - GP Co- Located Clinic  At or subsequent to triage, the patient has received advice about Emergency Department and alternative treatment options. Patient is redirected from the Emergency Department directly to the GP co-located clinic.  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.  **This campus**  27 Cardiac catheter laboratory  Patient departs the emergency department directly to a cardiac catheter laboratory or angiography suite.  *Excludes:*  Patient undergoing a procedure/investigation in a procedure room within the emergency department.  Patient leaving the emergency department to attend the radiology department.  28 Other procedure room or operating theatre  Patient departs the emergency department directly to an operating theatre or procedure room, including endoscopy suites.  *Excludes:*  Patient undergoing a procedure/investigation in a procedure room or theatre within the emergency department.  Patient departing the emergency department directly to a cardiac catheterisation laboratory or angiography suite (Use 27)  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)  Medical Assessment and Planning Unit (use 14).  3 Emergency Department (ED) Short Stay Unit (SSU)  *Excludes:*  Medical Assessment and Planning Unit (use 14);  Mental Health Observation/Assessment Unit (use 25)  **Refer to:** Section 2 Emergency Department (ED) Short Stay Unit  14 Medical Assessment and Planning Unit (MAPU)  *Excludes:*  Short Stay Observation Unit (use code 3);  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.  *Excludes:*  Patients transferred to the Mental Health and AOD Hub Short Stay Unit  **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 a Medical Assessment and Planning Unit (use 14) * depart to an Intensive Care Unit (use 15).   31 Mental Health and AOD Hub Short Stay Unit  Patient is transferred to the bed-based unit within the Mental Health and AOD Hub.  **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) * Returning to usual residence   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  A correctional or custodial facility refers to a structure used by police or government to lawfully secure, hold, detain or imprison a person, and *includes:*   * Watch-house * Holding cell * Lock-up * Prisoner   The Commonwealth 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 * No fixed abode   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.  Armed Forces Hospitals  The Commonwealth 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’.  **Telehealth**  T1, T2, T3, T4, T5, T6 or T7  Select the appropriate code for Telehealth presentations (Service Type code - 2 Telehealth) |
| **Validations** | E142 Dead on Arrival combination invalid  E182 First Seen By Treating Clinician date/time and Departure Status Combination invalid  E230 Departure Status invalid  E233 Unregistered Short Stay Observation Unit  E242 Referred to on Departure and Departure Status combination invalid  E260 Primary Diagnosis Blank  E342 Invalid combination between Primary Diagnosis and Departure Status  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  E382 Unregistered Mental Health Observation/Assessment Unit  E384 Campus does not have a designated GP Co-Located Clinic  E393 Clinical Decision to Admit date/time and Departure Status Combination invalid  E411 Departure Status and Service Type combination invalid  E412 Unregistered Mental Health and AOD Hub |
| **Related items** | Section 3 Transfer Destination  Referred to on Departure  Reason for Transfer  Departure Transport Mode  Diagnosis - Primary Diagnosis  Clinical Decision to Admit date/time  Section 4 Clinician Date Time and Departure Status  Dead on Arrival  Departure Status and Referred to on Departure  Primary Diagnosis |

Administration

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| **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; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 2000  2 1 July 2001  3 1 July 2002  4 1 July 2003  5 1 July 2006  6 1 July 2008  7 1 July 2009  8 1 July 2011  9 1 July 2019 |
| **Definition source** | NHDD (Department of Health modified) |
| **Code set source** | Department of Health |

## Departure Time

Specification

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| --- | --- |
| **Definition** | The time the patient physically leaves the clinical area of the Emergency Department. |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation. |
| **Reporting guide** | A valid 24-hour time (0000 to 2359)   * If Departure Status is This Campus (Departure Status Codes 3, 14, 15, 18, 22, 25, 26, 27, 28, and 31) then record the time the patient physically leaves the emergency department to go to the ward or procedure room. * If Departure Status is Returning to usual residence (Departure Status codes 1, 12, 23, and 24) then record the time the patient physically leaves the clinical area of the emergency department. NB Waiting rooms are not considered part of the clinical area. * If Departure Status is Transfer to another hospital campus (Departure Status codes 17, 19, 20, and 21) then record the time the patient physically leaves the emergency department. * If the Departure Status is Left at own risk or Left after clinical advice (Departure Status Codes 5, 10, 11, and 30) then record the time the patient physically leaves the emergency department or was first noticed as having left. * If the Departure Status is Died within ED (Departure Status Code 7) then record the time the body was removed from the emergency department. * If the Departure Status is Dead on arrival (Departure Status Code 8) then record the time the body was removed from the emergency department. However if the emergency clinician certifies the patient’s death outside the emergency department record the time of certification of death. * If the Departure Status is Telehealth (Departure Status Code T1, T2, T3, T4, T5, T6 and T7) then record the time when the ED clinician completes the final consultation and the audio-visual link ends. For example, some Telehealth presentations may require the patient to stay at the urgent care centre for observation. In this case there may be several Telehealth consultations via audio visual links between the ED and the urgent care centre. The departure time will be when the final Telehealth consultation is completed and the visual audio link ends. |
| **Validations** | E025 Duplicate Attendance  E210 Departure date/time invalid  E212 Departure date/time Before Nurse Initiation of Patient Management 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  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 Seen By Mental Health Practitioner date/time  E395 Departure date/time Before Clinical Decision to Admit date/time  E407 Ambulance at Destination date/time and Departure date/time invalid combination  E413 Ambulance Handover date/time and Departure date/time invalid |
| **Related items** | Section 2 Date/time fields  Verification/Certification of Death  Length of Stay  Section 3 Departure Date  Departure Status |

Administration

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| **Purpose** | Included in the calculation of various derived items:   * Length of Stay * Length of Treatment. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health for calculation of National Emergency Access Target (NEAT). NB Departure Status 30 is excluded for the NEAT calculation. |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 2000  2 1 July 2002  3 1 July 2006  4 1 July 2012  5 1 July 2019 |
| **Definition source** | NHDD (Department of Health modified) METeOR ID 746078 |
| **Code set source** | Department of Health |

## Departure Transport Mode

Specification

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| --- | --- |
| **Definition** | The type of transport used to transfer the patient from the Emergency Department to another hospital. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Presentations where Departure Status code is 17, 19, 20 and 21.  Must remain blank if Departure Status code is not 17, 19, 20 and 21 (Conditional mandatory). |
| **Code set** | **Code Descriptor**  1 Air ambulance - fixed wing aircraft (excludes helicopter)  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 - AV 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. |
| **Validations** | E255 Departure Transport Mode invalid |
| **Related items** | Section 3 Departure Status  Transfer Destination |

Administration

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| **Purpose** | Analysis of transport utilisation. |
| **Principal data users** | Monash University Accident Research Centre, Department of Health. |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1997  3 1 July 2000  4 1 July 2002 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Description of Injury Event

Specification

|  |  |
| --- | --- |
| **Definition** | Patient’s personal account or description of injury event provided at triage. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | All presentations where an injury code (S or T code) is in the Primary Diagnosis field unless completion of injury surveillance data elements is flagged as optional for that particular S or T code (refer to the VEMD Editing Matrix). |
| **Reporting guide** | Data entry prompts in software assist collection of the required components to describe the event.  Ensure that no identifying details are included in this text field.  Data entry staff should be aware that this text is sent to VEMD.  This field is a free text field and must not be auto filled with a defined code set value.  **Data entry prompts**  Briefly and concisely describe the injury event using the prompts. Information should be incorporated into a single description of the injury event for data transmission:  **Location**  Specific location of the person at the time the injury occurred.  For example, in the bathroom of own home, workshop or local shops.  **Activity**  Specific activity the person was undertaking at the time the injury occurred.  For example, playing, working on a forklift or playing competition netball.  **Product**  Specific product involved in the injury (where applicable).  For example, 50mls brand name X medicine, wooden pallet or football.  **Safety Equipment**  Safety devices in use or absent at the time the injury occurred (where applicable).  For example, wearing steel capped work boots, not wearing seatbelt, child resistant cap was on bottle or mouthguard worn.  Additional Information to Include:   * Nature of the injuries * What caused the injuries (subject) * Any other relevant information. |
| **Validations** | E290 Description of Injury Event invalid  E391 The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements |
| **Related items** | Section 2 Primary Diagnosis  Injury Surveillance  Section 3 Activity When Injured  Body Region  Diagnosis-Primary Diagnosis  Human Intent  Injury Cause  Nature of Main Injury  Place Where Injury Occurred. |

Administration

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| **Purpose** | To clarify the injury event (vital for identifying the interventions) and provide additional information relevant to the injury (product type, brand name, safety precautions). The narrative is very important to identify injury event features not captured by the coded data. |
| **Principal data users** | Monash University Accident Research Centre, Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2002 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Diagnosis - Additional Diagnoses 1 and 2

Specification

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| --- | --- |
| **Definition** | Additional diagnoses are those which:   * Existed at the time of presentation * Arose while patient was in the Emergency Department   Are expected to affect treatment plan or length of stay in the Emergency Department |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Mandatory if Primary Diagnosis is ‘Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment’.  Optional for all other Emergency Department presentations. |
| **Code set** | Refer to the VEMD library file for additional diagnosis codes. The VEMD Library File is available to health services and their vendors. For a copy email the [HDSS Helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <[hdss.helpdesk@health.vic.gov.au](mailto:hdss.helpdesk@health.vic.gov.au)> |
| **Reporting guide** | Additional Diagnoses must be substantiated by clinical documentation.  If the Primary Diagnosis is ‘Z099’, the Additional Diagnosis 1 code must identify the condition under review.  Additional diagnoses give information on factors which can result in increased length of stay, more intensive treatment, or the use of greater resources. Additional diagnosis can include diseases, conditions, injuries, poisoning, signs, symptoms, abnormal findings, complaints, or other factors influencing the patient’s health status.  Code Z099 must not be reported in either Additional Diagnosis field.  **Diagnosis code format:**  Diagnosis codes must be submitted in ICD-10-AM format. Ensure any punctuation (decimal points or obliques) are removed from ICD-10-AM codes before submission, as codes with punctuation will not be accepted.  Only codes detailed in the VEMD Library File will be accepted. |
| **Validations** | E261 Diagnosis code invalid  E264 Diagnosis code and Sex - check  E265 Diagnosis code and Age - check  E341 Primary Diagnosis equals ‘Z099’ but Additional Diagnosis blank  E390 Additional Diagnosis 1 or 2 equals ‘Z099’ |
| **Related items** | Section 3 Diagnosis – Primary Diagnosis  Section 2 Diagnosis |

Administration

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| **Purpose** | To facilitate epidemiological studies and other research |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2002 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Diagnosis - Primary Diagnosis

**Specification**

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| --- | --- |
| **Definition** | The diagnosis established at the conclusion of the patient’s attendance in an emergency department to be mainly responsible for occasioning the attendance following consideration of clinical assessment. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | All presentations excluding those with Departure Status:   * ‘11 – Left at own risk, without treatment’ * ‘T1– Left at own risk without consultation’   Optional for presentations with Departure Status:   * ‘10 – Left after clinical advice regarding treatment options’ * ‘30 – Left after clinical advice regarding treatment options – GP Co-Located Clinic’ * ‘31 – Mental Health and AOD Hub Short Stay Unit’ |
| **Code set** | Refer to the VEMD Library File for additional diagnosis codes. The VEMD Library File is available to health services and their vendors. For a copy email the [HDSS Helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au>. |
| **Reporting guide** | Primary Diagnosis must be substantiated by clinical documentation.  **Dead on Arrival**  If the Departure Status is ‘8 – Dead on Arrival’; the Primary Diagnosis must be ‘R99 – Death of unknown cause’ or ‘R959 Sudden Infant Death Syndrome (SIDS)’.  **Injury or Poisoning**  If the Primary Diagnosis code is an injury, poisoning or other consequence of an external cause (VEMD diagnosis codes beginning with S or T); ensure that the corresponding Nature of Main Injury and Body Region combination is correct. Refer to the VEMD Editing Matrix for valid combinations and completion of Injury Surveillance fields optional/mandatory indicator.  The VEMD Editing Matrix is available to health service and their vendors. Email the [HDSS Helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au> for a copy of the VEMD Editing Matrix.  **Follow up Attendance**  If the Primary Diagnosis code is ‘Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment’, an Additional Diagnosis 1 code is mandatory. The Additional Diagnosis 1 code must identify the condition under review.  **Diagnosis code format:**  Diagnosis codes must be submitted in ICD-10-AM format. Ensure any punctuation (decimal points or obliques) are removed from ICD-10-AM codes before submission, as codes with punctuation will not be accepted  Only codes detailed in the VEMD Library File will be accepted. |
| **Validations** | E142 Dead on Arrival combination invalid  E260 Primary Diagnosis Blank  E261 Diagnosis Code invalid  E264 Diagnosis Code and Sex — Check  E265 Diagnosis Code and Age — Check  E320 Nature of Main Injury, Body Region and Primary Diagnosis Combination invalid  E341 Primary Diagnosis Equals ‘Z099’ but Additional Diagnosis Blank.  E342 Invalid combination between Primary Diagnosis and Departure Status  E391 The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements |
| **Related items** | Section 2 Diagnosis  Section 3 Activity When Injured  Diagnosis- Additional Diagnosis 1 & 2  Body Region  Description of Injury Event  Human Intent  Injury Cause  Nature of Main Injury  Place Where Injury Occurred  Section 4 Dead on Arrival  Injury Surveillance  Primary Diagnosis |

Administration

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| --- | --- |
| **Purpose** | To facilitate epidemiological studies and other research. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1998  3 1 July 1999)  4 1 July 2002  5 1 July 2012  6 1 July 2016  7 1 July 2017  8 1 July 2019 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## DVA Number

Specification

|  |  |
| --- | --- |
| **Definition** | The Department of Veterans’ Affairs file number applicable for the patient. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Presentations with Compensable Status of ‘2 - Department of Veterans’ Affairs’ (Conditional mandatory). |
| **Reporting guide** | The DVA number is obtained from the patient.  **Layout**   * Part 1 State identifier   Valid codes: Q, N, V, T, S or W. ACT is included in N (NSW) and NT with S (SA).   * Part 2 War Group Code   Alphanumeric characters may be up to 3 characters.   * Part 3 Serial Number   Numeric characters may be 2 to 6 characters in length.   * Part 4 (Optional) Spouse or Dependent Identifier   May be 1 character in length.  **Valid Format** (see also above layout and following examples):   * only alphabetic and numeric characters and spaces are permitted * alphabetic characters must be in uppercase * a maximum of six numeric characters is permitted * trailing spaces (to the right) are permitted * spaces between characters are not permitted.   Examples:  N123456, VX123456, WXX123A or QXXX1B |
| **Validations** | E078 DVA Number invalid  E079 Compensable Status and DVA Number combination invalid |
| **Related items** | Section 3 Compensable Status  Family Name  Given Name |

Administration

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| **Purpose** | Required for analysis of service utilisation by eligible veterans and war widow(er)s. |
| **Principal data users** | Department of Veterans’ Affairs; Department of Health; Monash University Accident Research Centre. |
| **Collection start** | 1 July 2000 |
| **Version** | Version Effective date  1 1 July 2000 |
| **Definition source** | NHDD |
| **Code set source** | DVA |

## Family Name

Specification

|  |  |
| --- | --- |
| **Definition** | The family name of the DVA patient |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Presentations with Compensable Status of ‘2 - Department of Veterans’ Affairs’ (Conditional mandatory). |
| **Reporting guide** | The family name or surname of the patient. |
| **Valid format** | Permitted characters: A to Z (upper case), space, apostrophe, hyphen. |
| **Validations** | E405 Compensable Status and Family Name combination invalid |
| **Related items** | Section 3 Compensable Status  DVA Number  Given Name |

Administration

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| **Purpose** | To facilitate payment by DVA |
| **Principal data users** | Department of Veterans’ Affairs |
| **Collection start** | 1 July 2017 |
| **Version** | Version Effective date  1 1 July 2017 |
| **Definition source** | NHDD |

## First Seen by Doctor Date

Specification

|  |  |
| --- | --- |
| **Definition** | The date that a medical officer first assessed the patient. |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Mandatory for all presentations where the first practitioner treating the patient is a doctor  Optional for presentations where patient management has been initiated by a nurse or mental health practitioner. |
| **Reporting guide** | If both Nurse Initiation of Patient Management date/time AND Seen by Mental Health Practitioner date/time are blank then First Seen by Doctor date/time must be completed, except in the following circumstances:  Departure Status is:   * 10 - Left after clinical advice, regarding treatment options - leave blank * 11 - Left at own risk, without treatment - leave blank * 30 - Left after clinical advice regarding treatment options – GP Co-Located Clinic - leave blank * T1 - Left at own risk without consultation - leave blank * 31 - Mental Health and AOD Hub Short Stay Unit – leave blank if the patient was not treated prior to departure.   If treatment has been initiated by an allied health practitioner report the date/time in the First Seen By Doctor date/time fields.  Where a valid date has been entered in First Seen By Doctor Date, a valid time must be entered in First Seen By Doctor Time. If treatment has been initiated by an allied health practitioner report the date/time in the First Seen By Doctor date/time fields.  Where a valid date has been entered in First Seen By Doctor Date, a valid time must be entered in First Seen By Doctor Time. If treatment has been initiated by an allied health practitioner report the date/time in the First Seen By Doctor date/time fields. |
| **`** | E182 First Seen by Treating Clinician date/time and Departure Status Comb invalid  E195 First Seen by Treating Doctor date/time invalid  E196 First Seen by Doctor date/time Before Triage date/time  E351 Potentially Excessive Time to Initiation of Patient Management.  E389 Triage Category 1 patient – Excessive Time to Initiation of Patient Management |
| **Related items** | Section 2 Date / Time Fields  Length of Stay  Time to Initiation of Patient Management.  Section 3 First Seen by Doctor Time  Nurse Initiation of Patient Management Date  Nurse Initiation of Patient Management Time  Seen by Mental Health Practitioner Date  Seen by Mental Health Practitioner Time  Section 4 Clinician date/time and Departure Status  Dead on Arrival |

Administration

|  |  |
| --- | --- |
| **Purpose** | Used in the calculation of various derived items: Length of Treatment, Time to Initiation of Patient Management. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health. |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## First Seen by Doctor Time

Specification

|  |  |
| --- | --- |
| **Definition** | Time that a medical officer first assesses the patient. |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | All presentations where a valid date has been entered in First Seen By Doctor Date. |
| **Reporting guide** | A valid 24-hour time (0000 to 2359) |
| **Validations** | E182 Nurse Initiation of Patient Management date/time /First Seen by Doctor date/time and Departure Status combination invalid.  E195 First Seen by Treating Doctor date/time invalid  E196 First Seen by Doctor date/time Before Triage date/time  E351 Potentially Excessive Time to Initiation of Patient Management.  E389 Triage Category 1 patient – Excessive Time to Initiation of Patient Management |
| **Related items** | Section 2 Date/time fields  Section 3 First Seen by Doctor Date  Nurse Initiation of Patient Management Date  Nurse Initiation of Patient Management Time  First Seen by Mental Health Practitioner Date  First Seen by Mental Health Practitioner Time  Section 4 Clinician date/time and Departure Status  Dead on Arrival |

Administration

|  |  |
| --- | --- |
| **Purpose** | Used in the calculation of various derived items:   * Length of Treatment * Time to Initiation of Patient Management. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health. |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Given Name(s)

Specification

|  |  |
| --- | --- |
| **Definition** | The given name/s of the DVA patient |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Presentations with Compensable Status of ‘2 - Department of Veterans’ Affairs’. |
| **Reporting guide** | The given name/s of the patient |
| **Valid format** | Permitted characters: A to Z (upper case), space, apostrophe, hyphen.  The first character must be an alpha character (upper case). |
| **Reporting guide** | The given name/s of the patient.  Permitted characters: A to Z (uppercase), space, apostrophe and hyphen  The first character must be an alpha character. |
| **Validations** | E404 Compensable Status and Given Name combination invalid |
| **Related items** | Section 3 Compensable Status  DVA Number  Family Name |

Administration

|  |  |
| --- | --- |
| **Purpose** | To facilitate payment by DVA |
| **Principal data users** | Department of Veterans’ Affairs |
| **Collection start** | 1 July 2017 |
| **Version** | Version Effective date  1 1 July 2017 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Human Intent

Specification

|  |  |
| --- | --- |
| **Definition** | Clinician’s assessment of the most likely human intent in the occurrence of the injury or poisoning. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | All presentations where an injury code (S or T code) is in the Primary Diagnosis field unless completion of injury surveillance data elements is flagged as optional for that particular S or T code (refer to the VEMD Editing Matrix). |
| **Code set** | **Code Descriptor**  1 Non-intentional harm  18 Intentional self-harm - non-suicidal self-injury  19 Intentional self-harm - suicide attempt  20 Intentional self-harm, suicidal intent cannot be determined  12 Sexual assault by current or former intimate partner  13 Sexual assault by other family member (excluding intimate partner)  14 Sexual assault by other/unknown  15 Neglect, maltreatment, assault by current or former intimate partner  16 Neglect, maltreatment, assault by other family member (excluding intimate partner)  17 Neglect, maltreatment, assault by other/unknown  6 Police, legal intervention or operations of war  8 Adverse effect or complication of medical or surgical care  9 Intent cannot be determined |
| **Reporting guide** | **Family member**  The Family Violence Protection Act 2008 definition of ‘family member’ includes:   * a current or former spouse or domestic partner * a person who has, or has had, an intimate personal relationship with the relevant person * a current or former relative * a child who normally lives or has lived with the relevant person * a child of a person who has, or has had, an intimate personal relationship with the perpetrator of violence.   **Note:** Intimate partner includes a current or former spouse or domestic partner.  Select the first appropriate category, which best characterises the role of intent in the occurrence of the injury on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one listed first in the code set.  Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised. |
| **Validations** | E300 Human Intent Code invalid  E302 Human Intent Code and Age incompatible  E391 The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements |
| **Related items** | Section 3 Nature of Main Injury  Body Region  Description of Injury Event  Injury Cause  Place Where Injury Occurred  Activity When Injured  Section 4 Primary Diagnosis  Injury Surveillance |

Administration

|  |  |
| --- | --- |
| **Purpose** | To facilitate injury / poisoning research. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2003  3 1 July 2016 |
| **Definition source** | NHDD |
| **Code set source** | NHDD, modified |

## Indigenous Status

Specification

|  |  |
| --- | --- |
| **Definition** | Whether a person identifies as being of Aboriginal or Torres Strait Islander origin |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation |
| **Code set** | **Code Descriptor**  1 Aboriginal but not Torres Strait Islander origin  2 Torres Strait Islander but not Aboriginal origin  3 Both Aboriginal and Torres Strait Islander origin  4 Neither Aboriginal nor Torres Strait Islander origin  8 Question unable to be asked  9 Patient refused to answer |
| **Reporting guide** | This information must be collected for every emergency department presentation and updated each time the patient represents to the hospital for care.  Code 8 Question unable to be asked - should only be used under the following circumstances:   * When the patient’s medical condition prevents the question of Indigenous Status being asked; or * In the case of an unaccompanied child who is too young to be asked their Indigenous Status.   Note: Systems must not be set up to input a default code.  For further information refer to the National best practice guidelines for collecting Indigenous status in health data sets available on the [AIHW website](https://www.aihw.gov.au/reports/indigenous-australians/national-guidelines-collecting-health-data-sets/) <https://www.aihw.gov.au/reports/indigenous-australians/national-guidelines-collecting-health-data-sets/contents/table-of-contents> |
| **Validations** | E105 Indigenous Status invalid.  E107 Aboriginal or Torres Strait Islander Origin But Not Australian Born.  E360 Indigenous Status and Preferred Language Mismatch. |

Administration

|  |  |
| --- | --- |
| **Purpose** | To: enable planning and service delivery and monitoring of indigenous health at state and national level, facilitate application of specific funding arrangements. |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  2 1 July 1999  3 1 July 2005  4 1 July 2008  5 1 July 2020 |
| **Definition source** | NHDD METeOR ID 602543 |
| **Code set source** | NHDD, Department of Health modified |

## Injury Cause

Specification

|  |  |
| --- | --- |
| **Definition** | Event, circumstances, or condition associated with the occurrence of injury, poisoning or adverse effect. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | All presentations where an injury code (S or T code) is in the Primary Diagnosis field unless completion of injury surveillance data elements is flagged as optional for that particular S or T code (refer to the VEMD Editing Matrix). |
| **Code set** | **Code Descriptor**  1 Motor vehicle - driver  2 Motor vehicle - passenger  3 Motorcycle - driver  4 Motorcycle - passenger  5 Pedal cyclist - rider or passenger  6 Pedestrian  7 Horse related (fall from, struck or bitten by)  8 Other transport-related circumstance  9 Fall - low (same level or less than 1 metre, or no information on height)  10 Fall - high (greater than 1 metre)  11 Submersion or drowning - swimming pool  12 Submersion or drowning - other  13 Other threat to breathing (includes strangulation, asphyxiation)  14 Fire, flames, smoke  15 Scalds (hot drink, food, water, other fluid, steam, gas or vapour)  16 Contact burn (hot object or substance)  17 Poisoning - medication  18 Poisoning - other or unspecified substance  19 Firearm  20 Cutting, piercing object  21 Dog related  22 Other animal related (excludes dog and horse)  23 Struck by or collision with person  24 Struck by or collision with object  25 Machinery  26 Electricity  27 Hot conditions (natural origin, includes sunlight)  28 Cold conditions (natural origin)  29 Other specified external cause  30 Unspecified external cause |
| **Reporting guide** | Select the first appropriate category.  Code 22 - Other animal related -excludes dog (use code 21) and horse (use code 7).  Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised. |
| **Validations** | E295 Injury Cause Code invalid  E297 Injury Cause Code and Age incompatible  E391 The Primary Diagnosis for this record requires the completion of all Injury Surveillance data |
| **Related items** | Section 3 Nature of Main Injury  Body Region  Description of Injury Event  Human Intent  Place Where Injury Occurred  Activity When Injured  Section 4 Primary Diagnosis  Injury Surveillance |

Administration

|  |  |
| --- | --- |
| **Purpose** | To facilitate injury / poisoning research. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1997 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Interpreter Required

Specification

|  |  |
| --- | --- |
| **Definition** | The patient’s need for an interpreter, as perceived by the patient or person consenting for the patient. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation. |
| **Code set** | **Code Descriptor**  1 Yes  2 No  9 Not Stated / Inadequately Described |
| **Reporting guide** | Preferred Language to be asked before Interpreter Required.  If the Preferred language is English, Interpreter Required can be assumed to be ‘2 – No’.  This information must:   * Be checked for every Emergency Department presentation * Not be set up to a default code on computer systems * Be collected on, or as soon as possible after, arrival.   The standard question is:  [Do you] [Does the person] [Does (name)] require an interpreter?  The question:  ‘Do you require an interpreter?’ is asked to determine patient need for an interpreter, not the capacity of the hospital to provide an interpreter.  1 Yes  Use code 1 if the patient indicates they need an interpreter.  2 No  Use code 2 if the patient indicates they do not need an interpreter or where the Preferred Language is English.  9 Not Stated / Inadequately Described.  Use code 9 if neither Yes nor No can be accurately ascertained.  Includes where the Preferred Language is:   * 0002 Not Stated; or * 0000 Inadequately described.   Patient is unable to consent (for example: baby, child or elderly)  Where a person is not able to consent for themselves (for example baby, child or elderly) then the need for an interpreter is recorded for the person who is consenting. For example a guardian or someone with enduring power of attorney. |
| **Validations** | E358 Interpreter Required invalid  E359 Invalid combination of Interpreter Required/Preferred Language |
| **Related items** | Section 3 Country of Birth  Indigenous Status  Preferred Language |

Administration

|  |  |
| --- | --- |
| **Purpose** | For planning and to form the basis for future funding allocation for Culturally and Linguistically Diverse (CALD) hospital service provision. |
| **Principal data users** | Multiple internal and external data users. |
| **Collection start** | 1 July 2003 |
| **Version** | Version Effective date  1 1 July 2003 |
| **Definition source** | NHDD |
| **Code set source** | ABS Australian Standard Classification of Languages (ASCL), 2016 version |

## Locality

Specification

|  |  |
| --- | --- |
| **Definition** | Geographic location (suburb/town locality for Australian residents, country for overseas residents) of usual residence of the person (not postal address). |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation. |
| **Code set** | Refer to the Postcode/Locality reference file available from: [Reference files](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files> |
| **Reporting guide** | The Department of Health file excludes non-residential postcodes.  Locality must be blank if the Postcode is 1000 or 9988. Where the Postcode is 8888 (overseas), report the country the patient lives in, in Locality. The country code must be one that corresponds with a code against the listing of 8888 (overseas) codes in the Postcode/Locality/SLA reference file, available at: [Reference files](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files> |
| **Validations** | E115 Postcode/Locality combination invalid |
| **Related items** | Section 3 Postcode  Section 4 Locality/Postcode |

Administration

|  |  |
| --- | --- |
| **Purpose** | To enable calculation (with Postcode field) of the patient’s appropriate Statistical Local Area (SLA) which enables:   * Analysis of service utilisation and need for services * Identification of patients living outside Victoria * Identification of patients living outside Australia for the Reciprocal Health Care Agreement (RHCA) |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1999  3 1 July 2004  4 1 July 2009 |
| **Definition source** | Department of Health |
| **Code set source** | ABS National Locality Index (Cat. No. 1252) (Department of Health modified) |

## Medicare Number

Specification

|  |  |
| --- | --- |
| **Definition** | Personal identifier allocated by Medicare Australia to eligible persons under the Medicare scheme. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | All patients except in the circumstances covered under Medicare Suffix. |
| **Reporting guide** | The patient’s Medicare Number and individual reference number (IRN), issued by Medicare Australia.  Valid:   * First character can only be a: 2, 3, 4, 5, or 6 * Numeric or all blanks * Check digit (ninth character) is the remainder of the following equation:[(1st digit \* 1) + (2nd digit \* 3) + (3rd digit \* 7) + (4th digit \* 9) +(5th digit \* 1) + (6th digit \* 3) + (7th digit \* 7) + (8th digit \* 9)] / 10   Invalid:  Special characters (for example, $, #)  Alphabetic characters  Zero-filled (if the Medicare Number is not available or not applicable, the Medicare Number must be left blank)  Note: Deletion record  Eleven 9s in the Medicare Number field denote a deletion record, refer Section 5    Medicare Number from the Medicare card, the eleventh character being the IRN (the number printed on the Medicare Card, to the left of the printed name of the patient).  **Neonates**  For neonates who have not yet been added to the family Medicare Card, and therefore have no IRN, there are two reporting options:   * Mother’s/family’s Medicare Number in the first ten characters and a zero (0) as the eleventh character * Mother/family Medicare Number in the first ten characters and the mother’s IRN as the eleventh character. |
| **Validations** | E081 Medicare Number invalid  E086 Medicare IRN and Date of Birth combination invalid  E364 Medicare Last Digit Zero; Suffix Not ‘BAB’ |
| **Related items** | Section 3 Medicare Suffix  Section 5 Compensable Status  Deletion of records |

Administration

|  |  |
| --- | --- |
| **Purpose** | To assist in monitoring continuity of care across hospitals. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1999 |
| **Definition source** | NHDD, METeOR ID 270101 |
| **Code set source** | Medicare Australia |

## Medicare Suffix

Specification

|  |  |
| --- | --- |
| **Definition** | First three characters of the patient's first given name (as it appears on the Medicare card). |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | All Emergency Department presentations |
| **Code set** | Characters should be:   * The first three characters of the patient’s first given name in upper case   **Note:**   * If the patient’s name has only two characters type a space for the third character.   Characters permitted:   * Upper case alphas * Space as second and third characters * Space as third character   Hyphen or apostrophe as second character or hyphen or apostrophe as third character.  If Medicare Number is unavailable or the patient is not eligible for a Medicare Number, leave the Medicare Number blank (not zero-filled) and enter the appropriate suffix:  **Alternative Codes Descriptor**  C-U Card unavailable/Not applicable  N-E Not eligible for Medicare  P-N Prisoner |
| **Reporting guide** | **Unnamed neonate:**  For unnamed neonates where the family has a Medicare Number, report an alternative code of ‘BAB’. The Medicare Number issued to the mother/ family must also be reported with an 11th character of ‘0’ or the mother’s IRN.  **Prisoners:**  Prisoners are treated and funded as public patients |
| **Validations** | E087 Medicare Suffix invalid  E364 Medicare Last Digit Zero; Suffix Not ‘BAB’ |
| **Related items** | Section 3 Medicare Number  Section 5 Compensable Status |

Administration

|  |  |
| --- | --- |
| **Purpose** | To ensure the patient is an eligible Medicare patient. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1999 |
| **Version** | Version Effective date  1 1 July 1999 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Nature of Main Injury

Specification

|  |  |
| --- | --- |
| **Definition** | The patho-physical nature of the injury primarily responsible for the patient’s presentation at the Emergency Department |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | All presentations where an injury code (S or T code) is in the Primary Diagnosis field unless completion of injury surveillance data elements is flagged as optional for that particular S or T code. (refer to the VEMD Editing Matrix). |

|  |  |  |  |
| --- | --- | --- | --- |
| **Code set** | **Code** | **Descriptor** | **Body region** |
|  | 1 | Superficial (Includes abrasion, blister, contusion; excludes eye) | + |
|  | 2 | Open wound (excludes eye) | + |
|  | 3 | Fracture (excludes tooth) | + |
|  | 4 | Dislocation | + |
|  | 5 | Sprain or strain | + |
|  | 6 | Injury to nerve (includes spinal cord; excludes Intracranial injury) | + |
|  | 7 | Injury to blood vessel (major or named vessel) | + |
|  | 8 | Injury to muscle or tendon | + |
|  | 9 | Crushing injury | + |
|  | 10 | Traumatic amputation | + |
|  | 11 | Injury to internal organ | + |
|  | 12 | Burn or corrosion | + |
|  | 13 | Eye injury (Includes burn; excludes Foreign Body in external eye) | 22 |
|  | 14 | Foreign body | # |
|  | 15 | Intracranial injury (Includes concussion) | 22 |
|  | 16 | Dental injury (Includes fractured tooth) | 22 |
|  | 17 | Drowning, immersion | 22 |
|  | 18 | Asphyxia or other threat to breathing | 22 |
|  | 19 | Electrical injury | 22 |
|  | 20 | Poisoning, toxic effect (excludes Bite) | 22 |
|  | 21 | Bite (venomous) | + |
|  | 22 | Other specified nature of injury | + |
|  | 23 | Injury of unspecified nature | + |
|  | 24 | Multiple injuries (more than one nature of injury) | + |
|  | 26 | Bite (non-venomous) | + |

|  |  |
| --- | --- |
|  | **Code Descriptor**  + Non-foreign body injury requires ‘Body Region - Non-foreign body’ code, see Section 3 – Data Definitions (Body Region - Non-foreign body)  # Foreign body injury requires ‘Body Region - Foreign Body’ code, see Section 3 – Data Definitions (Body Region - Foreign Body). |
| **Reporting guide** | Select the first appropriate category.  Code 1 - Superficial - excludes eye - use code 13  Code 2 - Open wound - excludes eye - use code 13  Code 3 - Fracture - excludes tooth - use code 16  Code 13 - Eye injury - excludes Foreign Body in external eye - use code 14.  Code 20 - Poisoning, toxic effect - excludes bite - use code 21  Select the item, which best characterises the nature of the injury responsible for the patient’s presentation on the basis of the information available at the time it is recorded.  If two or more categories are judged to be equally appropriate, select the one that is sequenced first in the above code list. It is more significant to code a major injury, if present, rather than a minor injury.  If a major injury has been sustained (e.g. fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding ‘multiple injuries’.  As a general rule, any injury, which on its own would be unlikely to have led to the presentation, may be regarded as minor.  All diagnosis codes beginning with either an ‘S’ or ‘T’ are injury codes. Each injury code in the Primary Diagnosis field is matched in the Nature of Main Injury and Body Region matrix. The fields must be completed unless completion of injury surveillance data elements is flagged as optional for that particular S or T code (refer to the VEMD Editing Matrix).  For valid combination the VEMD Editing Matrix. A copy of the VEMD Editing Matrix can be obtained from the HDSS Helpdesk. |
| **Validations** | E281 Nature of Main Injury invalid  E320 Nature of Main Injury, Body Region and Primary Diagnosis Combination invalid  E391 The Primary Diagnosis for this record requires the completion of all Injury Surveillance data |
| **Related items** | Section 3 Activity When Injured  Body Region  Description of Injury Event  Diagnosis – Primary Diagnosis  Human Intent  Injury Cause  Place Where Injury Occurred  Section 4 Primary Diagnosis  Injury Surveillance |

Administration

|  |  |
| --- | --- |
| **Purpose** | To facilitate injury research. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1999  3 1 July 2002  4 1 July 2004 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Nurse Initiation of Patient Management Date

Specification

|  |  |
| --- | --- |
| **Definition** | The date on which a nurse-initiated management of the patient, according to an established clinical pathway, protocol or guidelines. |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Optional for presentations where patient management has been initiated by a doctor or mental health practitioner. |
| **Reporting guide** | Must complete Nurse Initiation of Patient Management Date where a nurse initiates management of a patient according to an established clinical pathway, protocol, set of guidelines, or accepted clinical practice,  Established clinical pathways, protocols, guidelines, or accepted clinical practice, are not necessarily documented but are agreed procedures of the emergency department.  Where patient management is initiated by a doctor or mental health practitioner, this should be reported in the relevant seen by date field.  Excludes:   * Observations taken to monitor a patient leading to a clinical decision regarding commencement of a clinical pathway, protocol, set of guidelines, or accepted clinical practice, do not represent initiation of patient management, however once a clinical pathway, protocol, set of guidelines or accepted clinical practice, has been determined, patient management may be initiated by the taking of observations. * Placement of a patient in a cubicle and/or routine initial assessment and/or observations does not, on its own, constitute initiation of patient management. * The process of re-triage is a continuation of the triage process and does not constitute initiation of patient management.   Refer: to Initiation of Patient Management – Case Studies in Section 2  Where a valid date has been entered in Nurse Initiation of Patient Management Date, a valid time must be entered in Nurse Initiation of Patient Management Time |
| **Validations** | E180 Nurse initiation of patient management date/time invalid  E181 Nurse initiation of patient management date/time before triage Date/time.  E182 Clinician date/time and Departure status combination invalid  E212 Departure date/time before Nurse Initiation of Patient Management date/time  E351 Potentially excessive time to initiation of patient management  E389 Triage Category 1 patient – Excessive Time to Initiation of Patient Management |
| **Related items** | Section 2 Time to Initiation of Patient Management.  Section 3 Nurse Initiation of Patient Management Time.  Section 4 Clinician date/time and Departure Status |

Administration

|  |  |
| --- | --- |
| **Purpose** | Used in the calculation of Time to Initiation of Patient Management. |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 2009 |
| **Version** | Version Effective date  1 1 July 2009 |
| **Definition source** | Department of Health (VEMD Technical Reference Group) |

## Nurse Initiation of Patient Management Time

Specification

|  |  |
| --- | --- |
| **Definition** | The time at which a nurse-initiated management of the patient, according to an established clinical pathway, protocol or guidelines. |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | All presentations where a valid date has been entered in Nurse Initiation of Patient Management Date |
| **Reporting guide** | A valid 24-hour time (0000 to 2359)  Nurse initiation of patient management occurs at the start of the occasion of contact between the patient and nurse/s when this protocol is implemented. |
| **Validations** | E180 Nurse initiation of patient management date/time invalid  E181 Nurse initiation of patient management date/time before triage date/time.  E182 Clinician date/time and Departure status combination invalid  E351 Potentially excessive time to initiation of patient management  E389 Triage Category 1 patient – Excessive Time to Initiation of Patient Management |
| **Related items** | Section 2 Time to Initiation of Patient Management  Section 3 Nurse Initiation of Patient Management Date  Section 4 Clinician date/time and Departure Status |

Administration

|  |  |
| --- | --- |
| **Purpose** | Used in the calculation of Time to Initiation of Patient Management. |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 2009 |
| **Version** | Version Effective date  1 1 July 2009 |
| **Definition source** | Department of Health (VEMD Technical Reference Group) |

## Patient Identifier

Specification

|  |  |
| --- | --- |
| **Definition** | An identifier unique to a patient within this hospital or campus (patient’s record number/unit record number). |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation |
| **Code set** | Hospital-generated. Individual sites may use their own alphabetic, numeric or alphanumeric coding system |
| **Reporting guide** | All newborns must have their own Patient Identifier. This cannot be the mother’s Patient Identifier but could be the mother’s Patient Identifier with a prefix or suffix. |
| **Validations** | E025 Duplicate Attendance  E030 Duplicate Unique Key  E065 Patient Identifier invalid |

Administration

|  |  |
| --- | --- |
| **Purpose** | To ensure hospitals can identify specific patient presentations. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995 |
| **Definition source** | Department of Health |

## Patient Location

Specification

|  |  |
| --- | --- |
| **Definition** | The physical location of the patient during a Telehealth presentation. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation where the Service Type is 2 - Telehealth |
| **Code set** | **Code Descriptor**  NNNN Campus code  9000 Residential aged care service  9997 Correctional facilities  9998 Other  9999 Unknown |
| **Reporting guide** | Enter the campus code of the Urgent Care Centre or Emergency Department or select the appropriate physical location of the patient as detailed below.  NNNN Campus code  The Campus Code of the Urgent Care Centre or Emergency Department. For the full code set refer to Reference Files on HDSS website.  9000 Residential aged care service  Government or non-government residential aged care service.  9997 Prison, correctional facility  Includes prisons, remand centres, police centres, youth training centres and juvenile justice centres.  9998 Other  The patient’s location is not covered by another code.  9999 Unknown  The location of the patient cannot be determined. |
| **Validations** | E408 Patient Location invalid  E409 Patient Location and Service Type combination invalid |
| **Related items** | Section 2 Emergency Department Presentation  Telehealth  Section 3 Patient Location  Departure Status |

Administration

|  |  |
| --- | --- |
| **Purpose** | To identify the location of a patient presenting via Telehealth. |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 2019 |
| **Version** | Version Effective date  1 1 July 2019 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Place Where Injury Occurred

Specification

|  |  |
| --- | --- |
| **Definition** | The specific physical location of the person at the time the injury occurred. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | All Presentations where an injury code (S or T code) is in the Primary Diagnosis field unless completion of injury surveillance data elements is flagged as optional for that particular S or T code (refer to the VEMD Editing Matrix). |
| **Code set** | **Code Descriptor**  H Home  *Includes*  House, home premises, farm house, non-institutional place of residence, apartment, boarding house, caravan park (resident), private: driveway to home, garage, garden/yard or home, path to home, swimming pool in private house, garden.  *Excludes*  Institutional place of residence (I), Abandoned or derelict house (O) Home under construction and not yet occupied (C).  I Residential institution  *Includes*  Children's home, orphanage, home for the sick, nursing home, old people's home, hospice, military camp, reform school, prison, pensioners home, dormitory.  *Excludes*  Hospital (M)  S School, day care centre, public administration area  *Includes*  Building (including adjacent grounds) used by the general public or by a particular group of the public such as: assembly hall, public hall, church, clubhouse, court house, post office, day care centre, preschool, youth centre, gallery, library, museum, cinema, theatre, opera house, concert hall, dance hall, school (public or private), college, university, institution for higher education, movie house, kindergarten, campus.  *Excludes*  Hospital (M), Recreation area (P),Athletics and sports area (A),Trade or service area (T), Building under construction (C), Residential institution (I)  M Medical hospital  *Includes*  Hospital  *Excludes*  Hospice, nursing home (I)  A Athletics and sports area  *Includes*  Cricket ground, football, hockey field, riding school, basketball court, golf course, stadium, skating rink, tennis, squash court, swimming pool.  R Road, street or highway  *Includes*  Freeway, footpath, motorway, pavement, road.  *Excludes*  Private driveway (H)  T Trade or service area  *Includes*  Bank, petrol station, supermarket, airport, cafe, casino, garage (commercial), gas station, hotel, market, office building, radio or television station, restaurant, service station, shop (commercial), shopping mall, station (bus/rail), warehouse.  *Excludes*  Garage in private home (H)  C Industrial or construction area  *Includes*  Any building under construction, industrial yard, workshop, dry dock, dock yard, factory building/ premises, gasworks, oil rig & other offshore installation, power station (coal/nuclear/oil), shipyard.  *Excludes*  Mine, quarry, tunnel under construction (Q)  Q Mine or quarry  *Includes*  Mine or quarry tunnel under construction  F Farm  *Includes*  Farm buildings and land, ranch  *Excludes*  Farm house & home premises of farm (H)  P Place for recreation  *Includes*  Public park, amusement park  *Excludes*  Athletics and sports area (A)  O Other specified place  *Includes*  Forest, beach, pond, abandoned or derelict house, campsite, canal, caravan site NOS, desert, dock NOS, harbour, hill, lake, marsh, military training ground, mountain, parking lot & parking place, prairie, public place NOS, railway line, river, sea, seashore, stream, swamp, water reservoir, zoo.  U Unspecified place |
| **Reporting guide** | Report the code which best characterises the location where the patient was situated at the time the injury occurred, on the basis of the information available at the time it is recorded.  If two or more categories are equally appropriate, select the code sequenced first in above code list.  Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised. |
| **Validations** | E305 Place Where Injury Occurred invalid.  E391 The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements |
| **Related items** | Section 3 Nature of Main Injury  Body Region  Description of Injury Event  Human Intent  Injury Cause  Activity When Injured  Section 4 Primary Diagnosis  Injury Surveillance |

Administration

|  |  |
| --- | --- |
| **Purpose** | To facilitate injury research |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995 |
| **Definition source** | Department of Health |
| **Code set source** | NHDD modified |

## Postcode

Specification

|  |  |
| --- | --- |
| **Definition** | Postcode in which the person usually resides (not postal address). |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation. |
| **Code set** | Refer to the Postcode/Locality reference file available from: [Reference files](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files%3e) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files> |
| **Reporting guide** | Non-residential postcodes are excluded from the department’s postcode locality file.  For newborns, use the postcode of mother’s residential address.  Locality must be blank if the Postcode is 1000 or 9988. Where the Postcode is 8888 (overseas), report the country the patient lives in, in Locality. The four digit country code must be one that corresponds with a code listed against 8888 (overseas) in the Postcode/Locality reference file. |
| **Validations** | E115 Postcode/Locality combination invalid. |
| **Related items** | Section 3 Locality  Section 4 Postcode/Locality |

Administration

|  |  |
| --- | --- |
| **Purpose** | To enable calculation (with Locality field) of the patient’s appropriate Statistical Local Area (SLA) which enables:   * Analyses of service utilisation and need for services * Identification of patients living outside Victoria |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995 |
| **Definition source** | Department of Health |
| **Code set source** | Australia Post |

## Preferred Language

Specification

|  |  |
| --- | --- |
| **Definition** | The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation. |
| **Code set** | Refer to HDSS website ‘Preferred language code set’ at: [Reference files](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files%3e) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files> |
| **Reporting guide** | This information must:   * be checked for every emergency presentation * be collected on, or as soon as possible after, arrival.   Ask the standard question:  **What is [your] [the person’s] preferred language?**  **Patient is unable to consent (for example baby, child or elderly):**  For example baby, child or elderly then the language of the person who is consenting will be recorded. For example a parent/guardian or someone with enduring power of attorney.  **8000 - Australian Indigenous languages, NEC**  Includes: All Australian Indigenous languages not shown separately on the code list.  **0002 - Not Stated**  Includes:   * Patients who are not able to respond to this question during their admission for example unconscious) * Unaccompanied child, who is too young to identify preferred language |
| **Validations** | E110 Preferred Language invalid  E359 Invalid combination of Interpreter Required and Preferred Language  E360 Indigenous Status and Preferred Language Mismatch  E361 Preferred Language is Unspecified |
| **Related items** | Section 3 Indigenous status  Interpreter required |

Administration

|  |  |
| --- | --- |
| **Purpose** | This item is an indicator of ethnicity and assists multilingual service planning and provision. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2012  3 1 July 2017 |
| **Definition source** | NHDD |
| **Code set source** | ABS Australian Standard Classification of Languages (ASCL), 2016 version |

## Reason for Transfer

Specification

|  |  |
| --- | --- |
| **Definition** | Reason for transfer of a patient to another hospital or health service |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Presentations with Departure Status of 17, 19, 20 and 21 (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. |
| **Validations** | E245 Reason for Transfer Code invalid |
| **Related items** | Section 3 Departure Status  Departure Transport Mode  Transfer Destination |

Administration

|  |  |
| --- | --- |
| **Purpose** | To monitor the reasons for patient transfer between hospitals |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1997 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Referred By

Specification

|  |  |
| --- | --- |
| **Definition** | Source from which patient was referred to this Emergency Department. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation |
| **Code set** | **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 (includes both admitted and non- admitted transfers)  14 Nurse on Call  15 Other Nurse  16 Mental health telephone assessment/advisory line  17 Telephone advisory line, not otherwise specified  18 Other mental health staff  19 Other  20 Other community services staff  21 Apprehended under Mental Health Act - Police/Protective Service Officer  22 Correctional Officer / Other police  23 Emergency use |
| **Reporting guide** | **6 Staff from another campus**  *Includes:*   * admitted and non-admitted transfers * record transfer Source   **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 Aged Care Residential Care Facility (both high and low level care), Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility. * Unspecified telephone advisory line/service (report code 17) * Mental Health telephone advisory service where this is specifically named by the patient (report code 16)   **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:*   * Suicide help line * Mental health area phone triage   *Excludes*:   * Unspecified telephone advisory line/service (report code 17) * Nurse on call where this is specifically named by the patient (report code 14).   **17 Telephone advisory line, not otherwise specified**  Patient indicated that they had been advised by a telephone advisory or referral service to present to the Emergency Department. Patient unable to advise the specific telephone service involved.  *Excludes:*   * Nurse on call where this is specifically named by the patient (report code 14). * Mental health telephone advisory service where this is specifically named by the patient (report code 16)   **18 Other mental health staff**  *Includes:*   * Psychiatric disability rehabilitation support service (PDRSS) * Crisis assessment team (CAT team)   *Excludes:*   * Triage/help line workers   **19 Other**  Includes:  Armed forces hospitals  These are not recognised by the Commonwealth and therefore admission from, or separation to, such facilities are not an inter-hospital transfer.  **20 Other community services staff**  *Excludes:*  Mental health services staff such as crisis assessment teams (report code 18)  Continuing care services  **21 Apprehended under Mental Health Act – Police/Protective Service Officer**  Where a patient has been apprehended by police/PSO under s351 of the Mental Health Act  **22 Correctional Officer / Other police**  *Includes:*  Prison hospitals  These are not recognised by the Commonwealth and therefore admission from, or separation to, such facilities are not an inter-hospital transfer.  *Excludes:*  Where a patient has been apprehended by police/PSO under s351 of the Mental Health Act (report code 21).  **23 Emergency use**  Only to be used under the direction of the Department of Health. The department will provide reporting guidelines when an ‘emergency use’ code is enacted. |
| **Validations** | 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 |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  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  8 1 July 2018  9 1 July 2021 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Referred to on Departure

Specification

|  |  |
| --- | --- |
| **Definition** | The agency to which the patient was referred for continuing care. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **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  9 Aged Care Assessment Service  10 Drug and Alcohol Treatment Service  11 Mental Health Community Service  12 Other community service  15 Emergency use  16 No referral  17 Not known  18 Other  19 Not applicable |
| **Reporting guide** | **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**  Medical Specialist  *Excludes:*  Allied health personnel, Dentist (report code 6-Other specialist health practitioner).  **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)  **9 Aged Care Assessment Service (ACAS)**  Used where a patient is referred to an ACAS in order to assess eligibility for access to Community Aged Care Packages or residential aged care.  The core objective of ACAS is to comprehensively assess the needs of frail older people and to facilitate access to available services appropriate to their needs. In meeting this objective, ACAS also determine eligibility for Commonwealth subsidised residential aged care (including residential respite), Community Aged Care Packages and some flexible care services, including Extended Aged Care at Home (EACH).  Where a patient is referred to any other aged care specific service the appropriate code should be used (e.g. if a referral is made to a geriatrician then use code ‘5 – Medical Specialist’)  **10 Alcohol and Drug Treatment Service (A&D Services)**  Used when a patient is 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:   * **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.   * **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 is 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   **15 Emergency use**  Only to be used under the direction of the department of Health. The department will provide reporting guidelines when an ‘emergency use’ code is enacted.  **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. |
| **Validations** | E142 Dead on Arrival combination invalid  E240 Referred to on Departure invalid  E242 Referred to on Departure and Departure Status combination invalid |
| **Related items** | Section 4 Dead on arrival  Departure Status and Referred to on Departure |

Administration

|  |  |
| --- | --- |
| **Purpose** | To promote and monitor the coordination of patient care. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1997  3 1 July 2003  4 1 July 2004  5 1 July 2009  6 1 July 2021 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Seen By Mental Health Practitioner Date

Specification

|  |  |
| --- | --- |
| **Definition** | The date the patient was first attended to by a Mental Health Practitioner |
| **Reported by** | All Victorian Hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation where the patient is seen by a mental health practitioner. |
| **Reporting guide** | Complete where the patient is seen by a Mental Health practitioner at any stage during the ED presentation; except where Departure Status is one of the following, then leave blank.   * Code 10 - Left after clinical advice regarding treatment options, * Code 11 - Left at own risk, without treatment or * Code 30 - Left after clinical advice regarding treatment options – GP Co-Located Clinic   Where a valid date has been entered in Seen by Mental Health Practitioner Date, a valid time must be entered in Seen by Mental Health Practitioner Time. |
| **Validations** | E373 Seen by Mental Health Practitioner date/time Before Arrival date/time  E374 Departure date/time Before Seen by Mental Health Practitioner date/time  E375 Seen by Mental Health Practitioner date/time invalid  E388 Seen by Mental Health Practitioner date/time Before Triage date/time  E351 Potentially Excessive Time to Initiation of Patient Management |
| **Related items** | Section 2 Mental Health Practitioner  Date/time fields  Section 3 First Seen by Doctor Date  First Seen by Doctor Time  Nurse Initiation of Patient Management Date  Nurse Initiation of Patient Management Time  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** | Department of Health |
| **Collection start** | 1 July 2006 |
| **Version** | Version Effective date  1 1 July 2006 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Seen By Mental Health Practitioner Time

Specification

|  |  |
| --- | --- |
| **Definition** | The time the patient was first attended to by a Mental Health Practitioner |
| **Reported by** | All Victorian Hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation where the patient is seen by a mental health practitioner. |
| **Reporting guide** | Where a valid date has been entered in Seen By Mental Health Practitioner Date, a valid time must be entered in Seen By Mental Health Practitioner Time.  HHMM (Must be in 24-hour format) between 0000 and 2359 |
| **Validations** | E182 First Seen by Treating Clinician date/time and Departure Status Combination invalid  E373 Seen by Mental Health Practitioner date/time Before Arrival date/time.  E374 Departure date/time Before Seen by Mental Health Practitioner date/time.  E375 Seen by Mental Health Practitioner date/time invalid.  E388 Seen by Mental Health Practitioner date/time Before Triage date/time  E351 Potentially Excessive Time to Initiation of Patient Management |
| **Related items** | Section 2 Mental Health Practitioner  Date/time fields  Section 3 First Seen by Doctor Date  First Seen by Doctor Time  Nurse Initiation of Patient Management Date  Nurse Initiation of Patient Management Time  Seen by Mental Health Practitioner Date  Section 4 Clinician date/time and Departure Status |

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** | Department of Health |
| **Collection start** | 1 July 2006 |
| **Version** | Version Effective date  1 July 2006 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Service Type

Specification

|  |  |
| --- | --- |
| **Definition** | The type of service provided to the patient by the Emergency Department |
| **Reported by** | All Victorian Hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation. |
| **Code set** | **Code Descriptor**  1 General Emergency Presentation  2 Telehealth  3 COVID-19 related: tested  4 COVID-19 related: NOT tested  5 Emergency use |
| **Reporting guide** | Select the appropriate service type as detailed below.  **1 General Emergency Presentation**  The patient is physically present at the general emergency department.  **2 Telehealth**  The ED clinician located in an emergency department provides, via an audio-visual link; the assessment, evaluation and treatment of a patient. The patient must be physically present with a nurse or doctor.  The Telehealth consultation must be equivalent to a face to face consultation. This means both the remote ED clinician and the patient must interact in a mutually responsive manner, utilising an audio-visual link. The patient’s presenting condition/injury must be visible to the remote ED clinician.  **3 COVID-19 related: tested**  The patient has presented to an Emergency Department, or a COVID-19 assessment clinic and a COVID-19 test has been performed.  **4 COVID-19 related: not tested**  The patient has presented to an Emergency Department or COVID19 assessment clinic and a COVID-19 test has not been performed.  **5 Emergency use**  Only to be used under the direction of the Department of Health. The department will provide reporting guidelines when an ‘emergency use’ code is enacted. |
| **Validations** | E125 Arrival Transport Mode invalid  E409 Patient Location and Service Type combination invalid  E410 Service Type invalid  E411 Departure Status and Service Type combination invalid |
| **Related items** | Section 2 Emergency Department Presentation  Telehealth  Section 3 Patient Location  Departure Status |

Administration

|  |  |
| --- | --- |
| **Purpose** | To identify patients presenting via Telehealth. |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 2019 |
| **Version** | Version Effective date  1 1 July 2019  2 1 July 2021 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Sex

Specification

|  |  |
| --- | --- |
| **Definition** | The sex of the person |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation. |
| **Code set** | **Code Descriptor**  1 Male  2 Female  3 Indeterminate  4 Other |
| **Reporting guide** | A person’s sex is usually described as either being male or female. Some people may have both male and female characteristics. Sex is assigned at birth and is relatively fixed.  A person’s sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment or transgender reassignment. However throughout the process, which may be over a considerable period of time, sex could be recorded as either Male or Female.  **3 Indeterminate**  Code ‘3 – Indeterminate’ should be used for infants with ambiguous genitalia, where the biological sex, even following genetic testing, cannot be determined. This code should not generally be used on data collection forms completed by the respondent.  Code 3 can only be used for infants aged less than 90 days.  **4 Other**  Includes:   * An intersex person, who because of a genetic condition was born with reproductive organs or sex chromosomes that are not exclusively male or female. * A person who identifies as neither male nor female.   Excludes: Transgender, transsexual and chromosomally indeterminate individuals who identify with a particular sex (male or female). |
| **Validations** | E090 Sex invalid  E092 Sex Indeterminate with Age Greater Than or Equal To 90 Days  E093 Sex Indeterminate and Age Less Than 90 Days  E264 Diagnosis Code and Sex - Check  E370 Sex Code ‘Other’ |
| **Related items** | Section 3 Diagnosis |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis of service utilisation and epidemiological studies. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 2003  3 1 July 2004  4 1 July 2017  5 1 July 2022 |
| **Definition source** | NHDD METeOR ID 741686 |
| **Code set source** | NHDD |

## Transfer Destination

Specification

|  |  |
| --- | --- |
| **Definition** | Identification of the hospital campus to which a person is transferred following departure from this hospital campus |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Presentations where Departure Status is 17, 19, 20 and 21 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 available at: [Reference files](https://www.health.vic.gov.au/data-reporting/reference-files) <https://www.health.vic.gov.au/data-reporting/reference-files>  This table is updated as required throughout the year.  **Hospital identifier for interstate/overseas hospital**  Compile a code according to the following convention:  **First character**  9 For all interstate and overseas hospitals.  **Second Character** *State/overseas identifier*  0 Queensland  1 New South Wales  2 Tasmania  3 South Australia  4 Western Australia  5 ACT  6 Northern Territory  7 New Zealand  8 Other overseas  **Third Character** *Hospital type*  0 Major specialist/teaching  1 Other public acute  2 Extended care  3 Private  5 Psychiatric (public only)  6 Rehabilitation (public only)  9 Other healthcare accommodation (for example early parenting centres.  **Fourth character**  7 For all interstate and overseas hospitals.  Example:  An extended care hospital in New South Wales would be coded 9127.  Forensic Hospitals (prisons) and Armed Forces Hospitals:  These are not generally recognised as hospitals by the Commonwealth.  Multiple campus hospital transfers:  The VEMD is a ‘campus’ based collection.  Where the patient transfers to another campus of the same hospital (different site identifier):   * Departure Status is 17, 19, 20 and 21 * Transfer Destination is Campus Code. * Unknown Transfer Destination:   It is expected that the sending hospital is aware of the specific receiving hospital to which the patient is being transferred.   * Unknown Transfer Destination of 9999 will result in a rejection. |
| **Validations** | E137 Transfer Destination / Source equals Campus Code  E235 Transfer Destination Code invalid |
| **Related items** | Section 3 Departure status. |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis of patient transfer patterns. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1997  3 1 July 1999 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Transfer Source

Specification

|  |  |
| --- | --- |
| **Definition** | Identification of the hospital campus from which the person has been transferred. |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Presentations where Departure Status is 17, 19, 20 and 21 irrespective of whether they were admitted or not admitted at the sending hospital (Conditional mandatory). |
| **Reporting guide** | Presentations where Referred By is ‘6 – Staff from Another Campus’, except if from a nursing home within such a facility (Conditional mandatory).  Reporting guide This item includes all patients who were transferred, whether admitted or not admitted at the transferring hospital and identifies the precise acute health care facility from which the patient was transferred to your hospital.  Item should be blank if patient has not been transferred or if transfer is from a nursing home.  Victorian hospital  If a patient is transferred from a Victorian hospital, report a valid Campus Code. The Campus code table is available at [Reference files](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files%3e) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files>  This table is updated as required throughout the year.  Hospital identifier for interstate/overseas hospital  Compile a code according to the following convention:  **First character**  9 For all interstate and overseas hospitals.  **Second Character** *State/overseas identifier*  0 Queensland  1 New South Wales  2 Tasmania  3 South Australia  4 Western Australia  5 ACT  6 Northern Territory  7 New Zealand  8 Other overseas  **Third Character** *Hospital type*  0 Major specialist/teaching  1 Other public acute  2 Extended care  3 Private  5 Psychiatric (public only)  6 Rehabilitation (public only)  9 Other healthcare accommodation (for example early parenting centres.  **Fourth character**  7 For all interstate and overseas hospitals.  **Example:**  An extended care hospital in New South Wales would be coded 9127  **Forensic Hospitals (prisons) and Armed Forces Hospitals:**  These are not generally recognised as hospitals by the Commonwealth.  **Multiple campus hospital transfers:**   * The VEMD is a ‘campus’ based collection. * Where the patient is transferred from another campus of the same hospital (different campus code): * Referred By is ‘6 – Staff from Another Campus’ * Transfer Source is Campus Code.   Where the patient is transferred from another campus of the same hospital (same campus code):   * Referred By is ‘0 – Staff from this campus’ * Transfer Source is blank   **Unknown Transfer Source:**  It is expected that the sending hospital is aware of the specific hospital from which the patient was transferred. Unknown Transfer Source of 9999 will result in a warning.  Refer Section 3 - Campus Code |
| **Validations** | E135 Transfer Source Code invalid  E136 Referred By and Transfer Source combination invalid  E137 Transfer Destination / Source Equals Campus Code  E371 Transfer Source Equals ‘9999 – Unknown’ |
| **Related items** | Section 3 Referred By  Campus Code |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis of patient transfer patterns. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1997  3 1 July 1999 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Triage Category

Specification

|  |  |
| --- | --- |
| **Definition** | Classification according to urgency of need for medical and nursing care, using the Australasian Triage Scale |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation |
| **Code set** | **Code Descriptor**  1 Resuscitation  2 Emergency  3 Urgent  4 Semi urgent  5 Non urgent  6 Dead on arrival |
| **Reporting guide** | The Triage Category is to be allocated by an experienced registered nurse or medical practitioner.  It is imperative that the VEMD accurately reflects the demand placed on Emergency Department services, therefore, once a patient is triaged, to one of the VEMD triage categories, the presentation must be recorded within the VEMD in all instances. This applies even when the patient did not wait for treatment to commence OR if registration was commenced but not completed.  Changes in Triage Category:  It is recognised that Triage Categories may alter during a presentation.  The following guideline should be followed when a patient changes Triage Category during an emergency presentation:   * If the Triage Category of a patient is altered during their presentation, the original Triage Category is to be submitted to the VEMD (regardless of whether the re-categorisation is higher or lower) * Changes in Triage Categories may be recorded locally but should not be submitted to the VEMD; only the original Triage Category should be reported.   **6 Dead on arrival**  This item is collected for VEMD purposes. It is not included in the National Triage Scale.  Refer Section 4 - Business Rules (Dead On Arrival) |
| **Validations** | E142 Dead on Arrival combination invalid  E175 Triage Category invalid  E351 Potentially Excessive Time to Initiation of Patient Management  E366 Departure Status and Triage Category combination invalid  E386 Unexpected combination between Triage Category and Type of Visit  E389 Triage Category 1 patient – Excessive Time to Initiation of Patient Management |
| **Related items** | Section 2 Triage  Initiation of Patient Management  Time to Initiation of Patient Management  Section 3 Arrival Date  Arrival Time  First Seen By Doctor date/time  Nurse Initiation of Patient Management date/time  Seen by Mental Health Practitioner date/time  Triage Date  Triage Time  Section 4 Dead on Arrival |

Administration

|  |  |
| --- | --- |
| **Purpose** | To identify and monitor the urgency of a patient’s presentation and corresponding time to initiation of patient management |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995 |
| **Definition source** | Department of Health |
| **Code set source** | NHDD |

## Triage Date

Specification

|  |  |
| --- | --- |
| **Definition** | Date the patient was first seen by a Triage nurse/doctor |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation |
| **Reporting guide** | If local work practices dictate that the Triage process occurs immediately upon arrival, then the Triage date/time will equal Arrival date/time.  See Section 2 Date / Time Fields |
| **Validations** | E165 Triage date/time invalid  E167 Triage date/time before Arrival date/time  E181 Nurse Initiation of Patient Management date/time before Triage date/time  E196 First Seen by Doctor date/time before Triage date/time  E387 Triage date/time after Departure date/time  E388 Seen by Mental Health Practitioner date/time Before Triage date/time  E400 Triage date/time before Ambulance at Destination date/time |
| **Related items** | Section 3 Triage Time |

Administration

|  |  |
| --- | --- |
| **Purpose** | Used in the calculation of various derived items |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995 |
| **Definition source** | NHDD |
| **Code set source** | NHDD |

## Triage Time

Specification

|  |  |
| --- | --- |
| **Definition** | Time the patient was first seen by a Triage nurse/doctor |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation |
| **Reporting guide** | If local work practices dictate that the Triage process occurs immediately upon arrival, then the Triage date/time will equal Arrival date/time.  See Section 2 Date / Time Fields |
| **Validations** | E165 Triage date/time invalid  E167 Triage date/time Before Arrival date/time  E181 Nurse Initiation of Patient Management date/time Before Triage date/time  E196 First Seen by Doctor date/time Before Triage date/time  E387 Triage date/time after Departure date/time  E388 Seen by Mental Health Practitioner date/time Before Triage date/time  E400 Triage date/time before Ambulance at Destination date/time |
| **Related items** | Section 3 Triage Date |

Administration

|  |  |
| --- | --- |
| **Purpose** | Used in the calculation of various derived items |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Type of Usual Accommodation

Specification

|  |  |
| --- | --- |
| **Definition** | Type of accommodation in which the patient usually lives |
| **Reported by** | Public hospitals  Private hospitals, optional |
| **Reported for** | Every Emergency Department presentation |
| **Code set** | **Code Descriptor**  1 Private Residence, living alone  2 Private Residence, living with other(s)  3 Residential aged care facility  4 Boarding/rooming house/hostel or hostel type accommodation (not including aged care hostel)  5 Community-based residential supported living facility or other supported accommodation  6 Psychiatric Hospital  7 Other Hospital Setting  8 Homeless Person’s Shelter  9 Shelter/refuge (not including homeless person’s shelter)  10 Public place (homeless)  11 Prison/Remand Centre/ Youth Training centre  18 Unknown/unable to determine  19 Other accommodation, not elsewhere classified |
| **Reporting guide** | 'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to presentation.  If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation.  In practice, receiving an answer strictly in accordance with the above definition may be difficult to achieve. The place the person perceives as their usual accommodation will often prove to be the best approximation.  **2 Private Residence, living with other(s)**  Includes: family or friends. Intended to capture those who would provide support on discharge.  **3 Residential aged care facility**  *Includes:*  Any of the following terms: nursing home, hostel, high care and low care  Only those facilities that are in receipt of subsidies from the Commonwealth Government under the Aged Care Act 1997 and provide accommodation and supported care (ranging from help with daily tasks and personal care to 24-hour nursing care) to eligible people  **5 Community-based residential supported living facility or other supported accommodation**  *Includes:*  Community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provide 24-hour support/rehabilitation on a residential basis  Group homes for people with disabilities, cluster apartments where a support worker lives on-site, community residential apartments, and congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care  Other supported accommodation facilities such as hostels for people with disabilities and Residential Services/Facilities. These facilities provide board and lodging, and rostered care workers provide client support services.  Privately operated Supported Residential Services  Specialised alcohol/other drug treatment residence  The intent of code 5 is to capture accommodation where there is some support available. Where there is no support available i.e. the hostel or other facility provides accommodation only, code 4 should be allocated.  **6 Psychiatric Hospital**  *Includes* alcohol/other drug treatment units in psychiatric hospitals  **7 Other Hospital Setting**  *Includes* respite and palliative care facilities. |
| **Validations** | E354 Type of Usual Accommodation invalid  E355 Type of Usual Accommodation and Age combination invalid  E356 Type of Usual Accommodation and Departure Status combination invalid  E357 Type of Usual Accommodation and Medicare Suffix combination invalid |
| **Related items** | Section 3 Date of Birth  Locality  Postcode |

Administration

|  |  |
| --- | --- |
| **Purpose** | To assist in the evaluation of acute / residential care interface issues and the implementation of strategies to address these issues. |
| **Principal data users** | Department of Health |
| **Collection start** | 1 July 2003 |
| **Version** | Version Effective date  1 1 July 2003 |
| **Definition source** | Department of Health |
| **Code set source** | Department of Health |

## Type of Visit

Specification

|  |  |
| --- | --- |
| **Definition** | The reason the patient presented to the Emergency Department |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation |
| **Code set** | **Code Descriptor**  1 Emergency presentation  2 Return visit - planned  8 Pre-arranged admission - clerical, nursing, clinical  10 Dead on arrival  20 Emergency use |
| **Reporting guide** | Select the first appropriate category from the following hierarchy of options.  **1 Emergency Presentation**  Attendance requiring acute unscheduled care.  *Includes:*   * Presentation due to an actual or suspected new clinical condition; OR * An unplanned presentation for a continuing actual or suspected condition; OR * Privately referred or privately treated patient   Example  Patient B is a 20 year old man with vague abdominal pain. Examination and tests do not suggest a serious cause (true of most cases of abdominal pain). In line with best practice, the nature of his illness is explained to the patient including the likelihood that it will settle down on its own. He is also warned of the small possibility that this will progress into something potentially serious - but that only time will tell. He is informed what symptoms to look out for and to return to ED should they develop.  The next day, pain has worsened a lot and moved to the right side of patient B's abdomen. As these are some of the symptoms he was told to look out for, he returns to ED where appendicitis is diagnosed.  Both are emergency presentations  **2 Return Visit - Planned**  *Includes:*   * Planned return to the ED as a result of a previous ED presentation or return visit. The return visit may be for planned follow-up treatment or as a consequence of test results indicating need for further treatment or as a result of a care plan initiated at discharge; OR * Outpatient appointment for a planned presentation.   Example  Patient A is a middle aged man with cellulitis. Most infections settle with oral antibiotics but a proportion do not and require intravenous antibiotics. The ED doctor prescribes oral antibiotics and instructs the patient to return the next day to make sure the infection is settling.  First presentation is emergency, second is a return visit – planned (the patient has been instructed to return to ED on a specific day for a specific purpose).  *Excludes:*  Where a visit follows a general exhortation to return if feeling unwell, this should not be recorded as a planned visit.  **8 Pre-arranged Admission-clerical, nursing, clinical.**  *Includes:*  Presentation at the ED for clerical, nursing or medical processes to be undertaken. Admission has been arranged by the referring medical officer and a ward bed allocated.  **10 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 intent to resuscitate.  **20 Emergency use**  Only to be use under the direction of the Department of Health. The department will provide reporting guidelines when an ‘emergency use’ code is enacted. |
| **Validations** | E140 Type of Visit invalid.  E142 Dead on Arrival combination invalid.  E386 Unexpected combination between Triage Category and Type of Visit |
| **Related items** | Section 4 Dead on Arrival |

Administration

|  |  |
| --- | --- |
| **Purpose** | Analysis of service utilisation. |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 2003  2 1 July 2021 |
| **Definition source** | NHDD METeOR ID 746599 |
| **Code set source** | Department of Health NHDD modified |

## Unique Key

Specification

|  |  |
| --- | --- |
| **Definition** | A unique identifier specific to an individual ED presentation. |
| **Reported by** | All Victorian hospitals (Public and Private) |
| **Reported for** | Every Emergency Department presentation |
| **Code set** | Hospital–generated.  The Unique Key can be computer-generated or have specific relevance at the hospital.  A Unique Key cannot be changed. In this scenario the episode would need to be deleted and re-submitted with a new Unique Key.  Do not re-use a Unique Key; a Unique Key must not be reassigned to another presentation for the same patient or to another patient.  **Note:**  When changing software supplier, care must be taken to ensure Unique Keys remain unique. That is new episodes should be allocated a number higher than the previous number allocation.  In the case of duplicate episodes being transmitted to the VEMD; once a record has been accepted into the VEMD, a deletion record is required to remove the episode.  Take necessary steps to delete record from the in-house EDIS.  Create a deletion record and transmit to VEMD. |
| **Validations** | E025 Duplicate Attendance  E030 Duplicate Unique Key  E060 Unique Key invalid |

Administration

|  |  |
| --- | --- |
| **Purpose** | To uniquely identify every ED presentation |
| **Principal data users** | Monash University Accident Research Centre; Department of Health |
| **Collection start** | 1 July 1995 |
| **Version** | Version Effective date  1 1 July 1995  2 1 July 1998  3 1 July 1999 |
| **Definition source** | Department of Health |
| **Code set source** | Hospital generated |

# Section 4: Business Rules

This section provides consolidated information about topics that involve two or more data items.

## Clinician date/time and Departure Status

Valid combinations of Departure Status and Clinician date/time values are as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| Departure Status | Seen by Mental Health Practitioner date/time | Nurse Initiation of Patient Management date/time | First Seen by Doctor date/time |
| 8-Dead on Arrival | Blank | Blank | Time patient’s death was certified |
| 10-Left after Clinical Advice regarding treatment options | Blank | Blank | Blank |
| 11-Left at own risk, without treatment | Blank | Blank | Blank |
| 30-Left after clinical advice regarding treatment options – GP Co-Located Clinic | Blank | Blank | Blank |
| T1 Left at own risk without consultation | Blank | Blank | Blank |

**Refer to** Section 6: E182 - Seen by Clinician date/time and Departure Status combination invalid

## Dead on Arrival

Departure Status ‘Dead on Arrival’ should only be accorded to a presentation where the:

* patient is certified dead by a medical practitioner or patient is verified dead by a registered nurse or other suitably qualified person, before (or without) being brought into the Emergency Department.

OR

* patient is brought into the Emergency Department but there is no intention to resuscitate them.

Where there is the intention to resuscitate a patient brought into the ED, but they are later pronounced dead, the patient should be recorded as having ‘Died within ED’.

If the Departure Status **is** Dead on Arrival then the following fields **MUST** contain these values:

|  |  |
| --- | --- |
| Field | Value |
| Arrival Transport Mode | Any mode – although majority should be 9 |
| Departure Status | 8 |
| Diagnosis | R959 or R99 |
| Referred to on Departure | 19 |
| Triage category | 6 |
| Type of Visit | 10 |
| First Seen By Doctor date/time | Time patient’s death was certified |
| Departure date/time | Patient certified dead by clinician outside the ED and body not brought to ED: Departure date/time = date/time of certification of death |

All other mandatory fields should also be reported.

If the Departure Status **is NOT** Dead on Arrival then the following fields **MUST NOT** contain these values:

|  |  |
| --- | --- |
| Field | Value |
| Arrival Transport Mode | 9 |
| Departure Status | 8 |
| Diagnosis | R959 or R99  (R959 and R99 permitted with Departure Status 7) |
| Triage Category | 6 |
| Type of Visit | 10 |

**Refer to** Section 2: Death – Verification and Certification and Section 6: E142 Dead on Arrival

## Departure Status and Referred to on Departure

The valid combinations of Departure Status and Referred to on Departure data items are as follows:

| 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 |
| 30 - Left after clinical advice regarding treatment options – GP Co - Located Clinic | 1 – 18 |
| 5 - Left at own risk, after treatment started | 19 |
| 7 - Died within ED | 19 |
| 8 - Dead on arrival | 19 |
| **This hospital:** |  |
| 27 - Cardiac catheter laboratory | 19 |
| 28 - Other procedure room or operating theatre | 19 |
| 15 - Intensive Care Unit - this campus | 19 |
| 22 - Coronary Care Unit - this campus | 19 |
| 25 - Mental Health Observation/Assessment Unit | 19 |
| 3 - Short Stay Observation Unit | 19 |
| 14 - Medical Assessment and Planning Unit | 19 |
| 26 - Other Mental Health Bed - this campus | 19 |
| 18 - Ward not elsewhere described (excludes SOU, EMU, MAPU, ICU, CCU and Mental Health Bed) | 19 |
| 31 - Mental Health and AOD Hub Short Stay Unit | 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. | 1 – 18 |
| 12 - Correctional/Custodial Facility | 1 – 18 |
| 1 - Home | 1 – 18 |
| **Telehealth:** |  |
| T1 - Left at own risk without consultation | 19 |
| T2 - Left at own risk after consultation started | 19 |
| T3 - Referred to GP | 4 |
| T4 - Discharged to usual residence | 1-18 |
| T5 - Transferred to ward setting | 19 |
| T6 - Transferred to another health service | 19 |
| T7 - Recommended for transfer to Telehealth Emergency Department | 1-2 |

## Injury surveillance

If a patient presents with an injury and receives treatment all the following data items must be reported (unless the S or T Primary Diagnosis code is flagged for optional completion of these fields in the VEMD Editing Matrix).

* Activity when Injured (See Section 3)
* Body Region (See Section 3)
* Description of Main Injury Event (See Section 3)
* Human Intent (See Section 3)
* Injury Cause (See Section 3)
* Nature of Main Injury (See Section 3)
* Place where Injury occurred (See Section 3)
* Primary Diagnosis code beginning with an S or T (See Section 3)

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

* As many Injury Surveillance fields as were collected prior to the patient’s departure
* Departure Status of 10, 11 or 30
* No Diagnosis codes for Departure Status 11
* Diagnosis optional for Departure Status 10 or 30
* Injury surveillance fields (including Description of Injury Event) are not permitted with any primary diagnosis that is not an injury code (starting with either ‘S’ or ‘T’).

The VEMD Editing Matrix lists S and T codes and flags those where completion of the Injury Surveillance fields is optional. A copy of the VEMD Editing Matrix is available from the HDSS Helpdesk.

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

Examples:

1. Poisoning as child ingested 8 paracetamol tablets (cardboard packet of brand X) found in bathroom cabinet while playing in the bathroom at home.

2. Crush injury to foot, wooden pallet dropped onto foot whilst working at a construction site, wearing safety boots with steel capped toes at the time.

3. Shop assistant received contusion to cheek, punched in face by angry customer at the local shopping centre.

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

To protect patient and employee privacy, collection staff should be instructed NOT to record identifying details in the Description of Injury field.

* For example:
* ‘Tripped on tree root in back yard. TBSB Dr Jacob’ *becomes* ‘Tripped on tree root in back yard’
* ‘James presented with third overdose this week’ *becomes* ‘Patient presented with third overdose this week.’

Hospitals and software vendors should contact [HDSS Helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au> if they have any further queries.

## VEMD Editing Matrix

The VEMD Editing Matrix specifies the valid combinations between Primary Diagnosis injury codes and particular injury surveillance fields.

Email the HDSS Helpdesk for a copy of the VEMD Editing Matrix.

## Interpreter Required and Preferred Language

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

|  |  |
| --- | --- |
| If Interpreter Required is | Preferred Language |
| 1 Yes | Must not be 0000 or 0002 or 1201 |
| 2 No | Must not be 0000 or 0002 |
| 9 Not Stated/Inadequately described | Must be 0000 or 0002 |
| If Preferred Language is | Interpreter Required must be |
| 1201 English | 2 |
| 97xx Non-verbal  (including sign languages) | 1 or 2 |
| 0002 Not stated | 9 |

Preferred Language ASCL Codeset is available at [reference files](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files%3e) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files>

**Validations** E359 Invalid comb int req/pref lang

## Left Without Treatment

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

|  |  |
| --- | --- |
| Field | Value |
| Departure Date / Time | Date and Time the patient left the ED |
| Departure Status | 10 - Left after clinical advice regarding treatment options,  11 - Left at Own Risk, Without Treatment,  30 - Left after Clinical advice regarding treatment options – GP Co-Located clinic, or  T1 - Left at own risk without consultation |
| Departure Transport Mode | Blank |
| Diagnosis - Primary | Blank (Optional for Departure Status 10 or 30) |
| First Seen By Doctor Date | Blank |
| First Seen By Doctor Time | Blank |
| Nurse Initiation of Patient Management Date | Blank |
| Nurse Initiation of Patient Management Time | Blank |
| Seen by Mental Health Practitioner Date | Blank |
| Seen by Mental Health Practitioner Time | Blank |
| Referred To On Departure | If Departure Status = 10 or 30 then any code between 1 and 18  If Departure Status = 11 or T1 then 19 – Not Applicable |

## Locality / Postcode

There are two categories of Postcode/Locality errors:

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

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

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

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

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

**Rejected** (validation E115) if there is not an exact match for both Locality and Postcode.

* The Locality is blank and the Postcode is not 1000 or 9988.
* The Locality is not blank and the Postcode is 1000 or 9988.
* Postcode is 8888 and Locality is not a valid country code from the Postcode/Locality reference file.

1. Format Error in the layout of either the Locality or Postcode, as summarised below:

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

Refer to the Postcode - Locality Reference file on the HDSS website at [reference files](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files>

## Nature of Main Injury and Body Region

Valid combinations for Nature of Main Injury and Body Region:

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

For further information refer to the VEMD Editing Matrix. A copy of the VEMD Editing Matrix can be obtained by emailing the HDSS Helpdesk.

## Primary Diagnosis

A Primary Diagnosis is MANDATORY unless Departure Status equals:

* 30 – Left after clinical advice regarding treatment options – GP Co-Located Clinic (Primary Diagnosis optional)
* 10 – Left after clinical advice regarding treatment options (Primary Diagnosis optional)
* 11 – Left at own risk, without treatment (Primary Diagnosis must be blank)
* 31 – Mental Health and AOD Short Stay Unit (Primary Diagnosis mandatory if the patient was treated prior to discharge)
* T1 – Left at own risk without consultation (Primary Diagnosis must be blank), or
* T2 – Left at own risk after consultation started (Primary Diagnosis optional).

If Departure Status equals:

* 8 – Dead on Arrival – Primary Diagnosis must be R959 or R99
* 7 – Died in ED – Primary Diagnosis may be R959 or R99

## 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 | 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 – private ambulance car – AV contracted  11 – Ambulance Service – hospital contracted  19 – Other |
| 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 |

## Departure status and transfer fields

The following table details the combinations of Departure Status codes, where the transfer fields are required to be:

* A valid code, OR
* Blank.

|  |  |  |  |
| --- | --- | --- | --- |
| Departure Status | Transfer Destination | Reason for Transfer | Departure Transport Mode |
| 17,19,20,21 | Valid Campus Code | Valid code | Valid code |
| 1,3,5,7,8,10,11,12,14,  15,18,22,23,24,25,26,27,28,30,  31, T1, T2, T3, T4, T5, T6, T7 | Blank | Blank | Blank |

## Referred By and Transfer Source

Valid combinations for Referred by and Transfer Source

|  |  |
| --- | --- |
| Referred By | Transfer Source |
| 6 | Valid Campus Code |
| 0,1,2,4,14,15,16,17,18,19,20,21,22 | Blank |

# Section 5: Compilation and Submission

This section explains how to compile and submit Emergency Department data to the Department of Health.

## Compilation overview

The required VEMD format for the financial year applies to presentations with a Departure Date on or after 1st July of that financial year. This includes patients who remain in the Emergency Department after midnight on the 30th June.

A financial year starts on the 1st July and ends at midnight on the 30th June.

Data for patients who present at the Emergency Department on 30th June 2022 and depart from the Emergency Department on or after 1st July 2022 must be reported in the 2022-23 format and follow the appropriate file naming convention.

Note: Data for patients who present and depart from the Emergency Department up to midnight on 30th June 2022, must be reported in the 2021-22 format.

VEMD time data is reported with a precision of minutes rounded down to the lowest minute:

For example:

* 4 hours 8 minutes 17 seconds is to be reported as 4 hours 8 minutes (0408)
* 4 hours 8 minutes 58 seconds is to be reported as 4 hours 8 minutes (0408)

As some data entry systems capture seconds, following this approach will avoid any ambiguity and ensure consistency between different sites.

## Submission overview

Every electronic file submitted to the VEMD must be:

* In the correct file structure
* Named according to the file naming convention
* Submitted in accordance with the schedule requirements
* Resubmitted until there are zero REJECTION and NOTIFIABLE errors.

## File naming convention

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

|  |  |  |  |
| --- | --- | --- | --- |
| File naming convention | AAAABnna.txt |  |  |
| Where | AAAA  Example 9999 | = | Campus Code |
|  | B  Example 7 | = | Version of the dataset  (2022-23 is version 27 code ‘7’ will be used) |
|  | nn  Example 08 | = | Month of submission (example 08= August) |
|  | a  Example a | = | Data submission indicator  1st July submission 08a  2nd July submission 08b  3rd July submission 08c  Must be sequential with no gaps commencing with ‘a’ for the first submission of the month. |
| Extract: 9999708a.txt |  |  |  |

## File structure

The file structure details the sequence, length, type and layout of data items to be submitted to the VEMD.

File Structure Notes:

* All fields are data type text
* All alpha characters must be in UPPERCASE (optional for Description of Injury Event)
* Do not zero fill items unless specified.
* Time must be in 24-hour format (0000 to 2359)
* Padding fields with space characters (either to the left or right) is unnecessary.

Mandatory items

See Table 2 (Key for Public and Private) for the conditions under which they become mandatory.

Table 1- Data Item format

| Data Item | Public | Private | Max Character | Layout/code set |
| --- | --- | --- | --- | --- |
| Campus Code | 1 | 1 | 4 | XXXX |
| Unique Key | 1 | 1 | 9 | XXXXXXXXX |
| Patient Identifier | 1 | 1 | 10 | XXXXXXXXXX |
| Medicare Number | 3 | 2 | 11 or blank | NNNNNNNNNNN or blank |
| Medicare Suffix | 1 | 2 | 3 | XXX |
| DVA Number | 14 | 2 | 9 | See Section 3 |
| Sex | 1 | 2 | 1 | 1, 2, 3, 4 |
| Date of Birth | 1 | 1 | 8 | DDMMYYYY |
| Date of Birth Accuracy Code | 1 | 2 | 3 | XXX |
| Country of Birth | 1 | 2 | 4 | XXXX |
| Indigenous Status | 1 | 2 | 1 | 1, 2, 3, 4, 8, 9 |
| Interpreter Required | 1 | 2 | 1 | 1, 2, 9 |
| Preferred Language | 1 | 2 | 4 | XXXX |
| Locality | 1 | 2 | 22 | XXXXXXXXXXXXXXXXXXXXXX |
| Postcode | 1 | 2 | 4 | NNNN |
| Type of Usual Accommodation | 1 | 2 | 2 | 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 18, 19 |
| Arrival Transport Mode | 18 | 1 | 2 | 1, 2, 3, 6, 8, 9, 10, 11, 99 or blank |
| Referred By | 1 | 2 | 2 | 0, 1, 2, 4, 6,14,15,16,17,18, 19, 20, 21, 22 |
| Transfer Source | 4 | 2 | 4 | XXXX or blank |
| Type of Visit | 1 | 1 | 2 | 1, 2, 8, 10 |
| Compensable Status | 1 | 1 | 1 | 1, 2, 3, 4, 5, 6, 7 |
| Ambulance Case Number | 16 | 2 | 10 | See Section 3 |
| Arrival Date | 1 | 1 | 8 | DDMMYYYY |
| Arrival Time | 1 | 1 | 4 | HHMM |
| Triage Date | 1 | 2 | 8 | DDMMYYYY |
| Triage Time | 1 | 2 | 4 | HHMM |
| Triage Category | 1 | 1 | 1 | 1, 2, 3, 4, 5, 6 |
| Nurse Initiation of Patient Management Date | 9 | 9 | 8 | DDMMYYYY or blank |
| Nurse Initiation of Patient Management Time | 9 | 9 | 4 | HHMM or blank |
| First Seen by Doctor Date | 10 | 10 | 8 | DDMMYYYY or blank |
| First Seen by Doctor Time | 10 | 10 | 4 | HHMM or blank |
| Seen by Mental Health Practitioner Date | 9 | 9 | 8 | DDMMYYYY or blank |
| Seen by Mental Health Practitioner Time | 9 | 9 | 4 | HHMM or blank |
| Procedure | 13 | 13 | 89 | XX (x30)  (Not collected from 1 July 2016) |
| Clinical Decision to Admit Date | 12 | 12 | 8 | DDMMYYYY or blank |
| Clinical Decision to Admit Time | 12 | 12 | 4 | HHMM or blank |
| Departure Date | 1 | 1 | 8 | DDMMYYYY or blank |
| Departure Time | 1 | 1 | 4 | HHMM or blank |
| Departure Status | 1 | 1 | 2 | 1, 3, 5, 7, 8, 10, 11, 12, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 30, 31, T1, T2, T3, T4, T5, T6, T7 |
| Transfer Destination | 6 | 2 | 4 | XXXX or blank |
| Referred to on Departure | 1 | 2 | 2 | 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 16, 17, 18, 19 |
| Reason for Transfer | 6 | 2 | 1 | 1, 2, 3, 4, 5, 6, 7, 9 or blank |
| Departure Transport Mode | 7 | 2 | 2 | 1, 2, 3, 4, 6, 7, 8, 10, 11, 19 or blank |
| Primary Diagnosis | 15 | 2 | 5 | VEMD subset of ICD-10-AM Codes |
| Additional Diagnosis 1 | 11 | 2 | 5 | VEMD subset of ICD-10-AM Codes |
| Additional Diagnosis 2 | 11 | 2 | 5 | VEMD subset of ICD-10-AM Codes |
| Nature of Main Injury | 8 | 2 | 2 | 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 or blank |
| Body Region | 8 | 8 | 2 | 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 | 8 | 2 | 250 | Free text |
| Injury Cause | 8 | 2 | 2 | 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 or blank |
| Human Intent | 8 | 2 | 2 | 1, 6, 8, 9, 12, 13, 14, 15, 16, 17, 18, 19, 20 or blank |
| Place Where Injury Occurred | 8 | 2 | 1 | H, I, S, A, R, T, C, Q, F, M, P, O, U or blank |
| Activity When Injured | 8 | 2 | 1 | S, L, W, E, C, N, V, O, U or blank |
| Ambulance at Destination Date | 16 | 16 | 8 | DDMMYYYY or blank |
| Ambulance at Destination Time | 16 | 16 | 4 | HHMM or blank |
| Ambulance Handover Complete Date | 16 | 16 | 8 | DDMMYYYY or blank |
| Ambulance Handover Complete Time | 16 | 16 | 4 | HHMM or blank |
| Advance Care Directive Alert | 1 | 2 | 1 | 1, 2, 3, 4 or blank |
| Given Name | 14 | 2 | 15 | See Section 3 XXXXXXXXXXXXXXX or blank |
| Family Name | 14 | 2 | 25 | See Section 3 XXXXXXXXXXXXXXXXXXXXXXXXX or blank |
| Service Type | 1 | 1 | 1 | 1, 2, 3, 4 |
| Patient Location | 19 | 2 | 4 | XXXX or blank |

Key for private and public (Table 2)

|  |  |
| --- | --- |
| Key | Descriptor |
| 1 | Mandatory item. |
| 2 | Optional for private hospitals. Report blanks or valid codes. |
| 3 | Mandatory if Medicare Suffix does not equal C-U, N-E or P-N |
| 4 | Mandatory if Referred By = 6 |
| 6 | Mandatory if patient is transferred to another hospital campus. Departure status is:  17 - Mental Health bed at another hospital campus  19 - Another hospital campus  20 - Another hospital campus – Intensive Care Unit  21 - Another hospital campus – Coronary Care Unit  Blank for Departure Status codes 10, 11, 30 or T1 |
| 7 | Mandatory if patient is transferred to another hospital campus. Departure status is:  17 - Mental Health bed at another hospital campus  19 - Another hospital campus  20 - Another hospital campus – Intensive Care Unit  21 - Another hospital campus – Coronary Care Unit  Blank for Departure Status codes 10, 11, 30 or T1 |
| 8 | See Section 4 – Business Rules, Injury Surveillance. |
| 9 | Blank if Departure Status = 8, 10, 11, 30, T1 |
| 10 | Blank if Departure Status is:   * 10 - Left after clinical advice, regarding treatment options, * 11- Left at own risk, without treatment, * 30- Left after clinical advice regarding treatment options - GP Co-Located Clinic. * T1 - Left at own risk without consultation |
| 11 | Mandatory if Primary Diagnosis code = ‘Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment’. |
| 12 | Mandatory if a clinical decision to admit was made, regardless of whether the patient is actually admitted. |
| 13 | Not collected from 1 July 2016 - data in field will not be persisted or validated by Department of Health |
| 14 | Mandatory if Compensable Status = 2 |
| 15 | Optional for Departure Status 10 - Left after clinical advice, regarding treatment options or 30 - Left after clinical advice regarding treatment options – GP Co-Located Clinic  Must be blank for Departure Status 11 - Left at own risk, without treatment,  Mandatory for all Departure Statuses other than 10, 11 or 30 |
| 16 | Mandatory if Arrival Transport Mode = 1, 2, 3, 10 or 11 |
| 17 | Mandatory for all Triage Categories other than 6 |
| 18 | Mandatory if Service Type = 1 |
| 19 | Mandatory if Service Type = 2 |

## File format

Every file must be submitted:

* In the order specified in this document, for patients who depart on and from 1 July 2022 to 30 June 2023 (See File Structure).
* In tab (not comma) delimited ASCII format. Where data in non-mandatory items is unavailable the field position should be denoted by a tab.
* File must contain only valid ASCII characters, with each record separated by a carriage return and line feed
* All data elements are data type text
* Saved as a text file (.txt)

Software suppliers are advised to have the capacity to generate earlier versions of the VEMD file formats to enable hospitals to extract files using the version appropriate for the extraction period up to the final consolidation date for that financial year.

Also note that in relation to data format:

* Data submitted to VEMD must only include codes specified in the File Structure. Local systems may collect data through the use of other codes, acronyms or text; however, these must be converted into appropriate VEMD format for submission to VEMD.
* Only include VEMD ICD-10-AM diagnosis codes from the VEMD Library File. Email the [HDSS Helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au> for a copy of the file.
* Do not use the ICD-10-AM coding books as not all codes are included.
* Procedure: From 1 July 2016 data in this field is not persisted or validated
* Description of Injury Event: The text for this item does not need to be enclosed in quotation marks (i.e. “textual information”) as each tab separates the items. Quotation marks can be used to emphasise words within the text.

## Data submission

All data must be submitted using Managed File Transfer (MFT). A separate account is required for each person sending or retrieving VEMD files.

Managed File Transfer: Connect to the MFT application to send your data file and retrieve your electronic reports.

Note: You must set your password before you can connect to [MFT production](https://prs2-mft.prod.services) <https://prs2-mft.prod.services>

Self Service Password Reset: Access the [Self Service Password Reset (SSPR](https://ehvfimpwdreset.prod.services)) <https://ehvfimpwdreset.prod.services> to reset your password at initial use and then on password expiry.

System requirements

One of the following browsers must be used:

* Firefox - latest and previous version
* Chrome - latest version
* Microsoft edge - latest version
* Safari - latest version

Please note that Cookies and JavaScript must be enabled in the browser.

Requesting a login

To request a login:

* Email the [HDSS Helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au>
* Start subject line with VEMD MFT

Provide the following information for the person/s who sends VEMD files or retrieves VEMD reports:

* First and last name
* Email address
* Day and month of birth
* Campus code and campus name

Your user account will be created, and your login details emailed to you.

Set your password using the instruction provided with your login details

Support

The HDSS Helpdesk has access to the technical support team at HTS and can request assistance on behalf of health services who experience any difficulties setting up their accounts.

Note that any queries about your service’s internal network and firewall configuration must be directed to IT support within your organisation

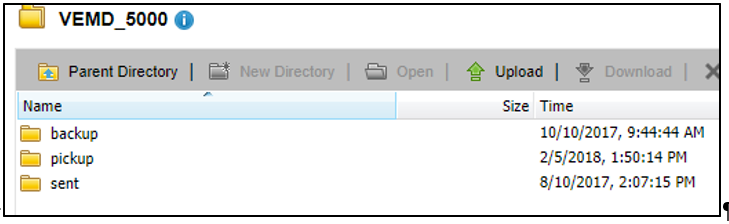
The HDSS Helpdesk can be contacted by emailing [HDSS Helpdesk](mailto:hdss.helpdesk@dhhs.vic.gov.au) <HDSS.helpdesk@health.vic.gov.au>

Please start the email subject line with VEMD MFT for all queries related to the VEMD data submission via the MFT.

## Uploading a submission file

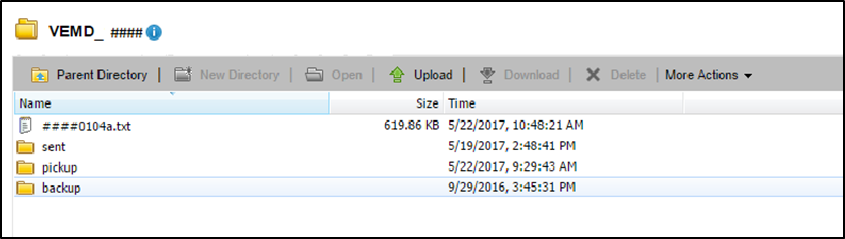
On connecting to the MFT application you will see a folder called VEMD\_#### where #### is the VEMD campus code. For users with access to multiple data collections and/or multiple sites, select the required folder from those listed.

Double click on the VEMD\_#### folder to be in the site’s VEMD HOME directory.

Select submission file

1. Click on 
2. Click on Chose File to select the submission file from your local drive/directory
3. Click on 

The file has been successfully uploaded if it is in the VEMD HOME directory folder as below



**Note:** The \sent and \backup folders are system folders and must not be accessed by users.

Collecting validation reports

After the file has processed your validation report file will be available for you to download in the \pickup folder. Select the Download option and save the report file to your local drive. A copy of the report will be moved to the \backup folder and be available from \backup for a further 7 days.

## Data submission timelines

All Victorian hospitals are required to submit data to the VEMD every business day.

Public and private hospital data submission timeline for 2022-23

|  |  |
| --- | --- |
| **VEMD 2022-23** | Timeline |
| All presentations for each day up to midnight | Submitted by 5pm the following business day |
| All presentations for the full month without errors | Must be complete and correct, i.e. zero rejection and notifiable validations by the 10th day of the following month, or the preceding working day if the 10th is a weekend or public holiday |
| Financial year consolidation - All errors for 2022-23 must be corrected and resubmitted before consolidation of the VEMD database | As advised in the Department of Health Policy and Funding Guidelines |

Where health services are noncompliant with the timelines specified above, penalties may apply. Refer to the [policy and funding guidelines](https://www2.health.vic.gov.au/about/policy-and-funding-guidelines) <https://www.dhhs.vic.gov.au/policy-and-funding-guidelines>.

Hospitals may submit more frequently than the above minimum requirements.

## Period of extract

All records for patients who depart in a particular calendar month should be submitted in the corresponding monthly file. That is, if a patient attends the Emergency Department on 31st July and departs on 1st August, the record should be submitted in the August file (containing departures from 1st August to 31st August), NOT in the July file.

## Penalties for non-compliance

Where health services are non-compliant with the timelines, the department may apply penalties as detailed in [policy and funding guidelines](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) < https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services>.

Data that is flagged as unfit for reporting and analysis will be regarded as non-compliant and penalties may apply.

## Exemptions from penalties

If difficulties are anticipated in meeting the relevant data submission timeframes, the health service must contact the department indicating the nature of the difficulties, remedial action being taken and the expected submission schedule.

A pro forma to assist this process is provided on the HDSS website at [submission templates](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/vemd) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd>.

Requests for an exemption from late penalties will only be considered if received prior to the relevant deadlines, and the manual aggregate data spreadsheet has been completed by the due date. Extensions or exemptions are not issued in advance. Late submissions penalties are assessed after the end-of-year consolidation deadline, considering the health service’s compliance performance for the financial year.

For any full month period that the health service is unable to supply unit record data, the health service is required to submit aggregate data using the manual aggregate data spreadsheet. The spreadsheet is available from the HDSS website at [submission templates](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/vemd) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd>.

Failure to complete the manual aggregate data spreadsheet by the due date will result in late submission penalties.

For further information please go to the Victorian Health Policy and Funding Guidelines at [policy and funding guidelines](https://dhhsvicgovau-my.sharepoint.com/personal/gaye_yee_dhhs_vic_gov_au/Documents/Department%20of%20Health%20and%20Human%20Services%20policy%20and%20funding%20guidelines%202020-21) < https://www.dhhs.vic.gov.au/policy-and-funding-guidelines>.

## Manual aggregate data submission

The completed aggregate data template should be emailed to [hdss helpdesk](mailto:hdss%20heldpesk) <hdss.helpdesk@health.vic.gov.au>

## Data resubmissions for previous months

Prior to resubmitting a data file, health services must email a Data Resubmission Request to [hdss helpdesk](mailto:hdss.helpdesk@health.vic.gov.au) <hdss.helpdesk@health.vic.gov.au>.

The Data Resubmission Request are available from [submission templates](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/vemd) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd>.

## Documented process requirements

It is expected that sites will have a robust succession policy to ensure that more than one staff member is aware of processes relating to submission and management of VEMD data at any point in time.

To ensure that management of VEMD data is not compromised by staff turnover or modifications to software all procedures relating to the extraction, correction, completeness, and accuracy of VEMD data must be clearly documented and accessible.

Leave and staff turnover issues will not automatically be viewed as sufficient grounds for waiving penalties for late submission.

## Input validations

Upon receipt, the Department of Health applies a series of ‘input validations’ (see Section 6 - Validations) to the data. These validations are intended to validate certain aspects of the data at the episode level.

Wherever possible, validations should also be maintained within the Emergency Department’s in-house data information system to minimise rejection of records from the Department of Health validation program.

**Section 6:** Validation Reports and Validations provides validations in number order with details of the validation title, data items involved, the effect of the validation, the problem and the remedy. The table below outlines the problem and remedy for the four possible validation effects:

|  |  |  |
| --- | --- | --- |
| Effect | Problem | Remedy |
| Run terminated | The monthly data file is corrupt or contains data that may compromise the dataset integrity. | Hospital determines and resolves the data problem and resubmits data file. |
| Rejection | Data item/s in the record did not meet the criteria specified in the business rules. | Hospital determines the cause of the rejection, corrects it and resubmits the monthly data file. Zero rejections must be achieved for each monthly data file. |
| Notifiable | E389 Triage Category 1 patient – excessive time to initiation of patient management | Triage Category reported may be incorrect. Arrival date/time or First Seen By date/time may be incorrect.  The immediate effect is identical to a rejection.  Hospital determines the cause of the notifiable validation and either:   * Corrects and re-submits the record. * Contacts the department via email as soon possible if the data triggering the notifiable is correct.   Zero notifiables must be achieved for each monthly data file. |
| Warning | Record was accepted but data item/s in the record were questionable. | Hospital checks that the data is valid. If necessary, the data is corrected and resubmitted. |

## Output validations

As well as validating the data at the presentation level, the department also routinely checks data at an aggregate level. It is possible for data to be valid at the presentation level, but meaningless when viewed from a different perspective. For example, reporting a Country of Birth of 6106 (Nepal) is valid at the episode level, but if Country of Birth for every episode for an entire month is 6106 then it would be highly unlikely that the data would be accurate. Resolution of these issues usually involves some dialogue between site and the department. It can occur several ways including:

* Resubmission
* Software or reference data alteration
* The department noting in metadata where unusual occurrences turn out to be accurate
* Changes in collection practices, clarification of aspects of collection.

It should be noted that data can be considered to be ‘rejected’ at the output validation level as well as the input validation level.

## Deletion of records

Deletion of a record previously submitted to VEMD requires the record to be resubmitted with eleven ‘9’s in the Medicare Number field. Please note for deletions to be successful the following fields must be completed as a minimum (ie cannot be null) Campus Code, Patient Identifier, Unique Key, Medicare Number and Arrival date/time.

Submitting a file without the deleted record is not enough because all previously submitted records are active unless overwritten by later records with the same Unique Key.

It is essential for software to have the capacity to report deletions that occur in-house as they can be a cause of significant confusion and difficulties in reconciliation.

## Test submissions

Software suppliers must send test submissions to test new programs or changes to existing applications before using them to send live data to VEMD. Hospitals and/or software suppliers are encouraged to send test submissions to test software changes for 1 July revisions.

Each test can be submitted via the MFT. Test files must be clearly identified by displaying “TEST” at the end of the file name eg: Test file for campus code 5000 for July “a” would be 5000607aTEST.txt.

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

## VEMD Editor

The department has developed a VEMD Editor that provides public hospitals with the opportunity to run their VEMD data through a validation process before sending it to the department.

The Editor is designed to reduce the number of submissions and associated administrative overheads that hospitals incur by identifying errors before submission. The VEMD Editor can be used as a guide to assist health services, but Validation Reports returned from the department need to be carefully checked as there may be differences when files are run in the production environment at the department.

The MS Access VEMD Editor will be updated to Edition 27 in June 2022. Download the Editor and VEMD Editor Process Notes from the website at [VEMD Editor](https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd) <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/vemd>.

MS Access 2000 or higher is required to run this software. Users are encouraged to identify deficiencies and suggest improvements. Instructions are available on the website.

Note: When downloading, disconnect the VEMD Editor from MS Access.

## Policy on data manipulation

The department does not condone manipulation of any data extracts (for example with Microsoft Excel, Notepad or any other data manipulation tool) that causes change in data values prior to processing by the department. The rationale for this is as follows:

It is expected that services have a contractual arrangement with software vendors that obliges vendors to provide software allowing them to meet their statutory reporting requirements. Services are strongly advised to factor into contract negotiations the impact of data quality and timeliness penalties that may apply where the vendor fails to deliver a product that meets statutory reporting requirements. In effect the vendor’s software should be capable of producing an extract in the format required by the department.

The department acknowledges that any software may have the potential to extract data that can trigger “Rejection” validations from time to time. Software vendors and health services should work together to ensure that, where this occurs, data is corrected via the service’s relevant operational database.

* ‘Correcting’ errors in the extract, but not in the hospital’s operational database can lead to a misrepresentation of the hospital’s true position.
* There is an audit requirement that data received by the department is an accurate reflection of the hospital’s medico legal system of record.

## Health service responsibilities

In situations where software does not allow the health service to meet its reporting obligations, services should report the problem to their software vendor immediately, and also notify the department. The terms of the contract with software vendors should ensure that these problems are addressed as a priority. In cases where the issues cannot be remedied the health service must:

* notify the department in writing of the specific problem, including the affected fields
* specify the plan and timeframe negotiated between the health service and vendor for the resolution of the situation

The department maintains a register of such occurrences. Failure to meet the above conditions may result in the application of data quality and timeliness penalties. If the problem has not been resolved within the timeframe, the service must advise the department of progress.

## Department responsibilities

In rare circumstances a health service may request that the department make a manual change to address a specific data quality issue. The department will only consider this where:

* it believes that all other avenues have been exhausted,
* the health service requests the changes in writing, confirming that it has made the changes to its own data (or indicating that this is not possible), and
* the changes accurately reflect the health service’s medico legal system of record.

The department maintains a register of such occurrences.

# Section 6: Validation Reports and Validations

This section contains descriptions and remedies for Victorian Emergency Minimum Dataset (VEMD) validations.

Validation Reports

The following validations are provided to the hospital via an Excel spreadsheet, after the submission has been processed at the department.

|  |  |
| --- | --- |
| Report | Description |
| **Edit Summary** | A table detailing the summary statistics for the submitted file. |
| **Edit List** | List of all records with validations allocated to them  Details include:   * Edit ID (validation reference number) * Edit Description (description of the validation) * Edit Effect (status of the validation ie: rejection, warning or notifiable) * Unique Key * Patient Identifier * Narrative (summary of the error and field(s) to be investigated) * Campus * Arrival date/time * Extract ID (identifies the extract that contained the record) |
| **Submission Metadata** | A table detailing the following:   * Campus code of the submitting site * The date the file was processed * The submission month * The date of the first record in the extract * The date of the last record in the extract * The total number of records received in the file * The total number of rejected records * The total number of accepted records * The total number of deletion records * The total number of notifiable validations * The total number of rejection validations * The total number of warning validations * Submission ID * Extract file name |

Any record not listed on the Edit List outlined above has passed the input validation process and been accepted into the VEMD. No further action is required on these records, unless the Department of Health or the health service, determine the data to be inaccurate or erroneous. All services are expected to conduct regular and timely reconciliation of Validation Reports.

## Validations

E001 File Naming convention invalid

|  |  |
| --- | --- |
| **Effect** | RUN TERMINATED |
| **Problem** | The filename is not correct. |
| **Remedy** | Correct the file name and re-submit data to VEMD |
| **See** | Section 5: File Naming Convention |

E003 File contains invalid characters

|  |  |
| --- | --- |
| **Effect** | RUN TERMINATED |
| **Problem** | The file contains a character(s) that is not included in the Valid ASCII Character reference table. This problem can affect the ability of the validation process to identify items and columns. |
| **Remedy** | You may need to re-submit data. Re-run the file extract procedure. If the error persists, contact your software supplier. |

E005 Empty transaction file

|  |  |
| --- | --- |
| **Effect** | RUN TERMINATED |
| **Problem** | The file submitted is empty.  Either the transmission file is empty, or the extract process to create the file has failed. |
| **Remedy** | Rerun the file extract procedure. If the error persists, contact your software supplier. |

E006 File delimiting invalid

|  |  |
| --- | --- |
| **Effect** | RUN TERMINATED |
| **Problem** | The format of the file is not valid. Every file submitted for processing on the VEMD must be tab delimited ASCII format with each record separated by a carriage return and line feed. |
| **Remedy** | Contact your software supplier. Correct the format of the file and re-submit data. |
| **See** | Section 5: File Structure |

E007 File structure invalid

|  |  |
| --- | --- |
| **Effect** | RUN TERMINATED |
| **Problem** | The column sequence or content in the monthly data file is not valid for the corresponding version of the VEMD. |
| **Remedy** | As this error is most likely to occur after annual changes to the VEMD, consult the Specifications for Revisions documents and ensure your software supplier has accommodated the changes.  Re-submit the data in the correct format. |
| **See** | Section 5: File Structure |

E010 Non VEMD Hospital

|  |  |
| --- | --- |
| **Effect** | RUN TERMINATED |
| **Problem** | The Campus Code detailed in this file is not valid for VEMD data provision. The transmission cannot be accepted. |
| **Remedy** | Correct the code and re-submit. |
| **See** | Section 2: Campus  Section 3: Campus Code |

E025 Duplicate Attendance

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | This record has the same Patient Identifier as another record but a different Unique Key, yet the Arrival and Departure Dates/Times of the attendances are either identical or overlap. |
| **Remedy** | Check the Patient Identifier and Unique Key of both attendances |
| **Problem** | This record has the same Patient Identifier as another record but a different Unique Key, yet the Arrival and Departure Dates/Times of the attendances are either identical or overlap.  If Unique Key is wrong, correct it and re-submit the record.  If Patient Identifier is wrong, correct it and re-submit the record.  If both are correct, check Arrival and Departure Dates/Times for the both the existing record and this record. Correct and re-submit as appropriate. |
| **See** | Section 2: Date/time fields  Section 3: Arrival Date  Arrival Time  Departure Date  Departure Time  Patient Identifier  Unique Key |

E030 Duplicate Unique Key

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | This record has the same Unique Key as another record but has a different Patient Identifier. Every emergency presentation must be identified by a distinct Unique Key. |
| **Remedy** | Check the Patient Identifier and Unique Key of all applicable attendances:  If Unique Key is wrong, correct it and re-submit the record.  If the Patient Identifier is wrong, correct it and re-submit the record. |
| **See** | Section 3: Patient Identifier, Unique Key |

E050 Campus Code invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | Campus Code is a mandatory data item for all emergency attendances  No Campus Code has been recorded on this file; OR  The Campus Code detailed on this file does not exist in the reference table; OR  The Campus Code detailed on this record differs from the Campus Code provided in the file name. |
| **Remedy** | Correct the record or the file name and re-submit. |
| **See** | Section 2: Campus  Section 3: Campus Code  Section 5: File Naming Convention |

E060 Unique Key invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Unique Key is invalid. Unique Key is a mandatory data item for all emergency attendances. |
| **Remedy** | Correct the Unique Key and re-submit the record.  The item should be automatically generated by your computer system.  Contact your software supplier if Unique Key is not being generated.  **Valid** Numeric characters  Length equal to 9 characters  Right justified, zero-filled  **Invalid** Blank  Special characters (for example: $, #)  Length not equal to 9 characters. |
| **See** | Section 3: Unique Key |

E065 Patient Identifier invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Patient Identifier is invalid. Patient Identifier is a mandatory data item for all emergency attendances. |
| **Remedy** | Correct Patient Identifier and re-submit the record.  **Valid** Numeric / alphabetic characters,  Length equal to 10 characters  **Invalid** Blank  Special characters (for example, $, #)  Length not equal to 10 characters  Embedded spaces |
| **See** | Section 3: Patient Identifier |

E078 DVA Number invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | Check the DVA number item file structure, correct the DVA number accordingly and re-submit the data. |
| **Remedy** | Check the DVA number item file structure, correct the DVA number accordingly and re-submit the data. |
| **See** | Section 3: DVA Number  Section 5: File Structure |

E079 Compensable Status and DVA Number combination invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The campus is public and:  Compensable Status is ‘2 - Department of Veterans’ Affairs’, but there is no DVA number; OR  The Compensable Status code is not ‘2 - Department of Veterans’ Affairs’, but a DVA number is reported.  A DVA number must only be reported for each DVA compensable patient. |
| **Remedy** | Check whether patient is DVA compensable.  If the patient is DVA, the compensable status must be ‘2’ and a valid DVA number must be submitted.  If the patient is not a DVA patient, correct the Compensable Status and ensure the DVA number item is blank. |
| **See** | Section 3: Compensable Status  DVA Number |

E081 Medicare Number invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Medicare Number including individual reference number (IRN) is not valid |
| **Remedy** | Correct Medicare Number and re-submit the record. |
| **See** | Section 2: Medicare Eligibility Status – Eligible Person  Medicare Eligibility Status – Ineligible Person  Section 3: Medicare Number |

E086 Medicare IRN and Date of Birth combination invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Medicare individual reference number (IRN), 11th character in the Medicare Number is zero, but the patient is greater than 12 months old. A Medicare IRN of zero is only acceptable for babes yet to be issued with their own Medicare Number that is, persons under 12 months of age. |
| **Remedy** | Report the correct Medicare IRN for this patient. |
| **See** | Section 3: Arrival Date  Arrival Time  Date of Birth  Medicare Number |

E087 Medicare Suffix invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Medicare Suffix reported is not valid. |
| **Remedy** | Check the Medicare Suffix and Medicare Number and amend as appropriate and re-submit the record.  If the Medicare Number was not reported but is available, enter the Medicare Number and Suffix. |
| **See** | Section 2: Medicare Eligibility Status – Eligible Person  Medicare Eligibility Status – Ineligible Person  Section 3: Medicare Number  Medicare Suffix |

E089 Medicare IRN and Date of birth combination invalid

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The Medicare individual reference number (IRN), 11th character in the Medicare Number item, is zero, but the patient’s Date of Birth indicates that the patient is older than six months.  It is unlikely that the patient does not yet have a Medicare Number and IRN. |
| **Remedy** | Determine whether the patient is on the family Medicare Card. If not, remind the family to contact Medicare to address this.  If the Medicare IRN is incorrect, correct the Medicare Number and the IRN for the patient, and re-submit the record. |
| **See** | Section 3: Date of Birth  Medicare Number |

E090 Sex invalid

|  |  |
| --- | --- |
| Effect | REJECTION |
| Problem | A Sex value has not been reported or the value specified does not exist in the Sex code set. |
| Remedy | Allocate an appropriate Sex code and re-submit the record. |
| See | Section 3: Sex |

E092 Sex Indeterminate with Age Greater than or Equal to 90 Days

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | A Sex value of ‘3 – Indeterminate’ has been reported, but the calculated difference between the dates of Arrival and Birth gives the age at Arrival as 90 days or more. To be valid with a Sex code of ‘3’, the age of the patient must be less than 90 days. |
| **Remedy** | Check patient’s Sex, Arrival Date and Date of Birth, correct as appropriate and re-submit the record. |
| **See** | Section 2: Age  Section 3: Arrival date/time  Date of Birth  Sex |

E093 Sex Indeterminate and Age Less Than 90 Days

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | A Sex value of ‘3 – – Indeterminate’ has been reported. Although the patient is aged less than 90 days, this code is rare, and the patient’s record should be checked. |
| **Remedy** | Correct the Sex item if appropriate and re-submit the record |
| **See** | Section 2: Age  Section 3: Arrival date/time  Date of Birth  Sex  Section 5: Data Quality |

E095 Date of Birth invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Date of Birth is invalid; or is later than the patient’s Arrival Date. |
| **Remedy** | Verify and insert the appropriate Date of Birth and re-submit the record. |
| **See** | Section 2: Date/time fields  Section 3: Arrival Date  Arrival Time  Date of Birth |

E100 Country of Birth invalid

|  |  |
| --- | --- |
| Effect | REJECTION |
| Problem | A Country of Birth value has not been reported or the specified value does not exist in the Country of Birth code set. |
| Remedy | Check patient record and determine country of birth as precisely as possible.  Insert appropriate code from Country of Birth code set and re-submit record. |
| See | Section 3: Country of Birth  **HDSS Website:** Country of Birth codes: HDSS reference files |

E102 Unusual Country of Birth

|  |  |
| --- | --- |
| **Effect** | 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  1600 Antarctica, not further defined  1601 to 1607 Antarctica territories  3103 Holy See |
| **Remedy** | Check the patient’s Country of Birth, correct, if appropriate, re-submit the record.  If you have used ‘0002 Country of Birth not elsewhere classified’ because there is no code for the country, contact the HDSS Helpdesk. |
| **See** | Section 3: Country of Birth  **HDSS Website:** Country of Birth codes: HDSS reference files |

E103 Invalid combination of Date of Birth, Arrival Date and Country of Birth

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The Arrival Date and Date of Birth are the same but the person’s birthplace is not Country of Birth 1101 Australia.  It is rare that a baby not born in Australia would be treated in a Victorian Emergency Department on the day of birth. |
| **Remedy** | Check the Arrival Date, Date of Birth and Country of Birth data items; if necessary, correct as appropriate and re-submit the record. |
| **See** | Section 2: Date/time fields  Section 3: Arrival Date  Arrival Time  Country of Birth  Date of Birth  Section 5 Data Quality  **HDSS Website:** Country of Birth codes: HDSS reference files |

E105 Indigenous Status invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | An Indigenous Status value has not been reported or the value specified does not exist in the Indigenous Status code set. |
| **Remedy** | Allocate an appropriate Indigenous Status code and re-submit the record. |
| **See** | Section 3: Indigenous Status |

E107 Aboriginal or Torres Strait Islander Origin but Not Australian Born

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The Indigenous Status specified in this record indicates that the patient is of Aboriginal or Torres Strait Islander origin, but the Country of Birth is not a code specific to Australia (1100 – 1102, 1199).  It is unusual for Aboriginal or Torres Strait Islanders to have been born outside Australia. |
| **Remedy** | Check the Indigenous Status and the Country of Birth data items; if necessary, correct as appropriate and re-submit the record. |
| **See** | Section 3: Country of Birth  Indigenous Status |

E110 Preferred Language invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | A Preferred Language value has not been reported or the value specified does not exist in the Preferred Language code set.  Preferred Language is a mandatory data item for all emergency attendances. |
| **Remedy** | Allocate the appropriate Preferred Language code and re-submit the record. |
| **See** | Section 3: Country of Birth  Indigenous Status  HDSS website: Preferred Language reference table: reference files |

E115 Postcode/Locality combination invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Locality specified in the record does not match the reported Postcode as listed in the Locality / Postcode Reference File |
| **Remedy** | Check Postcode and Locality, correct as appropriate and re-submit the record. |
| **See** | Section 3: Locality  Postcode  Section 4: Locality / Postcode  **HDSS Website:** Postcode Locality File: HDSS reference files |

E125 Arrival Transport Mode invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | An Arrival Transport Mode has not been reported and the Service Type is 1- General Emergency Presentation; or the value specified does not exist in the Arrival Transport Mode code set. |
| **Remedy** | Allocate an appropriate Arrival Transport Mode and re-submit the record. |
| **See** | Section 3: Arrival Transport Mode |

E130 Referred By invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | A Referred By value has not been reported or the value specified does not exist in the Referred By code set. |
| **Remedy** | Allocate an appropriate Referred By code and re-submit the record. |
| **See** | Section 3: Referred by |

E135 Transfer Source Code invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Transfer Source reported in this record does not exist in the Transfer Source Reference Table. |
| **Remedy** | Check the Transfer Source reference table, correct Transfer Source code and re-submit the record. |
| **See** | Section 3: Transfer Source  **HDSS Website:** Campus Code Table: HDSS reference files |

E136 Referred By and Transfer Source combination invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The combination of the Referred By and Transfer Source (which indicates transfer from another hospital) data items is invalid.  Refer to Section 4 Business Rules-‘Referred by and Transfer Source’. |
| **Remedy** | If patient was transferred from another hospital or campus, correct the Transfer Source and re-submit the record.  If patient was not transferred from another hospital or campus, correct the ‘Referred By’ to appropriate code and re-submit the record. |
| **See** | Section 3: Referred By  Transfer source |

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 record. |
| **See** | Section 3: Campus Code  Transfer Destination  Transfer Source  Section 4: Transfer to Another Hospital  **HDSS Website:** Campus Code Table: HDSS reference files |

E140 Type of Visit invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | A Type of Visit value has not been reported or the value specified does not exist in the Type of Visit code set. |
| **Remedy** | Allocate an appropriate Type of Visit code and re-submit the record. |
| **See** | Section 3: Type of Visit |

E142 Dead on Arrival combination invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | At least one of the following fields indicates that the patient was dead on arrival, but at least one of the remaining fields indicates that the patient was NOT dead on arrival.  Affected Data Fields   * Arrival Transport Mode * Departure Status * Diagnosis - Primary * Referred to on Departure * Triage Category * Type of Visit   Refer to Section 4 Business Rules -‘Dead on Arrival’. |
| **Remedy** | Ensure that all the fields listed above are accurate, correct any errors and re-submit the record. |
| **See** | Section 3: Type of Visit |

E145 Compensable Status invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | A Compensable Status value has not been reported or the value specified does not exist in the Compensable Status code set. |
| **Remedy** | Allocate an appropriate Compensable Status code and re-submit the record. |
| **See** | Section 3: Compensable Status |

E155 Arrival Date / Time invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | An Arrival date/time has not been reported or the date/time specified is in an invalid format. |
| **Remedy** | Allocate an appropriate Arrival Date and re-submit the record. |
| **See** | Section 2: Date/time fields  Section 3: Arrival date/time |

E165 Triage date/time invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Triage date/time has not been reported or the date/time specified is in an invalid format. |
| **Remedy** | Allocate the correct Triage date/time and re-submit the record. |
| **See** | Section 2: Date/time fields  Section 3: Triage date/time |

E167 Triage date/time before Arrival date/time

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Triage date/time specified in this record is earlier than the Arrival date/time.  The Triage date/time must be equal to or greater than the Arrival date/time. |
| **Remedy** | Check Triage and Arrival date/time, correct as appropriate and re-submit record. |
| **See** | Section 3: Arrival date/time, Triage date/time |

E175 Triage Category invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | A Triage Category value has not been reported or the value specified does not exist in the Triage Category code set. |
| **Remedy** | Allocate an appropriate Triage Category code and re-submit the record. |
| **See** | Section 3: Triage Category |

E180 Nurse Initiation of Patient Management date/time invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | Nurse Initiation of Patient Management date/time reported is not valid |
| **Remedy** | Correct Nurse Initiation of Patient Management date/time and re-submit the record.  Refer to Section 4 Business Rules -‘Left without Treatment’ |
| **See** | Section 2: Date/time fields  Section 3: Nurse Initiation of Patient Management  date/time |

E181 Nurse Initiation of Patient Management date/time before Triage date/time

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Nurse Initiation of Patient Management date/time reported is earlier than the Triage date/time.  The Nurse Initiation of Patient Management date/time must be equal to or greater than the Triage date/time. |
| **Remedy** | Check dates and times of Nurse Initiation of Patient Management and Triage, correct as appropriate and re-submit the record. |
| **See** | Section 3: Triage date/time  Nurse Initiation of Patient Management  date/time |

E182 First Seen By Treating Clinician date/time and Departure Status combination invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | This record has an invalid combination of Clinician date/time and Departure Status value. Clinician date/time fields include:   * First Seen by Doctor * Seen by Mental Health Practitioner * Nurse Initiation of Patient Management.   Refer to Section 4 Business Rules -‘Clinician Date / Time and Departure Status’. |
| **Remedy** | Correct as appropriate and resubmit. |
| **See** | Section 3: First Seen by Treating Clinician, Departure Status  Section 4: Clinician date/time and Departure Status |

E195 First Seen By Doctor date/time invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The First Seen by Doctor date/time reported in this record is not valid. |
| **Remedy** | Correct First Seen by Doctor date/time and re-submit the record. |
| **See** | Section 3: First Seen by Doctor date/time |

E196 First Seen By Doctor date/time before Triage date/time

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The First Seen By Doctor date/time reported in this record is earlier than the Triage date/time. |
| **Remedy** | Check dates/times of First Seen By Doctor and Triage, correct as appropriate and re-submit the record. |
| **See** | Section 2 Triage  Section 3 First Seen By Doctor date/time  Triage date/time |

E210 Departure Date / Time invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | A Departure date/time has not been reported or is invalid. |
| **Remedy** | Allocate an appropriate Departure date/time and re-submit the record. |
| **See** | Section 3: Departure date/time |

E212 Departure date/time before Nurse Initiation of Patient Management date/time

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure date/time reported is earlier than the Nurse Initiation of Patient Management date/time. |
| **Remedy** | Check dates and time of the Nurse Initiation of Patient Management and Departure, correct as appropriate and re-submit the record. |
| **See** | Section 3: Nurse Initiation of Patient Management  date/time |

E213 Departure date/time before First Seen by Doctor date/time

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure date/time reported in this record is earlier than the First Seen By Treating Doctor date/time. |
| **Remedy** | Check date/time of First Seen By Doctor and Departure, correct as appropriate and re-submit the record. |
| **See** | Section 3: First Seen by Doctor date/time  Departure date/time |

E217 Departure Date Conflicts with VEMD File Name

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure Date is before or after the month specified in the VEMD file name. |
| **Remedy** | If Departure Date is correct, re-submit the record in the correct month. Monthly submissions should only contain records for patients who depart in the month specified in the VEMD file name.  For example:  If a patient arrives at 11:59pm on 31st July and departs at 1:15am on 1st August, the record should be submitted in the August file and not the July file.  If Departure Date is incorrect, correct item, re-submit in correct month. |
| **See** | Section 2: Date/time fields  Section 3: Departure date/time  Section 5: Period of Extract |

E219 Length of Stay Greater Than 10 Days

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The calculated difference between the Arrival Date and Departure Date gives a Length of Stay greater than 10 days. |
| **Remedy** | Check the Arrival and Departure Dates correct any erroneous items and re-submit the record. If the Arrival and Departure dates are correct, contact the HDSS Helpdesk. |
| **See** | Section 2: Date/time fields  Length of Stay (LOS)  Section 3: Arrival Date  Arrival Time  Departure Date  Departure Time |

E230 Departure Status invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | A Departure Status value has not been reported or the value specified does not exist in the Departure Status code set. |
| **Remedy** | Allocate an appropriate Departure Status and re-submit the record |
| **See** | Section 3: Referred to on Departure  Dead on Arrival  Section 4: Left without Treatment  Transfer to Another Hospital |

E233 Unregistered Short Stay Observation Unit

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure Status is reported as ‘3 – Registered Short Stay Observation Unit’, but the Campus Code entered does not have a registered SOU with Department of Health. |
| **Remedy** | Check the Departure Status, correct as appropriate and re-submit the record. If departure status is correct contact the HDSS Helpdesk. |
| **See** | Section 2: Short Stay Observation Unit  Campus  Section 3: Campus Code  Departure Status |

E235 Transfer Destination Code invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Transfer Destination code reported does not exist in the Hospital Code table. |
| **Remedy** | Correct Transfer Destination code and re-submit the record. |
| **See** | Section 2: Transfer Destination  Section 4: Transfer to Another Hospital Campus  **HDSS Website:** campus code Table: HDSS reference files |

E240 Referred to on Departure invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | A Referred to on Departure value has not been reported or the value specified does not exist in the Referred to on Departure code set. |
| **Remedy** | Allocate an appropriate Referred to on Departure code and re-submit the record. |
| **See** | Section 3: Referred to on Departure  Dead on Arrival  Section 4: Left without Treatment  Transfer to Another Hospital |

E242 Referred to on Departure and Departure Status combination invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The combination of values in the Referred to on Departure and Departure Status fields is invalid. |
| **Remedy** | Refer to Section 4: Business Rules Departure Status and Referred to on Departure for valid combinations of these data items.  Correct as appropriate and re-submit the record. |
| **See** | Section 3: Departure Status  Referred to on Departure |

E245 Reason for Transfer Code invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Reason for Transfer code reported does not exist in the Reason for Transfer code set. |
| **Remedy** | Correct the Reason for Transfer code and re-submit the record. |
| **See** | Section 3: Reason for Transfer  Section 4: Transfer to Another Hospital Campus |

E255 Departure Transport Mode invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure Transport Mode code reported does not exist in the Departure Transport Mode code set. |
| **Remedy** | Correct Departure Transport Mode code and re-submit the record. |
| **See** | Section 3: Departure Transport Mode  Section 4: Transfer to Another Hospital |

E260 Primary Diagnosis Blank

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Primary Diagnosis has not been specified in this record. |
| Remedy | Check Departure Status. If Departure Status does not equal:   * 10 – Left after clinical advice regarding treatment options * 11 – Left at own risk, without treatment * 30 – Left after clinical advice regarding treatment – Co-Located GP Clinic * T1 – Left at own risk without consultation, or * T2 – Left at own risk after consultation started.   allocate an appropriate Primary Diagnosis.  Primary Diagnosis is optional for Departure Status 10, 11, 30, T1, T2.  If the Departure Status is 31 – Mental Health and AOD Short Stay Unit and the patient has been treated by a clinician, then a Primary Diagnosis must be recorded.  Alternatively, correct the Departure Status and resubmit the record. |
| See | Section 2: Diagnosis  Section 3: Departure Status;  Diagnosis – Primary Diagnosis  Section 4: Dead on Arrival  Left without Treatment  Transfer to Another Hospital  Primary Diagnosis |

E261 Diagnosis Code invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Diagnosis code reported does not exist in the VEMD ICD–10–AM Library File; OR  The Diagnosis code format is not valid, e.g. it has a decimal point (.), forward slash or includes a space; OR  There is a blank Primary Diagnosis code, but Additional Diagnosis 1 and/or 2 is complete; OR  Primary Diagnosis is complete, Additional Diagnosis 1 is blank, but Additional Diagnosis 2 is complete. |
| **Remedy** | Check the Diagnosis Codes (Primary and Additional) and formatting and re-submit the record.  Contact software supplier to ensure that blank diagnoses are not transmitted to the VEMD. |
| **See** | Section 2: Diagnosis  Section 3: Diagnosis – Additional 1 and 2  Diagnosis – Primary Diagnosis  Section 4: Dead on Arrival  Left without Treatment |

E264 Diagnosis Code and Sex – Check

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | Diagnosis code(s) reported is unusual for the patient’s sex. |
| **Remedy** | Check code(s) and note validations in the VEMD Library File. If necessary, correct code(s) and re-submit the record.  Check the sex; if necessary, correct and re-submit the record. |

E265 Diagnosis Code and Age – Check

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | Diagnosis code(s) reported is unusual for the patient’s age (as calculated by subtracting Arrival Date from Date of Birth) |
| **Remedy** | Check code(s) (note VEMD Library File validations) and Date of Birth, if needed correct as necessary, and re-submit the record. |
| **See** | Section 2: Age  Date/time fields  Diagnosis  Section 3: Arrival date/time  Date of Birth  Diagnosis-Additional 1 and 2  Diagnosis-Primary  HDSS Website: VEMD ICD-10-AM Library File: HDSS reference files |

E281 Nature of Main Injury invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Nature of Main Injury code has not been reported or the value specified does not exist in the Nature of Main Injury code set.  Nature of Main Injury is a mandatory data item for all emergency attendances where any other Injury Surveillance items have been completed, except for presentations with a Departure Status of 10, 11, 30, T1 or T2. If Departure Status is 10, 11, 30, T1 or T2 record as many Injury Surveillance fields as were collected prior to the patient’s departure. |
| **Remedy** | If the attendance was due to an injury, allocate an appropriate Nature of Main Injury and re-submit the record. |
| **See** | Section 2: Injury Surveillance  Section 3: Nature of Main Injury  Section 4: Injury Surveillance  Left without Treatment  Nature of Main Injury and Body Region |

E286 Body Region Code invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Body Region code has not been reported or the value specified does not exist in the Body Region code set.  Body region is a mandatory data item for all emergency attendances where any other Injury Surveillance items have been completed, except for presentations with a Departure Status of 10, 11, 30, T1 or T2. If Departure Status is 10, 11, 30, T1 or T2 record as many Injury Surveillance fields as were collected prior to the patient’s departure. |
| **Remedy** | If the attendance was due to an injury, allocate an appropriate Body Region and re-submit the record.  If the attendance was not due to an injury, remove all Injury Surveillance items and re-submit. |
| **See** | Section 2: Injury Surveillance  Section 3: Body Region  Section 4: Injury Surveillance  Left without Treatment  Nature of Main Injury and Body Region |

E290 Description of Injury Event invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Description of Injury Event has not been reported or the value detailed in this record is not valid.  The Description of Injury Event item is a mandatory data item for all emergency attendances where any of the other Injury Surveillance items have been completed, except for presentations with a Departure Status of 10, 11, 30, T1 or T2. If Departure Status is 10, 11, 30, T1 or T2record as many Injury Surveillance fields as were collected prior to the patient’s departure.  The Description of Injury event must be less than or equal to 250 characters. |
| **Remedy** | If the attendance was due to an injury, allocate an appropriate Description of Injury Event and re-submit the record.  If the Description of Injury event is greater than 250 characters shorten the description and re-submit the record.  This problem should be remedied using in-house validation. Ensure your software supplier is notified of the problem and necessary corrections are made. |
| **See** | Section 2: Injury Surveillance  Section 3: Description of Injury Event  Section 4: Injury Surveillance. |

E295 Injury Cause Code invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Injury Cause code has not been reported or the value specified does not exist in the Injury Cause code set.  Injury Cause is a mandatory data item for all emergency attendances where any other Injury Surveillance items have been completed, except for presentations with a Departure Status of 10, 11, 30, T1 or T2. If Departure Status is 10, 11, 30, T1 or T2 record as many Injury Surveillance fields as were collected prior to the patient’s departure. |
| **Remedy** | If the attendance was due to an injury, allocate an appropriate Injury Cause and re-submit the record.  If the attendance was not due to an injury, remove all Injury Surveillance items and re-submit record. |
| **See** | Section 2: Injury Surveillance  Section 3: Injury Cause  Section 4: Injury Surveillance |

E297 Injury Cause Code and Age incompatible

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | There is an invalid combination of the Injury Cause code and the patient’s age (as calculated from subtracting Date of Birth from Arrival Date).  The Injury Cause is ‘1 - Motor Vehicle driver’, or ‘3 - Motorcycle driver’, but the patient’s age is less than 14 years. |
| **Remedy** | Check Injury Cause code and Date of Birth, correct if appropriate and re-submit the record. |
| **See** | Section 2: Age  Section 3: Arrival Date  Arrival Time  Date of Birth  Injury Cause  Section 4: Injury Surveillance |

E300 Human Intent Code invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Human Intent code has not been reported or the value specified does not exist in the Human Intent code set.  Human Intent is a mandatory data item for all emergency attendances where any other Injury Surveillance items have been completed, except for presentations with a Departure Status of 10, 11, 30, T1 or T2. If Departure Status is 10, 11, 30, T1 or T2 record as many Injury Surveillance fields as were collected prior to the patient’s departure. |
| **Remedy** | If the attendance was due to an injury, allocate an appropriate Human Intent code and re-submit the record.  If the attendance was not due to an injury, remove all Injury Surveillance items and re-submit record. |
| **See** | Section 2: Injury Surveillance  Section 3: Human Intent  Section 4: Injury Surveillance |

E302 Human Intent Code and Age incompatible

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | There is an invalid combination of the Human Intent code and the patient’s age (as calculated from subtracting Date of Birth from Arrival Date).  If Human Intent is:  18-Intentional self-harm – non-suicidal self-injury, OR  19-Intentional self-harm – suicide attempt, OR  20-Intentional self-harm, suicidal intent cannot be determined;  Age should be greater than 10 years.  Age is calculated as [Arrival date/time] minus [Date of Birth]. |
| **Remedy** | Check Human Intent code and Date of Birth, correct as appropriate and re-submit the record. |
| **See** | Section 2: Age  Section 3: Arrival Date  Arrival Time  Date of Birth  Human Intent  Section 4: Injury Surveillance |

E305 Place Where Injury Occurred invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Place Where Injury Occurred code has not been reported or the value specified does not exist in the Place Where Injury Occurred code set.  Place Where Injury Occurred is a mandatory data item for all emergency attendances where any other Injury Surveillance items have been completed, except for presentations with a Departure Status of 10, 11, 30 or T1 If Departure Status is 10, 11, 30, or T1 record as many Injury Surveillance fields as were collected prior to the patient’s departure. |
| **Remedy** | If the attendance was due to an injury, allocate an appropriate Place Where Injury Occurred and re-submit the record.  If the attendance was not due to an injury, remove all Injury Surveillance items and re-submit record. |
| **See** | Section 3: Place Where Injury Occurred  Section 4: Injury Surveillance |

E310 Activity When Injured Code invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Activity When Injured code has not been reported or the value specified does not exist in the Activity When Injured code set.  Activity When Injured is a mandatory data item for all emergency attendances if any other Injury Surveillance items have been completed, except for presentations with a Departure Status of 10, 11, 30, T1 or T2. If Departure Status is 10, 11, 30, T1 or T2 record as many Injury Surveillance fields as were collected prior to the patient’s departure. |
| **Remedy** | If the attendance was due to an injury, allocate an appropriate Place Where Injury Occurred and re-submit the record.  If the attendance was not due to an injury, remove all Injury Surveillance items and re-submit record. |
| **See** | Section 3: Place Where Injury Occurred  Section 4: Injury Surveillance |

E320 Nature of Main Injury/Body Region/Primary Diagnosis combination invalid

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | Nature of Main Injury, Body Region and Primary Diagnosis do not correspond according to the Nature of Main Injury/Body Region Matrix Editing Tables |
| **Remedy** | Check Body Region Matrix; correct as appropriate, re-submit the record. |
| **See** | Section 3: Body Region  Diagnosis – Primary Diagnosis  Nature of Main Injury  Section 4: Injury Surveillance  Nature of Main Injury and Body Region |

E340 Departure date/time Less Than or Equal to Arrival date/time

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure Date specified in this record is earlier than the Arrival Date; OR  The record’s Departure Date equals the Arrival Date, but the Departure Time is equal to or less than the Arrival Time. |
| **Remedy** | The Departure Date must be a date equal to or later than the Arrival Date.  If the Arrival and Departure Date items are the same, the Departure Time must be later than the Arrival Time (i.e. Total Length of Stay cannot be less than one minute).  Confirm Arrival and Departure Dates and Times, correct as appropriate and re-submit the record. |
| **See** | Section 3: Arrival Date  Arrival Time  Departure Date  Departure Time |

E341 Primary Diagnosis Equals ‘Z099’ but Additional Diagnosis Blank

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Primary Diagnosis code in this record is ‘Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment’ but the Additional Diagnosis Code is blank.  An Additional Diagnosis code is a mandatory data item for all emergency attendances with a Primary Diagnosis of ‘Z099’. |
| **Remedy** | Allocate the appropriate Additional Diagnosis code to identify the condition under review during this emergency attendance. |
| **See** | Section 3: Diagnosis – Additional Diagnosis 1 and 2  Diagnosis – Primary Diagnosis  Section 4: Primary Diagnosis |

E342 Primary Diagnosis and Departure Status combination invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | This record has an invalid combination of Departure Status and Primary Diagnosis.  Refer to Section 4 Business Rules: Primary Diagnosis. |
| **Remedy** | Ensure that the recorded Departure Status is correct. Correct any Diagnosis Codes and re-submit the record. |
| **See** | Section 3: Departure Status  Diagnosis – Primary Diagnosis  Section 4: Primary Diagnosis  Left without Treatment |

E350 Length of Stay Greater Than 4 and Less Than 10 Days

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The calculated difference between the Arrival date/time and Departure date/time gives a Length of Stay greater than 4 days but less than 10 days. |
| **Remedy** | Check the Arrival and Departure date/times, correct any erroneous items and re-submit the record. |
| **See** | Section 2: Length of Stay (LOS)  Section 3: Arrival Date  Arrival Time  Departure Date  Departure Time  Section 5: Data Quality |

E351 Potentially Excessive Time to Initiation of Patient Management

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The Time to Treatment exceeds the value for the corresponding Triage category in the following table:  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 Initiation of Patient Management is correct.  The following fields require investigation and possible corrective action:   * Arrival date/time * Nurse Initiation of Patient Management date/time * First Seen by Doctor date/time, * Seen by Mental Health Practitioner date/time, * Triage Category   Correct and resubmit as required. |
| **See** | Section 2: Time to Initiation of Patient Management |

E354 Type of Usual Accommodation invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | A Type of Usual Accommodation value has not been reported or the value specified does not exist in the Type of Usual Accommodation code set. |
| **Remedy** | Correct as appropriate and re transmit. |
| **See** | Section 3: Type of Usual Accommodation |

E355 Type of Usual Accommodation and Age combination invalid

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | A Type of Usual Accommodation value of ‘1 – Private Residence, living alone’ or ‘3 – Residential aged care facility has been reported in this record: however, the age of the patient is calculated as less than 15 years.  It is unlikely that a child aged 15 years or under would be living in either of these accommodation types. |
| **Remedy** | If the data reported is incorrect, correct the appropriate data field and re-submit the record. |
| **See** | Section 2: Age  Section 3: Arrival date/time  Date of Birth  Type of Usual Accommodation |

E356 Type of Usual Accommodation and Departure Status combination invalid

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The record’s Type of Usual Accommodation is ‘11 – Prison/Remand Centre/Youth Training Centre’ but the Departure Status is 5, 10, 11, 23, 24, 30, T1, or T2. |
| **Remedy** | Correct as appropriate and resubmit. |
| **See** | Section 3: Departure Status  Type of Usual Accommodation |

E357 Type of Usual Accommodation and Medicare Suffix combination invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The record’s Type of Usual Accommodation is ‘11 – Prison/Remand Centre/Youth Training Centre’ but the Medicare Suffix is not ‘P-N’. |
| **Remedy** | Correct as appropriate and re transmit. |
| **See** | Section 2: Medicare Eligibility Status  Section 3: Medicare Suffix  Type of Usual Accommodation |

E358 Interpreter Required invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | An Interpreter Required value has not been reported or the value specified does not exist in the Interpreter Required code set. |
| **Remedy** | Correct as appropriate and re transmit. |
| **See** | Section 3: Interpreter Required |

E359 Interpreter Required /Preferred Language combination invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The record has an invalid combination of Interpreter Required and Preferred Language. |
| **Remedy** | Correct as appropriate and re transmit. |
| **See** | Section 3: Interpreter Required  Preferred Language  HDSS Website: Preferred Language ASCL Codeset: HDSS reference files |

E360 Indigenous Status / Preferred Language Mismatch

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | Indigenous Status (1, 2 or 3) indicates a person of Aboriginal or Torres Strait Islander origin but Preferred Language is not in the code set of languages commonly associated with indigenous status. |
| **Remedy** | Check the Indigenous Status and Preferred Language values, correct any errors and re-submit the record. |
| **See** | Section 3: Indigenous Status  Preferred Language  Section 5: Data Quality  HDSS Website: Preferred Language ASCL Codeset: HDSS reference files |

E361 Preferred Language is Unspecified

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | Preferred Language indicates unspecified status (9000, 0000, 0002). |
| **Remedy** | Check Preferred Language, amend as appropriate if necessary, and re transmit the record. |
| **See** | Section 3: Preferred Language  Section 5: Data Quality  HDSS Website: Preferred Language ASCL Codeset: HDSS reference files |

E364 Medicare Last Digit Zero; Suffix Not ‘BAB’

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The Medicare Number’s final digit, Medicare individual reference number (IRN), is zero (indicating the patient is not yet included on the family’s Medicare card) but the Medicare Suffix is not ‘BAB - Unnamed neonate’. |
| **Remedy** | Check Medicare Number and Medicare Suffix, amend as appropriate if necessary, and re transmit. If the baby is named, he/she should be registered with Medicare. |
| **See** | Section 2: Medicare Eligibility Status  Section 3: Medicare Number  Medicare Suffix |

E366 Departure Status and Triage Category combination invalid

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The records Departure Status is either:   * 10 - Left after clinical advice regarding treatment options * 11 - Left at own risk, without treatment * 30 - Left after clinical advice regarding treatment options – GP Co-Located clinic * T1 - Left at own risk without consultation * T2 - left at won risk after consultation started * T3 - Referred to GP * T4 - Discharged to usual residence * T5 - Transferred to ward setting * T6 - Transferred to another health service, or * T7 - Recommended for transfer to Telehealth Emergency Department campus   but the patient has a Triage Category of ‘1 – Resuscitation’. |
| **Remedy** | Check Departure Status, Triage Category and amend as appropriate if necessary, and re transmit. |
| **See** | Section 3: Departure Status  Triage Category  Section 4: Left without Treatment |

E370 Sex Code ‘Other’ – Check

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | This record’s Sex is ‘4 Other’, the patient’s record should be checked. |
| **Remedy** | Correct the Sex item if appropriate and re-submit the record. |
| **See** | Section 3: Sex |

E371 Transfer Source equals ‘9999 – Unknown’

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The Transfer Source reported in this record is ‘9999 – Unknown’ |
| **Remedy** | Confirm the Transfer Source, check the Transfer Source reference table, correct Transfer Source code and re-submit the record.  If the Transfer Source is unknown, contact HDSS Helpdesk. |
| **See** | See Section 3 Transfer Source  HDSS Website: Hospital Code Table at: HDSS reference files |

E372 Age invalid

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The age of this patient is more than 105 years.  Age is calculated as: Arrival Date minus Date of Birth. |
| **Remedy** | Check Arrival Date and Time, Date of Birth. Correct, if appropriate, and re-submit. |
| **See** | Section 2: Date/time fields  Section 3: Arrival Date  Arrival Time  Date of Birth  Section 5: Data Quality |

E373 Seen By Mental Health Practitioner date/time before Arrival date/time

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Seen By Mental Health Practitioner date/time reported is earlier than the Arrival date/time. Either or both date/times may be incorrect.  The Seen By Mental Health Practitioner date/time must be equal to or greater than the Arrival date/time. |
| **Remedy** | Check dates and times for   * Seen By Mental Health Practitioner, and * Arrival   Correct as appropriate and re-submit the record. |
| **See** | Section 3: Seen by Mental Health Practitioner  Arrival Date  Arrival Time |

E374 Departure date/time before Seen By Mental Health Practitioner date/time

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The Departure date/time reported in this record is earlier than the Seen By Mental Health Practitioner date/time. Either or both date/times may be incorrect. |
| **Remedy** | Check date/times for:   * Seen By Mental Health Practitioner * Departure |
| **See** | Section 3: Seen by Mental Health Practitioner date/time  Departure date/time |

E375 Seen By Mental Health Practitioner date/time invalid

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Seen by Mental Health Practitioner date/time reported in this record is not valid. |
| **Remedy** | Correct Seen by Mental Health Practitioner date/time and re-submit the record. |
| **See** | Section 3: Seen by Mental Health Practitioner date/time |

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 DH. |
| **Remedy** | Check the Departure Status, correct as appropriate and re-submit the record.  If you believe the campus drives have a registered MAPU please contact HDSS Helpdesk. |
| **See** | Section 2: Medical Assessment and Planning Unit  Section 3: Departure Status |

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 DH. |
| **Remedy** | Check the Departure Status, correct as appropriate and re-submit the record.  If you believe the campus does have an approved ICU contact the HDSS Helpdesk. |
| **See** | Section 2: Intensive Care Unit  Section 3: Departure Status |

E378 Unregistered Coronary Care Unit

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure Status is reported as 22 – Coronary Care Unit, but the campus does not have a CCU approved by DH |
| **Remedy** | Check the Departure Status, correct as appropriate and re-submit the record.  If you believe the campus does have an approved CCU contact the HDSS Helpdesk. |
| **See** | Section 2: Cardiac/Coronary Care Unit  Section 3: Departure Status |

E382 Unregistered MH Obs/Assess Unit

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure Status is reported as 25 – Mental Health Observation/Assessment Unit, but the reported Campus does not have a registered Mental Health Observation Assessment Unit, Psychiatric Assessment and Planning Unit or other similar registered unit. |
| **Remedy** | Check the Departure Status, correct as appropriate and re-submit the record.  If you believe the campus does have a registered MH Observation Assessment Unit, Psychiatric Assessment and Planning Unit or other similar requested unit contact the HDSS Helpdesk. |
| **See** | Section 3: Departure Status |

E383 Invalid Date of Birth Accuracy code

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | This record’s Date of Birth Accuracy code is null or invalid. |
| **Remedy** | Check Date of Birth Accuracy for valid format and values. |
| **See** | Section 3: Date of Birth  Date of Birth Accuracy Code |

E384 Campus does not have a designated GP Co-Located Clinic

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure Status is reported as 30 – Left after clinical advice regarding treatment options – GP Co-Located Clinic, but the reported Campus does not have a designated GP Co-Located GP Clinic. |
| **Remedy** | Check the Departure Status, correct as appropriate and re-submit the record. |
| **See** | Section 3: Departure status |

E385 Potentially excessive Length of Stay in ED

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The Length of Stay (LOS) in the Emergency Department for this record is calculated as greater than 24 hours. Length of Stay is a derived item calculated as [Departure date/time] minus [Arrival date/time]. |
| **Remedy** | Check documentation to determine whether the LOS is correct. The following fields require investigation:   * Arrival date/time * Departure date/time   If accurate, no further action is required.  If not accurate, correct and resubmit |
| **See** | Section 2: Date/Time fields  Length of Stay  Section 3 Arrival date/time  Departure Date/time |

E386 Unexpected combination between Triage Category and Type of Visit

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | A presentation with Triage Category 1 or 2 has been reported with a Type of Visit of:  2 – Return Visit Planned  8 – Pre-arranged admission – clerical, nursing, clinical  These combinations are unlikely and require further investigation. |
| **Remedy** | Correct as appropriate and retransmit. |
| **See** | Section 2: Triage  Section 3 Triage Category  Type of Visit |

E387 Triage date/time after Departure date/time

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Triage date/time specified in this record is later than the Departure date/time.  The Triage date/time cannot be greater than the Departure date/time. |
| **Remedy** | Check Triage and Departure date/time, correct as appropriate and re-submit the record. |
| **See** | Section 2: Triage  Section 3 Departure date/time  Triage date/time |

E388 Seen By Mental Health Practitioner before Triage date/time

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Seen by Mental Health Practitioner date/time reported in this record is earlier than the Triage date/time |
| **Remedy** | Check dates/times of Seen by Mental Health Practitioner and Triage. Correct as appropriate and re-submit the record. |
| **See** | Section 3 Seen by Mental Health Practitioner date/time  Triage date/time |

E389 Triage Category 1 patient - Excessive Time to Initiation of Patient Management

|  |  |
| --- | --- |
| **Effect** | NOTIFIABLE |
| **Problem** | This presentation is reported as Triage Category 1 and the Time to Treatment (in minutes) exceeds 1 minute |
| **Remedy** | Check documentation to determine whether the Triage Category reported is correct. Check documentation to determine whether Arrival date/time and First Seen By date/times are correct. The following fields require investigation and possible corrective action:   * Arrival date/time * Nurse Initiation of Patient Management date/time * First Seen by Doctor date/time, * Seen by Mental Health Practitioner date/time, * Triage Category   Correct and resubmit as required or notify DH immediately. |
| **See** | Section 2: Time to Initiation of Patient Management |

E390 Additional Diagnosis 1 or 2 equals ‘Z099’

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | Code Z099 – Attendance for Follow-up (includes injections)/Review following earlier treatment’ is reported in either of the Additional Diagnosis 1 or 2 fields.  Code Z099 can only be reported in the Primary Diagnosis field. |
| **Remedy** | Correct and resubmit. |
| **See** | Section 3: Diagnosis – Additional Diagnosis 1 and 2  Diagnosis-Primary  Section 4: Primary Diagnosis |

E391 The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements

|  |  |
| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Primary Diagnosis contains an injury (‘S’ or ‘T’) code which is flagged in the VEMD Editing Matrix as requiring mandatory completion of all injury surveillance items, but at least one of these elements is missing or invalid. |
| **Remedy** | Check Injury Surveillance fields and Primary Diagnosis; correct as appropriate, re-submit the record. |
| **See** | Section 2: Diagnosis  Injury Surveillance  Section 3: Diagnosis-Primary Diagnosis  Activity when Injured  Body Region  Description of Main Injury Event  Human Intent  Injury Cause  Nature of Main Injury  Place where Injury occurred  Section 4: Injury Surveillance |

E392 Invalid Ambulance Case Number

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | The Ambulance Case Number is in an invalid format |
| **Remedy** | Correct and resubmit |
| **See** | Section 3: Ambulance Case Number Activity when Injured |

E393 Clinical Decision to Admit date/time and Departure Status combination invalid

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| --- | --- |
| **Effect** | WARNING |
| **Problem** | Departure Status is 3, 14, 15, 18, 22, 25, 26, 27, 28, 31 but no Clinical Decision to Admit date/time has been recorded. |
| **Remedy** | Check Departure Status and Clinical Decision to Admit fields, correct as appropriate and re-submit the record. |
| **See** | Section 2: Date/time fields  Section 3: Departure Status  Clinical Decision to Admit date/time |

E394 Departure date/time Before Clinical Decision to Admit date/time

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure date/time reported in this record is earlier than the Clinical Decision to Admit date/time. |
| **Remedy** | Check date/time of Clinical Decision to Admit and Departure, correct as appropriate and re-submit the record. |
| **See** | Section 3: Departure date/time  Clinical Decision to Admit date/time |

E395 Clinical Decision to Admit date/time Before Arrival date/time

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Clinical Decision to Admit date/time reported is earlier than the Arrival date/time. |
| **Remedy** | Check date/time of Clinical Decision to Admit and Arrival, correct as appropriate and re-submit the record. |
| **See** | Section 3: Departure date/time  Clinical Decision to Admit date/time |

E396 Clinical Decision to Admit date/time invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Clinical Decision to Admit date/time is not valid. |
| **Remedy** | Correct Clinical Decision to Admit date/time and re-submit the record. |
| **See** | Section 3: Clinical Decision to Admit date/time |

E397 Ambulance at Destination date/time and Arrival Transport Mode invalid

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| --- | --- |
| **Effect** | WARNING |
| **Problem** | Either:   * Arrival Transport Mode is 1, 2, 3, 10 or 11 and Ambulance at Destination Date and/or Time is blank; OR * Arrival Transport Mode is NOT 1, 2, 3, 10 or 11 and Ambulance at Destination Date and/or Time is present |
| **Remedy** | Check whether patient arrived by Ambulance.   * If the patient did arrive by Ambulance (Arrival Transport Mode 1, 2, 3, 10 or 11) valid Ambulance at Destination Date and Ambulance at Destination Time must be submitted. * If the patient did not arrive by Ambulance, ensure the Ambulance at Destination Date and Ambulance at Destination Time are blank |
| **See** | Section 3: Ambulance at Destination date/time  Arrival Transport Mode |

E398 Ambulance at Destination date/time invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Ambulance at Destination date/time specified is in an invalid format. |
| **Remedy** | * Correct and re-submit the record. |
| **See** | Section 2: Date/time fields  Section 3: Ambulance at Destination date/time |

E399 Ambulance Handover Complete date/time invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Ambulance Handover Complete date/time specified is in an invalid format. |
| **Remedy** | Correct and re-submit the record. |
| **See** | Section 2: Date/time fields  Section 3: Ambulance at Handover date/time |

E400 Triage date/time before Ambulance at Destination date/time

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Ambulance at Destination date/time specified in this record is later than the Triage date/time  The Ambulance at Destination date/time cannot be greater than the Triage date/time. |
| **Remedy** | Check Triage date/time and Ambulance at Destination date/time, correct as appropriate and re-submit the record. |
| **See** | Section 3: Ambulance at Destination date/time  Triage date/time |

E401 Ambulance Handover Complete date/time and Arrival Transport Mode combination invalid

|  |  |
| --- | --- |
| **Effect** | WARNING |
| **Problem** | Either:  Arrival Transport Mode is 1, 2, 3, 10 or 11 and Ambulance Handover Complete Date and/or Time is blank; OR  Arrival Transport Mode is NOT 1, 2, 3, 10 or 11 and Ambulance Handover Complete Date and/or Time is present. |
| **Remedy** | If the patient arrived by ambulance, Arrival Transport Mode must be 1, 2, 3, 10 or 11 and valid Ambulance Handover Complete Date and Time must be submitted.  If the patient did not arrive by ambulance, ensure the Ambulance Handover Complete Date and Time are blank |
| **See** | Section 3: Ambulance Handover Complete date/time  Arrival Transport Mode |

E402 Ambulance Handover Complete date/time before Triage date/time

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Ambulance Handover Complete date/time specified in this record is before the Triage date/time  The Ambulance Handover Complete date/time cannot be before the Triage date/time. |
| **Remedy** | Check Ambulance Handover Complete date/time and Triage date/time, correct as appropriate and re-submit the record. |
| **See** | Section 3: Ambulance Handover Complete date/time  Triage Date/Time |

E403 Ambulance Handover Complete date/time after Departure date/time

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| --- | --- |
| **Effect** | WARNING |
| **Problem** | The Ambulance Handover Complete date/time specified in this record is later than the Departure date/time  The Ambulance Handover Complete date/time will usually not be greater than the Departure date/time. |
| **Remedy** | Check Ambulance Handover Complete date/time and Departure date/time, correct as appropriate and re-submit the record. |
| **See** | Section 3: Ambulance Handover Complete date/time  Departure date/time |

E404 Compensable Status and Given Name combination invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The campus is public and either:   * Compensable Status is ‘2 - Department of Veterans’ Affairs’, but there is no valid Given Name; OR * The Compensable Status code is not ‘2 - Department of Veterans’ Affairs’, but a Given Name is reported.   A Given Name must only be reported for each DVA compensable patient. |
| **Remedy** | Check whether patient is DVA compensable.  If the patient is DVA, the compensable status must be ‘2’ and a valid Given Name must be submitted.  If the patient is not a DVA patient, correct the Compensable Status and ensure the Given Name is blank. |
| **See** | Section 3: Compensable Status  Given Name |

E405 Compensable Status and Family Name combination invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The campus is public and either:   * Compensable Status is ‘2 - Department of Veterans’ Affairs’, but there is no Family Name; OR * The Compensable Status code is not ‘2 - Department of Veterans’ Affairs’, but a Family Name is reported.   A Family Name must only be reported for each DVA compensable patient. |
| **Remedy** | Check whether patient is DVA compensable.  If the patient is DVA, the compensable status must be ‘2’ and a valid Given Name must be submitted.  If the patient is not a DVA patient, correct the Compensable Status and ensure the Given Name is blank. |
| **See** | Section 3: Compensable Status  Family Name |

E406 Advance Care Directive Alert invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | Triage Category is 1, 2, 3, 4 or 5 and Advance Care Directive Alert has not been reported, or the value specified does not exist in the Advance Care Directive Alert code set |
| **Remedy** | Allocate an appropriate Advance Care Directive Alert code and re-submit the record. |
| **See** | Section 3: Advance Care Directive Alert |

E407 Ambulance at Destination date/time and Departure date/time invalid combination

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | Ambulance at Destination date/time is after Departure date/time, OR  Ambulance at Destination date/time is more than 10 days before Departure date/time |
| **Remedy** | Correct and re-submit the record. |
| **See** | Section 2: Date/time fields  Section 3: Ambulance at Destination date/time  Departure date/time |

E408 Patient Location invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Patient Location value specified does not exist in the Patient Location code set. |
| **Remedy** | Check the Patient Location, correct as appropriate and re-submit the record. |
| **See** | Section 3: Patient Location |

E409 Patient Location and Service Type combination invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The service type is 2 - Telehealth and the patient location is blank OR:  The service type is not 2 and the patient location is not blank. |
| **Remedy** | Check the Patient Location, correct as appropriate and re-submit the record. |
| **See** | Section 2: Telehealth  Section 3: Patient Location, Service Type |

E410 Service Type invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Service Type value specified does not exist in the Service Type code set. |
| **Remedy** | Check the Service Type code, correct as appropriate and re-submit the record. |
| **See** | Section 2: Telehealth  Section 3: Service Type |

E411 Departure Status and Service Type combination invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure Status code is:   * T% and the service type is not 2 - Telehealth, OR * Not T% and the service type is 2 - Telehealth |
| **Remedy** | Check the Service Type and Departure Status, correct as appropriate and re-submit the record. |
| **See** | Section 3: Departure Status, Service Type |

E412 Unregistered Mental Health and AOD Hub

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Departure Status value specified is 31 - Mental Health and AOD Hub Short Stay Unit, but the Campus does not have an approved Mental Health and AOD Hub Short Stay Unit.T6, or T7 and the Service Type value is 2 - Telehealth |
| **Remedy** | Check the Departure Status, correct as appropriate and re-submit the record. |
| **See** | Section 3: Departure Status |

E413 Ambulance Handover date/time and Departure date/time invalid

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| --- | --- |
| **Effect** | REJECTION |
| **Problem** | The Ambulance Handover Complete date/time is more than 24 hours after the Departure date/time OR Ambulance Handover Complete date/time is more than 10 days before Departure date/time |
| **Remedy** | Check the Ambulance Handover Completed date/time and the Departure date/time. Correct and re-submit the record. |
| **See** | Section 2: Date/time fields  Ambulance Handover Complete  Section 3: Ambulance Handover Complete date/time  Departure date/time |