Emergency Department Data Collection

Data Elements

Reference Manual
2019-2020

For Official Use Only-I1-A1

Government of South Australia
SA Health

Table of Contents

.

Document Control Information

Title:	Emergency Department: Data Elements: Reference Manual 2019-2020
Description:	This document describes the data elements used in the Emergency Department data collection.
Version	1.0
Version Date	14-Jan-2020
Document Owner:	Susan Sander: Senior Manager, Corporate Data Collection Systems
Contributors:	Damien Bourke: Data Steward Team Leader Georgia Lefty: Senior Project Officer Andrea Gregori: Data Steward Team Leader
Document Location:	\\dhgsf02\ims\Knowledge Management\Enterprise Information Services\CDCS\1 July Process\2019\02 EDDC\06 Manual
Document Classification	For Official Use Only-I1-A1

Change History

A printed version of this document may have been superseded. The current version of this document can be accessed via the project site document library in Project Server.

Document Version	Date	Updated By	Change Summary
0.1	01-May-2019	Damien Bourke: Data Steward Team Leader	Initial version
0.2	13-Nov-2019	Andrea Gregori: Data Steward Team Leader	Updates throughout to show current standard
0.3	07-Jan-2020	Andrea Gregori: Data Steward Team Leader	CDCS review
1.0	14-Jan-2020	Susan Sander: Senior Manager, Corporate Data Collection Systems	Final

Approvals

This document is approved on the basis that it meets the following acceptance criteria.

Document Endorsement

This document requires the following endorsement:

Version	Date	Name	Endorsed Yes/No?	Signature
1.0	14-Jan-2020	Susan Sander: Senior Manager, Corporate Data Collection Systems	Yes	SQS

Introduction

Purpose

The Emergency Department Data Collection (EDDC) contains state-wide data about patients presenting to public hospitals.

It provides SA Health with the information necessary to effectively fund, organise, evaluate, and plan health services in South Australia.

EDDC data also allows SA Health to meet national obligations through submissions to the Australian Institute of Health and Welfare (AIHW), the Independent Hospital Pricing Authority (IHPA), the National Health Performance Authority (NHPA) and the National Health Funding Body (NHFB).

The purpose of this document is to describe the data elements and associated collection guidelines required for the EDDC collection. The primary audience is expected to be hospitals submitting to EDDC. Others who will find this document useful are those working with the data (e.g. for planning, monitoring, research) and those assuring quality and integrity of the data.

Emergency Department Data Collection Scope

All public hospitals in South Australia are required to submit information about patient presentations to Emergency Departments and emergency services (provided/funded by a hospital) for the data collection.

Data submitted to EDDC should be timely, accurate and complete, reflecting the types of patients admitted and the treatment provided. These guidelines represent SA Health policy and are intended to be a reference for all hospital personnel who are involved in the collection and use of ED data.

Emergency Department data must be received by the Submit By Date in the Data Submission Schedule Appendix.

Emergency department activity data relating to SA residents hospitalised in interstate public hospitals is collected by the other State/Territory health authorities.

The scope includes only physical presentations to emergency departments.

Patients who leave the emergency department after being triaged and then advised of alternative treatment options are in scope.

Exclusions

The following patients are excluded from the Emergency Department Data Collection:

- Patients who are dead on arrival and do not receive resuscitation.

Contact details

The **Corporate Data Collection Systems** (CDCS) unit can assist with information about:

- Data submissions
- Due dates for submissions
- Obtaining reports or data
- Category definitions
- Data standards
- Error report distribution

- Correcting errors
- Content and maintenance of this manual
- Non-clinical data quality checks (edits/queries)

The CDCS unit can be contacted via:

Email: dataandreportingservices@sa.gov.au

Data quality statement

The management of this collection aligns to SA Health's Data Quality Management Framework policy directive and guidelines.

To ensure data is fit for multiple uses the submission and collection processes include the following features:

Accuracy: The EDDC reference manual is published on the SA Health website as a reference for the EDDC data submissions and collection requirements. It provides details of data definitions and describes the data tests (i.e. edit tests) undertaken to verify the accuracy of the data. Where quality issues are detected the health data suppliers are required to promptly correct the identified data quality issue.

Validity: The validation process includes making available validation reports to assist health data suppliers in identifying data elements requiring attention and correcting and resubmitting the data.

Completeness: The completeness of submitted data is monitored monthly to identify when submission deadlines are not met or when records are outstanding. Significant instances of incomplete submissions are published in the monthly collection refresh notices to ensure data end users such as analysts and researchers are notified of this quality issue.

Coherence: The EDDC collection is reviewed annually to ensure it provides SA Health with the information necessary to effectively fund, organise, evaluate, and plan health services and to meet its national obligations through submissions to the Australian Institute of Health and Welfare (AIHW), the Independent Hospital Pricing Authority (IHPA), National Health Performance Authority (NHPA) and the National Health Funding Body (NHFB). Common data elements are defined and consistent within and across collections.

Interpretability: The EDDC Manual provides details of the data concepts, definitions, edits and rules across the EDDC collection. The collection is reviewed annually in consultation with SA Health data suppliers.

Timeliness: The EDDC data is updated in accordance with the submissions made each month from data held in the EDDC processing database. Health services must submit data at least monthly.

With the introduction of the IHPA national quarterly submissions from 2018-19 data suppliers must ensure their supplied data quality reporting must be completed on a quarterly basis.

Accessibility: SA Health makes data accessible through various dashboards, reports, portals (eg QIP Hub) and the LARS website.

Reference Files

Reference files are available on the SA Health website for download from https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections

Related documents

Readers of this document may also be interested in the associated documents:

> Emergency Department – File Extract – Technical Specification
> Emergency Department – Data Quality Checks – Reference Manual
> SA Health Data Plan(s)

Confidentiality, Privacy and Security

Although no patient names or addresses are stored in the EDDC database, the sensitive nature of clinical information is recognised. Staff are bound by the Public Sector Act and the Code of Ethics to ensure that patient confidentiality is protected and maintained.

The use and release of EDDC data (e.g. through the Health Information Portal (HIP)) is governed by SA Health's Privacy Policy Directive, data management protocols, various legislation and other relevant privacy codes and regulations. Other usage is properly authorised before release.

The EDDC database and the SA Health Central Data Warehouse reside on physically and logically secure computer systems which are accessible to authorised staff only.

EDDC data are made available for research where approval by relevant Ethics Committees is evident.

Data Definitions

Introduction

This section describes the data elements required to complete the Emergency Department Data Collection. Mandatory code sets submitted by a hospital are mapped to State code sets (if applicable) which in turn are mapped to national code sets as applicable. The mandatory items below must be reported for each presentation at an Emergency Department for every patient.

Caveats

Certain fields are derived from other fields. For example:

[Presentation Date/Time] is the earlier of:

- [Clerical Date/Time]
- [Triage Date/Time]

[Seen By Date Time] is the earlier of:

- [Seen By Doctor Date/Time]
- [Seen By Nurse Data/Time]

Data definition format

Each data element is described using standard metadata. The meaning of these metadata are described below.

[Data element name] – *the commonly used name of the data element*

Identification – *the group of items that identify the data element*

Technical name:	*The name of the data element in the context of other metadata*
EDDC data item:	*Data item number within the collection – use in conjunction with file specifications.* ***Some quality edits reference this number to help identify which data item requires quality review***
SAHMR identifier:	*SA Health metadata item number reference.*
Registration status:	*Refers to the date upon which the data element became an authorised standard. This is not necessarily the same as the date from which it became actively used (i.e. a data element may become standard on 24 June but active from 1 July)*
Definition:	*Describes in detail the meaning and intent of the data element.*
Data element concept:	*Provides contextual understanding of the metadata.*

Value domain – *the group of items that describe acceptable values and format for the data element*

Class:	*Data value classification*
Type:	*Type of data to be recorded (e.g. string, numeric, etc.)*
Format:	*Format the data must take where A – alphanumeric, N – numeric, [?] – optional characters*
Length:	*The maximum length of the data for the data element*
Values:	*Describes the values or refers to a Reference File*

Obligation – *describes any dependencies associated with the data element*

Class:	*Conditional / Mandatory / Optional*
Dependency:	*Describes any dependencies (e.g. of other data elements) associated with this data element*

Collection – *any supporting information to assist with consistent interpretation and meaning of capture of the data element values*

Data Quality Checks – *lists any associated data quality checks for the data element*

[Accompanying Person]

Identification

Technical name:	Person – Accompanying Person
EDDC data item:	01
SAHMR identifier:	Not in SAHMR
Registration status:	Not registered.
Definition:	The person who has accompanied the patient to an emergency department.
Data element concept:	Patient

Value domain

	XML file	**Text file**
Class:	text	Text
Type:	String	Numeric
Format:	n/a	N
Length:	n/a	1
Values:	Free Text	

Obligation

Class:	Optional
Dependency:	None

Collection

[Accompanying Person] is an identification of the person who accompanied the patient to the Emergency Department.

Collected but not used.

Data Quality Checks

- None

[Admission Request Date/Time]

Identification

Technical name:	Patient admission – decision to admit date/time, DDMMYYYY hhmm
EDDC data item:	02
SAHMR identifier:	SA607 and SA608
Registration status:	SA Health, Standard 10/08/2009
Definition:	The date and time on which a request is made to admit the patient into hospital.
Data element concept:	Patient admission

Value domain

	XML file	**Text file**
Class:	DateTime	Text/Text
Type:	dateTime	Numeric/Numeric
Format:	YYYY-MM-DDThh:mm:ss	DDMMYYYY/hhmm
Length:	n/a	8/4
Values:	n/a	

Obligation

Class:	Conditional
Dependency:	Mandatory for: > Decision made to admit patient

Collection

Point in time at which Emergency Department staff decided that a patient is to be admitted to the hospital and commence the process of formal admission and finding a ward for a patient.

Data Quality Checks

- 0133: Remove default Admit Date/time (Admit Date/Time)
- 0405: Admit time not NULL for Mapped Departure Status 6 (Admit Date/Time, Mapped Departure Status)

[Arrival Mode]

Identification

Technical name:	Episode of care—arrival mode, code NN
EDDC data item:	03
SAHMR identifier:	SA594
Registration status:	SA Health, Standard 10/08/2009
Definition:	The mode of transport by which the patient arrives at an Emergency Department.
Data element concept:	Episode of care

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	NN	NN
Length:	n/a	2
Values:	1 (Air Ambulance) 2 (Helicopter) 3 (Ambulance Service) 4 (Community/Public Transport) 5 (Private car) 6 (Police vehicle) 7 (Walk in) 8 (Other) 9 (Volunteer transport) 10 (Taxi) 99 (Unknown/not stated)	

Obligation

Class:	Conditional
Dependency:	Mandatory for: > Patient presentation to ED

Collection

The mode of transport by which the patient arrives at the Emergency Department. For journeys involving more than one transport mode, select the mode of transport in which the greater distance of the journey was undertaken.

For example: Most patients transported by air require road transportation to the hospital. Where the air transport involves the greater distance, record 1 (Air Ambulance) or 2 (Helicopter) as appropriate.

This data element may assist in the analysis of transport service utilisation and coordination.

1 (Air Ambulance)

Patient has been transported to the hospital via air ambulance e.g. Royal Flying Doctor Service. This is irrespective of the patient's arrival via ambulance service from the airport.

2 (Helicopter)

Patient has been transported to the hospital in a helicopter. This is irrespective of the patient's arrival via ambulance service from the helicopter landing pad which may not be located on the hospitals premises.

3 (Ambulance Service)

Patient has been transported to the hospital in an ambulance.

4 (Community/public transport)

Patient used public transport or a community transport service (e.g. community bus service offered by a city council) to arrive at the hospital.

5 (Private car)

Patient arrived at the hospital in a private car.

6 (Police vehicle)

Patient has been transported to the hospital in a police vehicle. This includes patients under section 57 of the Mental Health Act 2009 – Sect 57 Powers of police officers relating to persons who have or appear to have mental illness.

7 (Walk in)

Patient did not use any form of transport to arrive at the hospital.

8 (Other)

Arrival at the hospital is not covered in any of the categories e.g. government car.

9 (Volunteer transport)

Patient arrived at the hospital by a transport service provided by volunteers.

10 (Taxi)

Patient arrived at the hospital in a taxi.

99 (Unknown/not stated)

Patient transport arrival not known

Data Quality Checks

- 0130: FMC Arrival Mode 01 mapped to 03 (Mapped from/Mapped to)
- 0131: FMC Arrival Mode 03 mapped to 93 (Mapped from/Mapped to)
- 0215: Mapped arrival mode not 1, 2, 8 or 9 (Native Arrival Mode, Mapped Arrival Mode)

[Attendance Type]

Identification

Technical name:	Person – Attendance Type
EDDC data item:	32
SAHMR identifier:	Not in SAHMR
Registration status:	Not registered.
Definition:	Identifies whether the patient did or did not see a Doctor.
Data element concept:	Patient

Value domain

	XML file	**Text file**
Class:	Text	n/a
Type:	String	n/a
Format:	AAA(-AAA)	n/a
Length:	n/a	n/a
Values:	DNW (Did not wait) MED (Medical (DOC)) NON-MED (Non-medical (NODOC))	

Obligation

Class:	Optional
Dependency:	None

Collection

[Attendance Type] used to identify if the patient saw a Doctor or did not see a doctor e.g. saw Nurse only. It is also used to capture a Did Not Wait attendance.

Collected but not used. The data element is used by country hospitals not on Sunrise EMR.

DNW (Did not wait)

Patient did not wait to be attended by a health care professional.

MED (Medical (DOC))

Patient who received unplanned or emergency-type treatment from a medical practitioner.

NON-MED (Non-medical (NODOC))

Patient who received unplanned treatment from a health professional other than a medical practitioner. It is by the patient's choice that a medical practitioner is not present for treatment.

Data Quality Checks

- None

[Clerical Date/Time]

Identification

Technical name:	Patient – clerical date/time, DDMMYYYY hhmm
EDDC data item:	04
SAHMR identifier:	SA634 and SA635
Registration status:	SA Health, Standard 10/08/2009
Definition:	The date and time on which the patient's details are checked and recorded by clerical staff.
Data element concept:	Patient

Value domain

	XML file	**Text file**
Class:	DateTime	Text/Text
Type:	dateTime	Numeric/Numeric
Format:	YYYY-MM-DDThh:mm:ss	DDMMYYYY/hhmm
Length:	n/a	8/4
Values:	n/a	

Obligation

Class:	Conditional
Dependency:	Mandatory for: > Patient presentation to ED

Collection

The date and time the patient's details are checked and recorded by clerical staff in the Emergency Department. This may be the first recorded contact in the Emergency Department.

This data element may be used in the calculation of various derived items e.g. start of presentation date and time.

Data Quality Checks

- 0000: Null Hospital Code (Hospital Code) / Null URN (URN) / Null presentation Date/Time (Triage Date/Time / Clerical Date/Time)
- 0156: Presentation after Seen (Presentation Date/Time, Seen by Date/Time)
- 0163: Date of birth after Presentation (Date of birth, Presentation Date/time)
- 0304: Presentation after Triage (Presentation Date/Time, Triage Date/Time)
- 0305: Presentation after Departure (Presentation Date/Time, Departure Date/Time)
- 0309: Wait Time less than zero (Wait time (Minutes), Mapped Departure Status)
- 0310: Visit Time less than zero (Visit time (Minutes), Mapped Departure Status)

- 0400: Wait Time > 12 hours (Wait Time (mins), Mapped Departure Status)
- 0401: Visit Time > 5 Days (Visit Time (Hours), Mapped Departure Status)
- 0406: Patient under 18 with Compensable Status DVA (Age in years, Compensable Status)
- 0407: Seen By Doctor Date/Time before Presentation Date/Time (Seen By Doctor Date/Time, Presentation Date/Time)
- 0408: Seen by Nurse Date/Time before Presentation Date/Time (Seen By Doctor Date/Time, Presentation Date/Time)

[Compensable Status]

Identification

Technical name:	Patient - compensable status, code AAA
EDDC data item:	05
SAHMR identifier:	SA597
Registration status:	SA Health, Standard 10/08/2009
Definition:	A patient's eligibility for compensation with respect to an injury or disease.
Data element concept:	Patient admission - Admission election (care type)

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Alphanumeric
Format:	XXX	XXX
Length:	n/a	3
Values:	C (Compensable – Other) CNM (Non-Medicare) CSH (Compensable – Shipping) CV (Compensable – Vehicle Accident) CW (Compensable – Workers Compensation) DVA (Department of Veterans Affairs) O (Ordinary) 9 (Unknown)	

Obligation

Class:	Mandatory
Dependency:	None

Collection

A patient who is entitled to receive or has received a compensation payment with respect to an injury or disease or:

- Is entitled to claim damages under Motor Vehicle Third Party insurance, or
- Is entitled to claim damages under worker's compensation, or
- Has an entitlement to claim under public liability or common law damage.

For SA Health it also includes eligible beneficiaries of the Department of Veterans' Affairs.

This data element assists in the analysis of utilisation and health care funding.

Compensable funding source takes precedence over all other types of funding source with the exception of Defence Force Personnel who should be recorded as Defence, irrespective of their compensable status. Refer to the SA Health Fees & Charges Manual (20 September 2019)

C (Compensable – Other)

Use this value when a patient has an entitlement to claim under public liability or common law damages.

CNM (Non-Medicare)

Use for any patient presenting to ED who is:

- An overseas visitor who resides in a country which does not have a Reciprocal Health Care Agreement (RHCA) with Australia.

Patients for whom travel insurance is the major funding source should be recorded in this category.

For eligible RHCA patients who do not choose to be admitted under RCHA.

CSH (Compensable – Shipping)

Use this value when a patient is eligible to make a claim for damages as a Seaman under the Navigation Act.

CV (Compensable – Vehicle Accident)

Use this value when a patient is eligible to make a claim for damages under Motor Vehicle Third Party insurance.

CW (Compensable – Workers Compensation)

Use this value when a patient is eligible to make a claim for damages under Worker's Compensation.

DVA (Department of Veterans Affairs)

A Veteran's Affairs patient is a person who holds a current Department of Veteran's Affairs Health entitlement card. In cases where a patient with Veterans' Affairs status presents for treatment with a condition covered by workers compensation, motor vehicle accident, or other compensable claim, the patient must be classified as compensable.

O (Ordinary)

Use for any patient admitted whose funding will be sourced from the public health care system.

People who reside in Australia are eligible to receive services under Medicare if they meet any of the following criteria:

- Hold Australian citizenship;
- Have been issued with a permanent visa;
- Hold New Zealand citizenship; OR
- Have applied for a permanent visa, restrictions apply to persons who have applied for a parent visa (other requirements apply).
- Patient who is an overseas visitor who resides in a country which has a Reciprocal Health Care Agreement (RHCA) with Australia.
- Use for any patient admitted who is currently a member of the Australian Defence Force.

9 (Unknown)

Patients compensable status not known**.**

Data Quality Checks

- 0216: Mapped compensable Status not 1, 2 or 9 (Native Compensable Status, Mapped Compensable Status)
- 0406: Patient under 18 with Compensable Status DVA (Age in years, Compensable Status)

[Country Of Birth]

Identification

Technical name:	Patient - country of birth, code NNNN
EDDC data item:	06
SAHMR identifier:	SA445
Registration status:	SA Health, Standard 01/07/1995
Definition:	The country in which the person was born.
Data element concept:	Patient - Country of birth

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	NNNN	NNNN
Length:	n/a	4
Values:	Reference file	

Obligation

Class:	Mandatory
Dependency:	None

Collection

Enter the country code from the reference file as follows, using leading zeros where necessary. For example, Australia:

- [Country Of Birth]: 1101
- The Standard Australian Classification of Countries 2016 (SACC) is a four-digit, three-level hierarchical structure specifying major group, minor group and country.
- A country, even if it comprises other discrete political entities such as states, is treated as a single unit for all data domain purposes.

This data element is important in the study of access to services by different population sub-groups and required for the analysis of service utilisation and need for services.

Reference File

Country of Birth codes are described in the spreadsheet **Country of Birth July 2019** available from the Admitted Patient Care (APC), Admitted Patient Care resources:

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Data Quality Checks

- 0129: Country code mapped to current code (Mapped from/Mapped to)
- 0202: Country of birth Invalid (Country of birth Code)
- 0402: Indigenous Status 1, 2 or 3 but Country of Birth not Australia (Mapped Indigenous Status, Country of Birth Code)

[Date Of Birth]

Identification

Technical name:	Patient - date of birth, DDMMYYYY
EDDC data item:	07
SAHMR identifier:	SA1095
Registration status:	SA Health, Standard 24/04/2013
Definition:	The date on which the patient was born.
Data element concept:	Patient - Date of birth

Value domain

	XML file	**Text file**
Class:	Date	Text
Type:	dateTime	Numeric
Format:	DDMMYYYY	DDMMYYYY
Length:	n/a	8
Values:	n/a	

Obligation

Class:	Mandatory
Dependency:	None

Collection

Enter the patient's full date of birth using day, month and year and leading zeros where necessary.

If the Date of Birth is known and confirmed (e.g. to 05-Jul-1946):

- [Date Of Birth]: 05071946

If the Date of birth is unknown, then use a default (i.e. 01-Jul-1890):

- [Date Of Birth]: 01071890

This data element is used in the calculation of derived items.

Data Quality Checks

- 0100: Null Date of birth (Date of birth)
- 0163: Date of birth after Presentation (Date of birth, Presentation Date/time)
- 0302: Date of birth before 1900-01-01 (Date of birth)
- 0406: Patient under 18 with Compensable Status DVA (Age in years, Compensable Status)
- 0415: Birthdate changed since last visit (Birth Date/Previous Birth Date)

[Departure Date/Time]

Identification

Technical name:	Patient's separation from service – departure from ED date/time, DDMMYYYY hhmm
EDDC data item:	08
SAHMR identifier:	SA626 and SA627
Registration status:	SA Health, Standard 10/08/2009
Definition:	The date and time on which a patient departs an Emergency Department.
Data element concept:	Patient's separation from service

Value domain

	XML file	**Text file**
Class:	DateTime	Text/Text
Type:	dateTime	Numeric/Numeric
Format:	YYYY-MM-DDThh:mm:ss	DDMMYYYY/hhmm
Length:	n/a	8/4
Values:	n/a	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The date and time on which the patient was discharged from the Emergency Department indicating the end of the ED episode. The patient may then be discharged:

- from hospital
- admitted to a ward
- referred to another provider etc.

Where the patient has been admitted to the EECU the [Departure Date] is the date the patient is discharged from the EECU.

Patients admitted to any other ward or bed within the emergency department have not physically departed the emergency department until they leave the emergency department.

If the patient is admitted and subsequently dies before leaving the emergency department, then record the date the body was removed from the emergency department.

If the patient did not wait, then record the date the patient leaves the emergency department or was first noticed as having left.

If the patient was dead on arrival, then record the date the body was removed from the emergency department. If an emergency department physician certified the death of the patient outside the emergency department, then record the date the patient was certified dead.

If the patient was registered, advised of another health-care service, and left the emergency department without being attended by a health-care professional, then record the date the patient leaves the emergency department.

This data element has been developed for the purpose of State and Territory compliance with the National Healthcare Agreement and the agreed national access performance indicator.

This data element is used in the calculation of various derived items e.g. length of stay, length of treatment.

Data Quality Checks

- 0002: Null Departure Date/Time (Departure Date/Time)
- 0156: Presentation after Seen (Presentation Date/Time, Seen by Date/Time)
- 0168: Seen By Date Time after Departure Date Time (Seen by Date/Time, Departure Date/Time)
- 0305: Presentation after Departure (Presentation Date/Time, Departure Date/Time)
- 0310: Visit Time less than zero (Visit time (Minutes), Mapped Departure Status)
- 0313: Triage Date Time after Departure Date Time (Triage Date, Departure Date/Time)
- 0401: Visit Time > 5 Days (Visit Time (Hours), Mapped Departure Status)
- 0411: Seen By Doctor Date Time After Departure Date Time
- 0412: Seen by Nurse Date/Time after Departure Date/Time (Seen By Doctor Date/Time, Departure Date/Time)

[Departure Referral]

Identification

Technical name:	Patient's separation from service – referral destination code NN
EDDC data item:	09
SAHMR identifier:	SA598
Registration status:	SA Health, Standard 10/08/2009
Definition:	Where the patient was referred upon departure from the Emergency Department.
Data element concept:	Patient's separation from service

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	NN	NN
Length:	n/a	2
Values:	1 (Not referred) 3 (Other Private Health Practitioner) 4 (Hospital OPD) 5 (Community Mental Health) 6 (Other Community Health) 7 (Admission) 8 (Nursing Home) 9 (Police) 10 (Other Hospital) 57 (Private Specialist) 58 (LMO/GP) 59 (OPD – Diabetes) 60 (Morgue) 61 (Coroner) 70 (Priority Care Centre) 98 (Other) 99 (Not stated/unknown)	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The place or person to whom the patient was referred on departure from the Emergency Department.

01 (Not referred)

If on discharge, there has been no arrangement made for further health care for continuing care/treatment of a condition which relates to the current ED presentation.

03 (Other Private Health Practitioner)

Includes referrals to allied health professionals, psychologists, social workers, other health professionals such as chiropractor, physiotherapist, dentist, dietician and homeopath.

04 (Hospital OPD)

Patients referred to an outpatient clinic for follow up care by inpatient teams and/or allied health

05 (Community Mental Health)

Includes referrals to all South Australian Mental Health Service, GROW, COPE and similar self-help groups, northern and southern CAMHS.

06 (Other Community Health)

Patients referred for further care to a community health service. For example visits by the community welfare nurse or RDNS.

7 (Admission)

Patients referred to be admitted within the treating hospital.

8 (Nursing Home)

Patients referred to a nursing home.

9 (Police)

Patients referred to police.

10 (Other Hospital)

Patient is referred to another hospital. This includes referrals to another Emergency Department, inpatient admission to another hospital including admission to a private hospital.

57 (Private Specialist)

Patients referred for further care to a private medical specialist. Includes patients who are referred back to their private specialist for follow-up appointments.

58 (LMO/GP)

Patients referred for further care to their general practitioner.

59 (OPD – Diabetes)

Patients referred to a diabetic outpatient clinic for follow up care.

60 (Morgue)

Patient is deceased and referred to the morgue.

61 (Coroner)

Patient is deceased and referred to the coroner for an autopsy.

70 (Priority Care Centre)

Patients are assessed by an SA Health Emergency Department or SA Ambulance Service and will be able to choose to attend a Centre with no out of pocket expenses or wait for their care to be delivered at an emergency department.

98 (Other)

If, on discharge, arrangements not covered in the above categories, have been made for further care/treatment of a condition that relates to the current condition.

99 (Not stated/unknown)

If on discharge referral arrangements are not known.

Data Quality Checks

- None

[Departure Status]

Identification

Technical name:	Patient's separation from service – nature of separation, departure status code NN
EDDC data item:	10
SAHMR identifier:	SA609
Registration status:	SA Health, Standard 10/08/2009
Definition:	Status of the patient upon departure from an Emergency Department.
Data element concept:	Patient's separation from service

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	NN	NN
Length:	n/a	2
Values:	1 (Episode complete – Home) 2 (Admission to ward) 4 (Transfer out of this hospital to another) 5 (Left at own risk after treatment started) 6 (Did Not Wait to be Seen (DNW)) 7 (Died within ED (includes DOA with resus)) 8 (Dead on Arrival, no resus) 9 (Episode complete – Nursing Home) 10 (Admission to Emergency Extended Care Unit (EECU)) 85 (Advised of Alternate Treatment Options (AATO)) 98 (Episode complete–Other) 99 (Not stated/unknown)	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The status of the patient at completion of the non-admitted patient ED service episode.

From 1 July 2018, Admission within ED is no longer an acceptable departure status. Refer to CFM Technical Bulletin 2018-19 Number 26 – Admission Criteria For ED Shortstay Admissions.

This data element assists to identify and monitor the status and location of patients on departure from the ED.

1 (Episode complete – Home)

Patient returning home or to their usual residence, or being transferred to other facilities where health care is not available, including

- Transferred to jail;
- Discharged to accommodation facilities that do not provide medical/nursing care i.e. backpackers hostels and hotels/motels.
- Discharged/transferred to a residential aged care facility if this is their usual residence.

2 (Admission to ward)

Patients referred to be admitted within the treating hospital to an inpatient ward. This includes referral to hospital in the home. ECCU is not included in this code and code 10 (Admission to Emergency Extended Care Unit (EECU)) must be used.

4 (Transfer out of this hospital to another)

Patient is referred to another hospital. This includes referrals to another Emergency Department, inpatient admission to another hospital including admission to a private hospital.

5 (Left at own risk after treatment started)

Patient has been seen by an ED clinician or meaningful treatment has commenced and left at own risk before treatment has ended. Meaningful treatment as initiated by an ED nurse.

6 (Did Not Wait to be Seen (DNW))

Patient did not wait to be seen by an ED clinician and/or meaningful treatment has not commenced. Meaningful treatment as initiated by an ED nurse.

7 (Died within ED (includes DOA with resus))

Patients that die while physically located in the ED. This includes treatment administered in an ambulance outside the ED.

8 (Dead on Arrival, no resus)

Patient who are dead on arrival where there is no intention to resuscitate. This includes where an ED clinician certifies the death of the patients or the clinician certifies the death outside the ED while in an ambulance outside the ED.

9 (Episode complete – Nursing Home)

Patient is referred to a nursing home/residential aged care facility (which is not the patient's usual residence) providing medical or nursing care.

10 (Admission to Emergency Extended Care Unit (EECU))

Patient referred to be admitted to EECU within the treating hospital.

85 (Advised of Alternate Treatment Options (AATO))

Patients advised of another health care service and left the ED without being attended by a clinician. The following criteria must be met:

- Clerical registration has commenced
- Provided with advice about another health care service that could provide assessment and/or treatment of their condition and
- Leave the ED without receiving clinical care.
- They may leave the emergency department immediately after being advised of the other health care service, or may leave after a period of time.
- Use departure status 6 – did not wait to be seen if it is unclear whether the patient intended to seek further treatment from another health care service.

The health care service to which the patient is referred may include primary care/general practitioner (GP) clinics, other clinics that provide specialised treatment (e.g. for mental health care or drug and alcohol care), or other health services (such as the patient's usual general practitioner). The service may be co-located with the hospital in which the emergency department is located, or may be a separate facility.

98 (Episode complete–Other)

Departure status is not covered in any of the other categories.

99 (Not stated/unknown)

If the departure status is not known.

Data Quality Checks

- 0125: FMC - Set EECU DT to Departure DT and Departure Status to 50 where Unit Code is EECU (New Departure Status/New EECU Date/Time)
- 0126: FMC Update EECU DT to Departure DT where Departure Status is 83 (Departure Status/New EECU Date/Time)
- 0127: Departure status changed from 3 to 50 (EECU) where EECU Date/Time is not null (Mapped from/Mapped to)
- 0134: Record removed by WAU filter (Diagnosis Code/Presenting Problem code)
- 0156: Presentation after Seen (Presentation Date/Time, Seen by Date/Time)
- 0166: Departure status 3 with No EECU Date/Time (Departure Status/EECU Date/Time)
- 0167: Seen By Date Time Blank and Mapped departure Status not 4, 7 or 8 (Seen by Date/Time, Mapped Departure Status)
- 0168: Seen By Date Time after Departure Date Time (Seen by Date/Time, Departure Date/Time)
- 0175: EPAS sites EECU Date/Time set to Departure Date/Time (Departure Status/New EECU Date/Time)
- 0217: Mapped Departure Status not 1, 2, 3, 4, 5, 6, 7, 8 or 9 (Native Departure Status, Mapped Departure Status)
- 0304: Presentation after Triage (Presentation Date/Time, Triage Date/Time)
- 0305: Presentation after Departure (Presentation Date/Time, Departure Date/Time)

- 0306: Mapped Departure Status 7 and Mapped Type of Visit not 5 (Mapped Departure Status, Mapped Type Of Visit)
- 0307: Mapped Departure Status 9 (Mapped Departure Status)
- 0309: Wait Time less than zero (Wait time (Minutes), Mapped Departure Status)
- 0310: Visit Time less than zero (Visit time (Minutes), Mapped Departure Status)
- 0311: Triage Date Time Blank Where Departure Status is Not 4, 7 or 8
- 0312: Triage Date Time after Seen By Date Time (Triage Date, Seen by Date/Time)
- 0313: Triage Date Time after Departure Date Time (Triage Date, Departure Date/Time)
- 0400: Wait Time > 12 hours (Wait Time (mins), Mapped Departure Status)
- 0404: Triage Category 1 and Mapped Departure Status 4 (DNW) (Triage Category, Mapped Departure Status)
- 0405: Admit time not NULL for Mapped Departure Status 6 (Admit Date/Time, Mapped Departure Status)

[Detained Patient Status]

Identification

Technical name:	Patient – detained status
EDDC data item:	11
SAHMR identifier:	Not in SAHMR
Registration status:	Not registered.
Definition:	Whether or not the patient was detained under mental health legislation.
Data element concept:	Patient

Value domain

	XML file	**Text file**
Class:	Text	Code
Type:	String	Numeric
Format:	N	N
Length:	n/a	1
Values:	0 (Not detained) 1 (Detained) 9 (Unknown/Not Stated)	

Obligation

Class:	Optional
Dependency:	None

Collection

A patient who presents to ED may be detained under the mental health legislation for the purpose of assessment or provision of appropriate treatment or care.

Collected but not used.

Data Quality Checks

- None

[Diagnosis]

Identification

Technical name:	Patient - diagnosis type, code AN[NNN]
EDDC data item:	12
SAHMR identifier:	SA466
Registration status:	SA Health, Standard 01/07/1985
Definition:	The principal diagnosis established at the conclusion of the patient attendance following consideration of clinical assessment by an Emergency Department clinician.
Data element concept:	Patient - Diagnosis type

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Alphanumeric
Format:	AN[NNN]	AN[NNN]
Length:	n/a	5
Values:	Per ICD-10-AM 8th to 11th edition reference data. Forward mapping applied.	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The correct ED Principal Diagnosis helps to identify the reasons people access the Australian health care system through EDs for the purposes of research, education, service planning, and administration. This information is also utilised to facilitate payment of health services, determine utilisation patterns and evaluate the appropriateness of health care costs. A valid diagnosis code is required to determine the appropriate Urgency Related Group (URG).

See [[Medicare Number] in the Appendices

Data Quality Checks

- 0134: Record removed by WAU filter (Diagnosis Code/Presenting Problem code)
- 0170: Diagnosis Mapped from ICD-10-AM 8th Edition to 9th Edition (Mapped from/Mapped to)
- 0171: Diagnosis Mapped from ICD-10-AM 9th Edition to 10th Edition (Mapped from/Mapped to)
- 0205: Diagnosis Code has no Shortlist Mapping (Diagnosis Code, Submitted diagnosis)
- 0421: Diagnosis code NULL (Diagnosis Code, Submitted diagnosis)
- 0423: Gender Code not consistent with Diagnosis (Mapped Gender Code, Diagnosis Code)

[EECU Admit Date/Time]

Identification

Technical name:	Episode of care – EECU admit date/time, DDMMYYYY hhmm
EDDC data item:	14
SAHMR identifier:	Not in SAHMR
Registration status:	Not registered.
Definition:	The date and time on which the patient was admitted to an Extended Emergency Care Unit (EECU).
Data element concept:	Episode of care

Value domain

	XML file	**Text file**
Class:	DateTime	Text/Text
Type:	dateTime	Numeric/Numeric
Format:	YYYY-MM-DDThh:mm:ss	DDMMYYYY/hhmm
Length:	n/a	8/4
Values:	n/a	

Obligation

Class:	Conditional
Dependency:	Mandatory for: > an admission to EECU

Collection

The date and time the patient was discharged from ED and admitted to the EECU of the hospital.

Data Quality Checks

- 0125: FMC - Set EECU DT to Departure DT and Departure Status to 50 where Unit Code is EECU (New Departure Status/New EECU Date/Time)
- 0126: FMC Update EECU DT to Departure DT where Departure Status is 83 (Departure Status/New EECU Date/Time)
- 0127: Departure status changed from 3 to 50 (EECU) where EECU Date/Time is not null (Mapped from/Mapped to)
- 0166: Departure status 3 with No EECU Date/Time (Departure Status/EECU Date/Time)
- 0175: EPAS sites EECU Date/Time set to Departure Date/Time (Departure Status/New EECU Date/Time)
- 0413: Seen By Doctor Date/Time after EECU Arrival Date/Time (Seen By Doctor Date/Time, EECU Arrival Date/Time)

- 0414: Seen By Nurse Date/Time after EECU Arrival Date/Time (Seen By Nurse Date/Time, EECU Arrival Date/Time)

[Employment Status]

Identification

Technical name:	Patient - employment status, code N
EDDC data item:	13
SAHMR identifier:	SA1100
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient's employment status immediately prior to an Emergency Department presentation.
Data element concept:	Patient - Employment status

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	N	N
Length:	n/a	1
Values:	0 (Not applicable) 1 (Child not at school) 2 (Student) 3 (Employed) 4 (Unemployed) 5 (Home duties) 6 (Other) 9 (Unknown (Default Value))	

Obligation

Class:	Optional
Dependency:	None

Collection

0 (Not applicable)

Patient is not a psychiatric admission of the designated psychiatric units listed above.

It is optional for hospitals not included in the list above to collect and report this data item.

1 (Child not at school)

Includes:

- Pre-school children
- Handicapped children under 16 not otherwise employed

2 (Student)

Includes:

- Child at school, full-time or with study occupying > 20 hours per week or more. If less than 20 hours study and does not fit into any other category record [Employment Status] as 6 (Other).

3 (Employed)

Employed (part-time or full-time); self-employed; employer.

4 (Unemployed)

Unemployed, whether looking for work or not OR receiving unemployment benefits or not.

5 (Home duties)

Use this when it is the sole role of the patient.

6 (Other)

Includes retired persons and/or pensioner; volunteers.

9 (Unknown)

The patient's employment status is unknown.

Data Quality Checks

- None

[Hospital Insurance]

Identification

Technical name:	Patient - insurance flag, status code N
EDDC data item:	17
SAHMR identifier:	SA1107
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient's private health insurance status.
Data element concept:	Patient - Insurance flag

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	N	N
Length:	n/a	1
Values:	1 (Hospital insurance) 2 (No hospital insurance) 9 (Unknown)	

Obligation

Class:	Mandatory
Dependency:	None

Collection

This data item identifies whether a patient has private health insurance or not.

1 (Hospital insurance)

Hospital insurance includes:

- Insurance with a private health fund for private admitted patient hospital accommodation

Hospital insurance does not include:

- Extras cover

2 (No hospital insurance)

No hospital insurance includes:

- No private health insurance
- Extras cover only

9 (Unknown)

The patient has private health insurance; however, the level of coverage is unknown.

Data Quality Checks

- None

[Hospital Number]

Identification

Technical name:	Hospital – administrative identifier code, NNNN
EDDC data item:	15
SAHMR identifier:	SA1053
Registration status:	SA Health, Standard 01/07/1985
Definition:	The hospital of the Emergency Department at which the patient presented.
Data element concept:	Hospital

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	NNNN	NNNNN
Length:	n/a	5
Values:	Reference file	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The hospital identifier for the ED presentation.

This data element is used to identify the reporting hospital.

See [Hospital Number] in the Appendices.

Reference File

Hospital codes are described in the spreadsheet **Emergency Department Reference Table Hospital Codes** available from the Emergency Department Data Collection (EDDC), Non-Admitted Emergency Activity resources:

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections

Data Quality Checks

- 0000: Null Hospital Code (Hospital Code) / Null URN (URN) / Null presentation Date/Time (Triage Date/Time / Clerical Date/Time)
- 0004: Duplicate Record (Triage Date time/URN)

[Indigenous Status]

Identification

Technical name:	Patient - indigenous status, code N
EDDC data item:	16
SAHMR identifier:	SA1104
Registration status:	SA Health, Standard 24/04/2013
Definition:	The patient's Aboriginal and/or Torres Strait Islander origin status.
Data element concept:	Patient - Indigenous categorisation

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	N	N
Length:	n/a	1
Values:	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) 9 (Not stated / Inadequately described)	

Obligation

Class:	Mandatory
Dependency:	None

Collection

This metadata item is based on the Australian Bureau of Statistics (ABS) standard for Indigenous status. For detailed advice on its use and application please refer to the ABS Website.

The classification for Indigenous status has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level.

This data element is used to

- enable planning and service delivery, and monitoring of indigenous health at state and national level
- facilitate application of specific funding arrangements

See [[Medicare Number] in the Appendices.

1 (Aboriginal but not Torres Strait Islander origin)

An Aboriginal is a person of Aboriginal descent who identifies as an Australian Aboriginal.

2 (Torres Strait Islander but not Aboriginal origin)

A Torres Strait Islander is a person of Torres Strait Island descent who identifies as Torres Strait Islander.

3 (Both Aboriginal and Torres Strait Islander origin)

A person who identifies as both an Australian Aboriginal and Torres Strait Islander.

4 (Neither Aboriginal nor Torres Strait Islander origin)

A person who identifies as neither an Australian Aboriginal nor Torres Strait Islander. Termed non-indigenous.

9 (Not stated)

Use this category if the indigenous status of the patient cannot be accurately established (not stated).

This category is not to be available as a valid answer to the questions but is intended for use:

- Primarily when importing data from other data collections that do not contain mapped data.
- Where an answer was refused.
- Where the question was not able to be asked prior to completion of the ED presentation because the client was unable to communicate or a person who knows the client was not available.

Data Quality Checks

- 0219: Mapped Indigenous Status not 1, 2, 3, 4, or 9 (Mapped Indigenous Status)
- 0402: Indigenous Status 1, 2 or 3 but Country of Birth not Australia (Mapped Indigenous Status, Country of Birth Code)
- 0416: Indigenous Status changed since last visit (Indigenous Status/ Previous Indigenous Status)

[Medicare Number]

Identification

Technical name:	Patient - Medicare number, identifier N(10)
EDDC data item:	18
SAHMR identifier:	SA1110
Registration status:	SA Health, Standard 24/04/2013
Definition:	The full number found above the patient's name on the patient's Medicare card.
Data element concept:	Patient - Medicare Number

Value domain

	XML file	**Text file**
Class:	Identifier	Text
Type:	String	Numeric
Format:	NNNNNNNNNN	NNNNNNNNNN
Length:	n/a	10
Values:	Free text	

Obligation

Class:	Mandatory
Dependency:	None

Collection

Most patients will have their Medicare cards and every effort should be made to obtain the number. If the patient does not have a card, or a record of the number, the patient should be asked to arrange for a relative or friend to obtain the number.

This data element is used to ensure eligibility for publicly funded health care.

See [[Medicare Number] in the Appendices.

Data Quality Checks

- None

[Medicare Suffix]

Identification

Technical name:	Patient - Medicare suffix, identifier N
EDDC data item:	31
SAHMR identifier:	Not in SAHMR
Registration status:	Not registered.
Definition:	The single digit to the left of the patient's name on the patient's Medicare card.
Data element concept:	Patient - Medicare Number

Value domain

	XML file	**Text file**
Class:	Identifier	n/a
Type:	String	n/a
Format:	N	n/a
Length:	n/a	n/a
Values:	n/a	

Obligation

Class:	Optional
Dependency:	None

Collection

An individual reference number representing each family member on the Medicare Card.

Data Quality Checks

- None

[Patient Unit Record Number]

Identification

Technical name:	Patient admission - patient unit record number, identifier N(10)
EDDC data item:	19
SAHMR identifier:	SA1078
Registration status:	SA Health, Standard 24/04/2013
Definition:	The Patient Unit Record Number, also known as the Unit Record Number (or URN), is an identifier unique to a patient within a hospital. It is allocated to a patient on the first visit to a hospital/health care service and retained for all subsequent visits and treatments at that hospital.
Data element concept:	Patient admission - Patient unit record number

Value domain

	XML file	**Text file**
Class:	Identifier	Text
Type:	String	Numeric
Format:	NNNNNNNNNN	NNNNNNNNNN
Length:	n/a	10
Values:	Free text	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The use of a unit record numbering system is a prerequisite of the system.

Any one patient should have only one Unit Record Number at any one hospital. Conversely, the issuing of the same number to more than one patient should not occur.

The same number should be used for the same patient on all visits; the number should not be allocated to any other patient.

Though a patient may die or not receive treatment for a considerable period of time, with the medical record being moved to an inactive filing area, the Unit Record Number should NOT be reused for any other patient.

Enter the number assigned to the patient by your hospital. Use numbers only. The unit record number should be entered as follows, using leading zeros where necessary:

For example, [Patient Unit Record Number] 537859:

> 0000537859

Data Quality Checks

- 0000: Null URN (URN)
- 0004: Duplicate Record (Triage Date time/URN)
- 0132: FMC administrative records deleted (URN)

[Postcode]

Identification

Technical name:	Patient - home postcode, code NNNN
EDDC data item:	20
SAHMR identifier:	SA431
Registration status:	SA Health, Standard 01/07/1985
Definition:	The postcode where the patient usually resides – not postal address.
Data element concept:	Patient - Home postcode

Value domain

	XML file	**Text file**
Class:	Code	Text
Type:	String	Numeric
Format:	NNNN	NNNN
Length:	n/a	4
Values:	Reference file	

Obligation

Class:	Mandatory
Dependency:	None

Collection

Apart from the postcode of the patient's residential address, two other postcodes are valid:

[Postcode] 0999 should be entered for the following:

- Babies for Adoption
- Unconscious patients
- No Fixed Abode
- Not Known

[Postcode] 9999 should be entered for the following:

- Overseas

This data element is used to enable calculation of the patient's appropriate Statistical Area Level 2.

See Locality in the Appendices

Reference File

Locality reference table available from Admitted Patient Care (APC), Admitted Patient Care resources.

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Data Quality Checks

- 0417: Invalid suburb and Postcode (Suburb, Postcode)
- 0418: Invalid Postcode (Suburb, Postcode)
- 0420: Invalid Suburb + Postcode Combination (Suburb, Postcode)

[Presenting Problem]

Identification

Technical name:	Patient – presenting problem, code NNNN
EDDC data item:	21
SAHMR identifier:	Not in SAHMR
Registration status:	Not registered
Definition:	The patient's presenting problem or complaint for attending an Emergency Department as assessed by the Triage Nurse.
Data element concept:	Patient

Value domain

	XML file	**Text file**
Class:	Code	Text
Type:	String	Numeric
Format:	NNNN	NNNN
Length:	n/a	4
Values:	n/a	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The clinical interpretation of the patient's [Presenting Problem], or complaint as assessed by the triage nurse in ED as the main reason for the patient's Emergency Department presentation.

Data Quality Checks

- 0134: Record removed by WAU filter (Diagnosis Code/Presenting Problem code)

[Referring Hospital]

Identification

Technical name:	Episode of care – referring hospital number, code NNNN
EDDC data item:	21
SAMHR identifier:	Not in SAHMR
Registration status:	Not registered
Definition:	The hospital referring the patient to the Emergency Department for treatment.
Data element concept:	Episode of care

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	NNNN	NNNN
Length:	n/a	4
Values:	Reference file	

Obligation

Class:	Optional
Dependency:	Source of Referral

Collection

The unit/hospital that referred the patient to the ED.

Reference File

Hospital codes are described in the spreadsheet **Hospital Listing spreadsheet** available from the Admitted Patient Care (APC), Admitted Patient Care resources:

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Data Quality Checks

- None

[Seen By Doctor Date/Time]

Identification

Technical name:	Episode of care – seen by doctor date/time, DDMMYYYY, hhmm
EDDC data item:	23
SAHMR identifier:	SA632 and SA633
Registration status:	SA Health, Standard 10/08/2009
Definition:	The date and time on which the patient was seen by a treating doctor.
Data element concept:	Episode of care

Value domain

	XML file	**Text file**
Class:	DateTime	Text/Text
Type:	dateTime	Numeric/Numeric
Format:	YYYY-MM-DDThh:mm:ss	DDMMYYYY/hhmm
Length:	n/a	8/4
Values:	n/a	

Obligation

Class:	Conditional
Dependency:	Mandatory > for all presentations where the first practitioner treating the patient is a doctor > Optional > for all presentations where meaningful treatment/patient management has been initiated by a nurse.

Collection

The date and time the patient was seen by a treating doctor in ED.

This data element is used in the calculation of Emergency Department waiting time to clinical care commencement.

Data Quality Checks

- 0122: Triage Category 1 over 2 mins (Triage Category, Minutes)
- 0156: Presentation after Seen (Presentation Date/Time, Seen by Date/Time)
- 0167: Seen By Date Time Blank and Mapped departure Status not 4, 7 or 8 (Seen by Date/Time, Mapped Departure Status)
- 0168: Seen By Date Time after Departure Date Time (Seen by Date/Time, Departure Date/Time)

- 0309: Wait Time less than zero (Wait time (Minutes), Mapped Departure Status)
- 0312: Triage Date Time after Seen By Date Time (Triage Date, Seen by Date/Time)
- 0400: Wait Time > 12 hours (Wait Time (mins), Mapped Departure Status)
- 0407: Seen By Doctor Date/Time before Presentation Date/Time (Seen By Doctor Date/Time, Presentation Date/Time)
- 0409: Seen By Doctor Date/Time before Triage Date/Time (Seen By Doctor Date/Time, Triage Date/Time)
- 0411: Seen By Doctor Date Time After Departure Date Time
- 0413: Seen By Doctor Date/Time after EECU Arrival Date/Time (Seen By Doctor Date/Time, EECU Arrival Date/Time)

[Seen By Nurse Date/Time]

Identification

Technical name:	Episode of care – seen by nurse date/time, DDMMYYYY, hhmmss
EDDC data item:	25
SAHMR identifier:	SA632 and SA633
Registration status:	SA Health, Standard 10/08/2009
Definition:	The date and time on which the patient was seen by a treating nurse.
Data element concept:	Episode of care

Value domain

	XML file	**Text file**
Class:	DateTime	Text/Text
Type:	dateTime	Numeric/Numeric
Format:	YYYY-MM-DDThh:mm:ss	DDMMYYYY/hhmm
Length:	n/a	8/4
Values:	n/a	

Obligation

Class:	Conditional
Dependency:	Mandatory > for all presentations where meaningful treatment/patient management has been initiated by a nurse. Optional > for all presentations where the first practitioner treating the patient is a doctor

Collection

The date and time the patient was seen by a treating nurse in ED.

This data element is used in the calculation of Emergency Department waiting time to clinical care commencement.

See Sex and Gender in the appendices.

Data Quality Checks

- 0122: Triage Category 1 over 2 mins (Triage Category, Minutes)
- 0156: Presentation after Seen (Presentation Date/Time, Seen by Date/Time)
- 0167: Seen By Date Time Blank and Mapped departure Status not 4, 7 or 8 (Seen by Date/Time, Mapped Departure Status)

- 0168: Seen By Date Time after Departure Date Time (Seen by Date/Time, Departure Date/Time)
- 0309: Wait Time less than zero (Wait time (Minutes), Mapped Departure Status)
- 0312: Triage Date Time after Seen By Date Time (Triage Date, Seen by Date/Time)
- 0400: Wait Time > 12 hours (Wait Time (mins), Mapped Departure Status)
- 0408: Seen by Nurse Date/Time before Presentation Date/Time (Seen By Doctor Date/Time, Presentation Date/Time)
- 0410: Seen by Nurse Date/Time before Triage Date/Time (Seen By Doctor Date/Time, Triage Date/Time)
- 0412: Seen by Nurse Date/Time after Departure Date/Time (Seen By Doctor Date/Time, Departure Date/Time)
- 0414: Seen By Nurse Date/Time after EECU Arrival Date/Time (Seen By Nurse Date/Time, EECU Arrival Date/Time)

[Sex]

Identification

Technical name:	Patient - sex, code N
EDDC data item:	24
SAHMR identifier:	SA639
Registration status:	SA Health, Standard 10/08/2009
Definition:	Identifies whether or not a patient is biologically male or female.
Data element concept:	Patient

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	N	N
Length:	n/a	1
Values:	1 (Male) 2 (Female) 3 (Intersex or indeterminate) 9 (Not stated/inadequately described)	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The [Sex] of the patient. [Sex] refers to the anatomical differences between males and females.

See Sex and Gender in the appendices.

1 (Male)

Patient presents with male genitalia.

2 (Female)

Patient presents with female genitalia.

3 (Intersex or indeterminate)

Patient who, because of a genetic condition, was born with reproductive organs or sex chromosomes that are not exclusively male or female or whose sex has not yet been determined for whatever reason.

Only used to classify patients aged less than 90 days when it is not possible for the sex to be determined.

9 (Not stated/inadequately described)

Use this category if the sex of the patient cannot be accurately established.

Data Quality Checks

- 0218: Mapped Gender not 1, 2, 3 or 9 (Mapped Gender)

[Source Of Referral]

Identification

Technical name:	Patient admission – source of referral code, NN
EDDC data item:	26
SAHMR identifier:	SA623
Registration status:	SA Health, Standard 10/08/2009
Definition:	Source from where the patient was referred/transferred.
Data element concept:	Patient admission

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	NN	NN
Length:	n/a	2
Values:	1 (Self/family/friends) 2 (GP) 3 (Police) 4 (Hospital) 5 (Private medical specialist/other MO) 11 (Nursing home) 12 (Locum service) 13 (Community health) 15 (First aid provider) 30 (Disaster) 31 (Other department in this hospital) 32 (Other private health provider) 34 (Hostel) 35 (ED staff (for review)) 36 (Coroner) 37 (SA Gov Health Call Centre 98 (Other) 99 (Not stated/unknown)	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The [Source Of Referral] for the patient presenting to ED irrespective of their [Arrival Mode].

This data element may assist in the analysis of referral patterns.

1 (Self/family/friends)

Patients presenting to the ED not referred by anyone.

2 (GP)

Patients referred to the ED by their GP. Generally with a referral letter from the GP.

3 (Police)

Patients referred to the ED by the Police while in Police custody/watch-house. This includes patients placed by the police under section 57 of the Mental Health Act 2009 – Sect 57 Powers of police officers relating to persons who have or appear to have mental illness.

4 (Hospital)

Patients referred to the ED by another public or private hospital.

5 (Private medical specialist/other MO)

Patients referred to the ED by a private medical specialist/other MO. This does not include referral from the GP, use code 2 for referrals from the GP.

11 (Nursing home)

Patients referred to the ED from a nursing home/residential aged care facility.

12 (Locum service)

Patients referred to the ED from a locum service.

13 (Community health)

Patients referred to the ED directly from a community health service e.g. Aboriginal Health, DOM Care, Community Nursing, Mental Health, Rehab Programs, Shine.

15 (First aid provider)

Patients referred to the ED directly from a first aid provider e.g. ambulance services, St Johns. This includes patients placed by the ambulance officer under Section 56 – Care and Control under the Mental Health Act 2009.

30 (Disaster)

Patients referred to the ED as part of a disaster. This includes internal and/or external disaster where a disaster management plan is activated.

31 (Other department in this hospital)

Patients referred to the ED from other department in this hospital e.g. outpatient department.

32 (Other private health provider)

Patients referred to the ED from e.g. allied health professionals, psychologists, social workers, other health professionals such as chiropractor, physiotherapist, dentist, dietician and homeopath.

34 (Hostel)

Patients referred to the ED from an establishment (hostel) which provides group accommodation and personal care.

35 (ED staff (for review))

Patients referred back to the ED for review by ED staff (planned review).

36 (Coroner)

Patients referred to the ED by the coroner for certification before taken for autopsy.

37 (SA Gov Health Call Centre)

Patients referred to the ED by *healthdirect*. Health direct is a National health advice and information service which provides online and telephone access to trusted health information and advice.

98 (Other)

Any patient referred to the ED through other avenues not listed in this data item.

99 (Not stated/unknown)

Patient source of referral not known.

Data Quality Checks

- None

[Statistical Local Area]

Identification

Technical name:	Patient - home SLA, code NNNN
EDDC data item:	22
SAHMR identifier:	SA1102
Registration status:	SA Health, Standard 24/04/2013
Definition:	The Australian Bureau of Statistics' Statistical Local Area of the patient's home address.
Data element concept:	Patient - Home SLA

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	NNNN	NNNN
Length:	n/a	4
Values:	Reference file	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The EDDC does not store:

- Patient name
- Patient address

[Postcode] and [Statistical Local Area] are used to classify patients into demographic regions.

See Locality in the Appendices.

Reference File

Locality reference table available from Admitted Patient Care (APC), Admitted Patient Care resources.

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Data Quality Checks

- None

[Suburb / Locality]

Identification

Technical name:	Patient - home suburb/locality, identifier X[20]
EDDC data item:	27
SAHMR identifier:	SA1103
Registration status:	SA Health, Standard 24/04/2013
Definition:	The suburb / locality of the patient's home address.
Data element concept:	Patient - Home suburb/locality

Value domain

	XML file	**Text file**
Class:	Code	Text
Type:	String	Numeric
Format:	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
Length:	n/a	20
Values:	Free text	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The suburb of the patient's usual residence. If the patient is from interstate, enter the patient's usual (permanent) address and not their holiday (temporary) address.

See Locality in the Appendices

Reference File

Locality reference table available from Admitted Patient Care (APC), Admitted Patient Care resources.

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

Data Quality Checks

- 0157: Address in Suburb Deleted (Suburb from/Suburb to)
- 0417: Invalid suburb and Postcode (Suburb, Postcode)
- 0419: Invalid Suburb Name (Suburb, Postcode)
- 0420: Invalid Suburb + Postcode Combination (Suburb, Postcode)

[Triage Category]

Identification

Technical name:	Patient – triage category, code N
EDDC data item:	28
SAHMR identifier:	SA606
Registration status:	SA Health, Standard 10/08/2009
Definition:	The urgency of the patient's need for medical care, using the National Triage Scale.
Data element concept:	Patient

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	N	N
Length:	n/a	1
Values:	1 (Resuscitation) 2 (Emergency) 3 (Urgent) 4 (Semi-Urgent) 5 (Non-Urgent) 9 (Not Assigned)	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The urgency of the patient's need for medical and nursing care, using a code set by the Australian College of Emergency Medicine.

The [Triage Category] is allocated by an experienced registered nurse or medical practitioner. If the triage category changes, both triage categories can be captured, but the original category must be reported.

This data element is used to identify and monitor the urgency of a patient's presentation and corresponding time of clinical care commencement.

Triage Category 1

Resuscitation - Immediate simultaneous assessment and treatment.

Triage Category 2

Emergency - Assessment and treatment within 10 minutes of arrival.

Triage Category 3

Urgent - Assessment and treatment start within 30 minutes of arrival.

Triage Category 4

Semi-Urgent Assessment and treatment start within 60 minutes of arrival.

Triage Category 5

Non-urgent - Assessment and treatment start within 120 minutes of arrival.

Data Quality Checks

- 0122: Triage Category 1 over 2 mins (Triage Category, Minutes)
- 0134: Record removed by WAU filter (Diagnosis Code/Presenting Problem code)
- 0315: Triage Category 9 (Triage Category)
- 0403: Mapped Type of Visit 3 or 5 and Triage Category 1 or 2 (Mapped Type of Visit, Triage Category)
- 0404: Triage Category 1 and Mapped Departure Status 4 (DNW) (Triage Category, Mapped Departure Status)

[Triage Date/Time]

Identification

Technical name:	Episode of care – triage date/time, DDMMYYY hhmm
EDDC data item:	29
SAHMR identifier:	SA628 and SA629
Registration status:	SA Health, Standard 10/08/2009
Definition:	The date and time on which the patient was triaged.
Data element concept:	Episode of care

Value domain

	XML file	**Text file**
Class:	Date/Time	Text/Text
Type:	dateTime	Numeric/Numeric
Format:	YYYY-MM-DDThh:mm:ss	DDMMYYYY/hhmm
Length:	n/a	8/4
Values:	n/a	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The date and time a patient is triaged in the Emergency Department by a triage nurse or doctor.

Data Quality Checks

- 0000: Null presentation Date/Time (Triage Date/Time / Clerical Date/Time)
- 0004: Duplicate Record (Triage Date time/URN)
- 0122: Triage Category 1 over 2 mins (Triage Category, Minutes)
- 0304: Presentation after Triage (Presentation Date/Time, Triage Date/Time)
- 0311: Triage Date Time Blank Where Departure Status is Not 4, 7 or 8
- 0312: Triage Date Time after Seen By Date Time (Triage Date, Seen by Date/Time)
- 0313: Triage Date Time after Departure Date Time (Triage Date, Departure Date/Time)
- 0409: Seen By Doctor Date/Time before Triage Date/Time (Seen By Doctor Date/Time, Triage Date/Time)
- 0410: Seen by Nurse Date/Time before Triage Date/Time (Seen By Doctor Date/Time, Triage Date/Time)

[Visit Type]

Identification

Technical name:	Episode of care – reason for ED visit, code NN
EDDC data item:	30
SAHMR identifier:	SA618
Registration status:	SA Health, Standard 10/08/2009
Definition:	The reason a patient presents to an Emergency Department
Data element concept:	Episode of care

Value domain

	XML file	**Text file**
Class:	Code	Code
Type:	String	Numeric
Format:	NN	NN
Length:	n/a	2
Values:	1 (Emergency) 2 (Trauma) 3 (Planned review) 4 (Unplanned review) 5 (Planned admission) 98 (Other) 99 (Unknown)	

Obligation

Class:	Mandatory
Dependency:	None

Collection

The reason the patient presents to the Emergency Department.

1 (Emergency)

Where a patient presents to the Emergency Department for an actual or suspected condition which is sufficiently serious to require acute unscheduled care. This includes patients for whom resuscitation is attempted.

2 (Trauma)

Where a patient presents to the Emergency Department who has suffered a serious or life threatening injury as a result of an event e.g. car accident, gunshot wound, crush injuries or fall. Traumatic injuries may affect many parts of the body, including the brain, the extremities and internal organs.

3 (Planned review)

Where a patient presents to the Emergency Department for a return visit, as a result of a previous Emergency Department presentation. The return visit may be for planned follow-up treatment, as a consequence of test results becoming available indicating the need for further treatment, or as a result of a care plan initiated at discharge.

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

4 (Unplanned review)

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

5 (Planned admission)

Where a patient presents to the Emergency Department for an admission to either a non-emergency department ward or other admitted patient care unit that has been arranged prior to the patient's arrival, and the patient receives clinical care in the emergency department.

Exclusion: Where a patient presents for a pre-arranged admission and only clerical services are provided by the emergency department, the patient should not be recorded.

98 (Other)

Where the type of visit is not covered in any of the categories.

99 (Unknown)

Where the type of visit is not known.

Data Quality Checks

- 0134: Record removed by WAU filter (Diagnosis Code/Presenting Problem code)
- 0220: Mapped Type of visit not (1, 2, 3, 5, 9) (Mapped Type Of Visit)
- 0306: Mapped Departure Status 7 and Mapped Type of Visit not 5 (Mapped Departure Status, Mapped Type Of Visit)
- 0308: Mapped Type of Visit 9 (Mapped Type Of Visit)
- 0403: Mapped Type of Visit 3 or 5 and Triage Category 1 or 2 (Mapped Type of Visit, Triage Category)

Appendices

Constructs

Dates and Times

Enter dates with leading a zero where appropriate (e.g. the first day of a month is entered as “01” instead of “1”).

- Thus, a date of 06-Aug-2019 is entered as: 06092019.

Enter time with a leading zero where appropriate (e.g. a time between five and six o’clock is entered as “05” instead of “5”).

- Thus, a time of 05:05 is entered as: 0505.

The following data elements are in scope for dates:

- [Admission Request Date/Time]
- [Clerical Date/time]
- [Date Of Birth]
- [Departure Date/Time]
- [EECU Admit Date/Time]
- [Seen By Doctor Date/Time]
- [Seen By Nurse Date/Time]
- [Triage Date/Time]

Diagnosis Codes

ICD-10-AM (11th edition) [Diagnosis] codes must be recorded in the following format:

- Without decimal points
- Include lead alpha characters
- Record codes in sequence order
- Left justify, blank fill
- Where there is no 4th digit, but a 5th digit is required use "0" as a filler

Example

The codes for:

- [Diagnosis]: M0001 / M00.01 (Staph arthritis & polyarthritis shoulder)

- Are entered as:
  - [Diagnosis]: M0001

SNOMED diagnosis codes can be recorded and will be mapped to ICD-10-AM where mapping is available. There is no comprehensive mapping from SNOMED to ICD-10-AM and some SNOMED codes recorded cannot be mapped and a URG cannot be assigned.

[Hospital Number]

Public hospitals have three digit codes and require a leading zero.

The number should be entered as follows:

- [Hospital Number]: 0106

Private hospitals, including day surgery facilities, have four digit codes beginning with a ‘4’, and should be entered as follows:

- [Hospital Number]: 4313

Reference File

Hospital codes are described in the spreadsheet **Emergency Department Reference Table Hospital Codes** available from the Emergency Department Data Collection (EDDC), Non-Admitted Emergency Activity resources:

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections

[Indigenous Status]

This element should always be asked even if the person does not 'look' like they are Aboriginal or Torres Strait Islander origin.

When requesting information on [Indigenous Status] the following question structure is recommended: [Are you] [Is the person] [is (name)] of Aboriginal or Torres Strait Islander origin?

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander
- Yes, Both Aboriginal and Torres Strait Islander

This question is recommended for self-enumerated or interview-based collections. It can also be used in circumstances where a close relative, friend or another member of the household is answering on behalf of the person.

When someone is not present, the person answering for them should be in a position to do so i.e. this person must know the person about whom the question is being asked well and feel confident to provide accurate information about them. However, it is strongly recommended that this question be asked directly wherever possible.

In circumstances where it is impossible to ask the person directly, such as in the case of death, the question should be asked of a close relative or friend, and only if a relative or friend is not available should the undertaker or other such person answer.

The classification for [Indigenous Status] has a hierarchical structure comprising two levels. There are four categories at the detailed level of the classification which are grouped into two categories at the broad level. Based on the response for this data element, the broad classifications are:

- Indigenous
    - 1 (Aboriginal but not Torres Strait Islander origin)
    - 2 (Torres Strait Islander but not Aboriginal origin)
    - 3 (Both Aboriginal and Torres Strait Islander origin)
- Non-Indigenous
    - 4 (Neither Aboriginal nor Torres Strait Islander origin)
- For further information refer to the National best practice guidelines for collecting Indigenous status in health data sets available on the AIHW website at https://www.aihw.gov.au/reports/indigenous-australians/national-guidelines-collecting-health-data-sets/contents/table-of-contents

Locality

Three data elements are used with respect to locality:

- [Postcode]
- [Statistical Local Area]
- [Suburb / Locality]

[Postcode]

Apart from the postcode of the patient's residential address, two other postcodes are valid:

- [Postcode]: 0999 for:
    - Babies for Adoption
    - Unconscious patients
    - No Fixed Abode
    - Not Known
- [Postcode]: 9999 for:
    - Overseas

[Statistical Local Area]

The obsolete construct Statistical Local Area is expected to be replaced by the current construct Statistical Area Level 2 in 2021 or 2022.

Enter the statistical local area codes using leading zeros where necessary:

- [Statistical Local Area]: 4620
- [Statistical Local Area]: 0070

While Statistical Local Area is in use, note the above exception values in [Postcode].

[Suburb / Locality]

The suburb of the patient's usual residence. If the patient is from interstate, enter the patient's usual (permanent) address and not their holiday (temporary) address.

Reference file

Locality reference table available from Admitted Patient Care (APC), Admitted Patient Care resources.

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+performance/our+data+collections/admitted+patient+care/admitted+patient+care+resources

[Medicare Number]

[Medicare Number] is a ten-digit number which comprises:

- Eight digits
- A check digit (one digit)
- An issue number (one digit)

Note: the first digit of the Medicare card number should be in the range 2 to 6.

There are three broad categories of [Medicare Number].

- NNNNNNNNNN: A valid Medicare number (refer Medicare Number Check Digit Calculation below)
- 0000000009: Ineligible for Medicare
- 0000000000: Eligible but number unavailable

Up to date information on Medicare eligibility is available from the Department of Human Services:

https://www.humanservices.gov.au/individuals/services/medicare/medicare-card/eligibility/who-can-get-it

[Medicare Number IRN] is a one-digit number:

- 1-9: An individual reference number representing each family member on the Medicare card

Example

A Medicare-eligible patient with a Medicare Number of 4961 99187 1 who is the second individual reference number on the card is recorded as:

- [Medicare Number]: 4961 99187 1
- [Medicare Number IRN]: 2

A patient who is eligible for Medicare, but is not yet registered, is recorded as:

- [Medicare Number]: 0000000000
- [Medicare Number IRN]: 0

A patient who is ineligible for Medicare is recorded as:

- [Medicare Number]: 0000000009
- [Medicare Number IRN]: 0

A patient who is registered, but after considerable attempts the hospital is unable to obtain the Medicare number, is recorded as:

- [Medicare Number]: 0000000000
- [Medicare Number IRN]: 0

Medicare Number Check Digit Calculation

1. Calculate the sum of:
    - [(digit 1) + (digit 2 * 3) + (digit 3 * 7) + (digit 4 * 9) + (digit 5) + (digit 6 * 3) + (digit 7 * 7) + (digit 8 * 9)] where digit 1 is the first digit of the Medicare card number and digit 8 is the eighth digit of the Medicare card number.
    - Example: for Medicare card number '2123 45670 1', digit 1 is 2 and digit 8 is 7.
2. Divide the calculated sum by 10.

3. The check digit is the remainder.
    - Example: For Medicare card number 2123 4567.
    - (2) + (1 * 3) + (2 * 7) + (3 * 9) + (4) + (5 * 3) + (6 * 7) + (7 * 9) = 170
    - Divide 170 by 10. The remainder is 0.
    - The check digit for this Medicare number is 0

Nurse Initiated Management Plan

Treatment commences where a nurse initiates meaningful treatment according to an established clinical pathway. Established clinical pathways, protocol, set of guidelines, or accepted clinical practice, are not necessarily documented but are agreed procedures of the Emergency Department e.g. cannulation, radiology, ECG, vitalograph followed by administration of Ventolin nebs.

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 meaningful treatment.
- 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.

Patient number

Enter patient numbers with leading zeros where appropriate (e.g. pad the number with leading zeros to make it a 10-character number).

Thus, a patient number of 537859 is entered as: 0000537859.

The following data elements are in scope for patient numbers:

- [Patient Unit Record Number]

Reciprocal Health Care Agreements (RCHA)

As at May 2018, Australia has Reciprocal Health Care Agreements (RCHA) with 11 countries:

- Belgium
- Finland
- Italy
- Malta
- Netherlands
- New Zealand
- Norway
- Ireland
- Slovenia
- Sweden
- United Kingdom

Up to date information on overseas patient's eligibility is available from the Department of Human Services:

https://www.humanservices.gov.au/individuals/services/medicare/reciprocal-health-care-agreements/when-you-visit-australia

Patients presenting under a RCHA are treated as Medicare patients.

Sex and Gender

Sex refers to the anatomical differences between males and females, while the term Gender refers to the socially expected/perceived dimensions of behaviour associated with males and females: i.e. masculinity and femininity.

Work is underway to develop a national strategy to incorporate both Sex and Gender into the patient record.

It is recognised that collecting the Sex of a transsexual or transgender person can be very sensitive. Wherever possible, it is preferred that transsexuals and people with transgender issues have their Sex at the time of hospital admission recorded and not their preferred Gender. This avoids problems with data quality checks and in allocation of some DRGs.

Where uncertainty exists about the Sex of the person, the Sex to be recorded is to be based on the Sex nominated by the person themselves or on the observations or judgement of the interviewer. Although this may lead to some error, it is considered preferable to any offence that may be caused by a question that suggests that there is some doubt about the person's Sex or sexuality.

Hospitals should endeavour to resolve the Sex of a patient within the current hospital admission.

Statistical Local Area

The obsolete construct Statistical Local Area is expected to be replaced by the current construct Statistical Local Area 2 in 2021 or 2022.

Enter the statistical local area codes using leading zeros where necessary:

- [Statistical Local Area]: 5519
- [Statistical Local Area]: 0070

While Statistical Local Area is in use the following exception values:

- 0999 for patients:
    - Babies for adoption
    - No fixed abode
    - Unconscious patients
    - Unknown address
- 0009 for patients:
    - Usually residing overseas.

Data Submission Schedule

Data as at Month	Emergency	
	Submit by	File Refresh
Jul-19	07-Aug-19	13-Aug-19
Aug-19	06-Sep-19	12-Sep-19
Sep-19	08-Oct-19	11-Oct-19
Oct-19	07-Nov-19	13-Nov-19
Nov-19	06-Dec-19	12-Dec-19
Dec-19	07-Jan-20	14-Jan-20
Jan-20	07-Feb-20	13-Feb-20
Feb-20	06-Mar-20	12-Mar-20
Mar-20	07-Apr-20	13-Apr-20
Apr-20	08-May-20	13-May-20
May-20	05-Jun-20	11-Jun-20
Jun-20	07-Jul-20	13-Jul-20

For more information

Corporate Data Collection Systems
Data and Reporting Services
Level 6 11 Hindmarsh Square
Adelaide SA 5000
www.sahealth.sa.gov.au

For Official Use Only-I1-A1

www.ausgoal.gov.au/creative-commons

Government of South Australia
SA Health

© Department for Health and Wellbeing, Government of South Australia. All rights reserved