Specifications for revisions to the Victorian Emergency Minimum Dataset (VEMD) for 1 July 2019

December 2018

VICTORIA State Government | Health and Human Services

To receive this publication in an accessible format phone 03 9096 8595, using the National Relay Service 13 36 77 if required, or email HDSS.helpdesk@dhhs.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Department of Health and Human Services December 2018.

Available at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/annual-changes

Contents

Executive Summary ... **1**

Introduction ... **2**

Orientation to this document ... 2

Outcome of proposals ... **3**

Specifications for changes from 1 July 2019 ... **4**

Extend VEMD scope to collect activity for emergency presentations via telehealth and add codes for patients transferred to mental health and AOD hubs ... **4**

Section 3 Data definitions ... 4

Patient Location (new) ... 4

Service Type (new) ... 5

Departure Status (amend) ... 6

Departure Date (amend) ... 11

Departure Time (amend) ... 12

Diagnosis - Primary Diagnosis (amend) ... 13

First Seen by Doctor Date (amend) ... 13

Arrival Date (amend) ... 14

Arrival Time (amend) ... 14

Section 2 Concept and derived item definitions ... 15

Telehealth (new) ... 15

Emergency Department Presentation (amend) ... 15

Registration (amend) ... 16

Section 6 Validation reports and validations ... 16

E408 Patient location invalid (new) ... 16

E409 Patient location and service type combination invalid (new) ... 16

E410 Service type invalid (new) ... 16

E411 Departure status and service type combination invalid (new) ... 17

E412 Unregistered Mental Health and AOD Hub (new) ... 17

E125 Arrival transport mode invalid (amend) ... 17

E260 Primary diagnosis blank (amend) ... 18

E356 Type of usual accommodation and departure status combination invalid (amend) ... 18

E366 Departure status and triage category combination invalid (amend) ... 19

E182 First Seen By Treating Clinician Date/Time and Departure Status Combination Invalid (change to function only) ... 19

Section 4 Business rules ... 20

Clinician Date/Time and Departure Status (amend) ... 20

Departure Status and Referred to on Departure (amend) ... 21

Left Without Treatment (amend) ... 22

Primary Diagnosis (amend) ... 23

Departure Status and transfer fields (amend) ... 23

Amend Human Intent code set ... 24

Section 3 Data definitions ... 24

Human intent (amend) ... 24

Section 6 Validation reports and validations ... 25

E300 Human intent code invalid (change to function only) ... 25

E302 Human intent code and age incompatible (amend) ... 25

E391 The primary diagnosis for this record requires the completion of all Injury Surveillance data elements (change to function only) ... 25

Amend reporting guide for Advance Care Directive Alert ... 26

Section 3 Data definitions ... 26

Advance Care Directive Alert (amend) ... 26

Updated file naming convention for 2019-20 submissions ... 27

Section 5 Compilation and submission ... 27

File Naming Convention (amend) ... 27

Updated VEMD library file and editing matrices 2019-20 ... 27

Updated File structure ... 28

File Structure ... 28

Attachment 1: Service type and data items ... 32

Executive Summary

The revisions for the Victorian Emergency Minimum Dataset (VEMD) for 1 July 2019 are summarised below:

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 matrices for 2019-20.

Introduction

Each year the Department of Health and Human Services review the VEMD to ensure that the data collection supports the department's business objectives, including national reporting obligations, and reflects changes in hospital funding and service provision arrangements for the coming financial year.

Comments provided by the health sector in response to *Proposals for revisions to the VEMD for 1 July 2019* have been considered, and where possible, suggestions have been accommodated, resulting in changes to or withdrawal of some proposals.

The revisions set out in this document are complete as at the date of publication. Where further changes are required during the year, for example to reference files such as the postcode locality file, data validation rules or supporting documentation, these will be advised via the HDSS Bulletin.

An updated VEMD manual will be published in due course. Until then, the current VEMD manual and subsequent HDSS Bulletins, together with this document, form the data submission specifications for 2019-20.

Victorian health services must ensure their software can create a submission file in accordance with the revised specifications and ensure reporting capability is achieved to maintain compliance with reporting timeframes set out in the relevant *Department of Health and Human Services policy and funding guidelines.*

Orientation to this document

- New data items are marked as (new).
- Changes to existing data items are highlighted in green.
- Redundant values and definitions relating to existing items are ~~struck through~~.
- Comments relating only to the proposal document appear in *[square brackets and italics].*
- New validations are marked ###
- Validations to be changed are marked * when listed as part of a data item or below a validation table.
- Changes are shown under the appropriate manual section headings.

Outcome of proposals

Proposal 1 - Addition of data elements to indicate alcohol or drug impairment in a patient during an ED presentation

The proposal does not proceed.

Proposal 2 - Out of scope

Proposal 3 - Library file ICD code modification request

The proposal proceeds.

Proposal 4 - Collecting a lead indicator for suicide

The proposal proceeds.

Proposal 5 - Add codes for patients transferred to Mental Health and AOD Hub

The proposal proceeds as revised.

Proposal 6 - Removal of ambulance at destination and ambulance handover data items

The proposal does not proceed.

Proposal 7 - Addition of warning for ambulance off stretcher time if over 40 mins

The proposal does not proceed.

Proposal 8 - Withdrawn

Proposal 9 - Amendment of VEMD scope to report activity for Emergency presentations via telehealth video consultations

The proposal proceeds as revised.

Proposal 10 – Withdrawn

Proposal 11 - Level of frailty

The proposal does not proceed.

Proposal 12 - Amend reporting guide for Advance Care Directive Alert

The proposal proceeds.

Specifications for changes from 1 July 2019

Extend VEMD scope to collect activity for emergency presentations via telehealth and add codes for patients transferred to mental health and AOD hubs

Section 3 Data definitions

Patient Location (new)

Specification

Definition

The physical location of the patient during a Telehealth presentation.

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

This section: Patient location

Departure status

Service Type (new)

Specification

Definition The type of service provided to the patient by the emergency department

Reported for Every Emergency Department presentation.

Code Set

Code	Descriptor
1	General Emergency Presentation
2	Telehealth

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.

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

This section: Patient location

Departure status

Departure Status (amend)

Specification

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

Reported for Every Emergency Department presentation.

Code set Select the first appropriate category.

Code	Descriptor
Departure before treatment completed:	
11	Left at own risk, without treatment
10	Left after clinical advice regarding treatment options
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 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 Short Stay Unit.
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
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 – 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

[No change to remainder of item]

Departure Date (amend)

Specification

Definition The date the patient leaves the clinical area of the Emergency Department.

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. 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 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.

[No change to remainder of item]

Departure Time (amend)

Specification

Definition The time the patient leaves the clinical area of the Emergency Department.

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.

[No change to remainder of item]

Diagnosis - Primary Diagnosis (amend)

Specification

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 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'

[No change to remainder of item]

First Seen by Doctor Date (amend)

Specification

Definition

The date that a medical officer first assessed the patient.

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.

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

[No change to remainder of item]

Arrival Date (amend)

Specification

Definition The date on which the patient~~/client~~ presents for delivery of an Emergency Department service.

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.

[No change to remainder of item]

Arrival Time (amend)

Specification

Definition The time at which the patient presents for delivery of an Emergency Department service

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.

[No change to remainder of item]

Section 2 Concept and derived item definitions

Telehealth (new)

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 sub-regional RACS. 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 https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/telehealth/about-telehealth

Emergency Department Presentation (amend)

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 ("Telehealth") 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 sub-regional 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.

Registration (amend)

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.

Section 6 Validation reports and validations

E408 Patient location invalid (new)

Effect REJECTION

Problem The Patient Location code reported does not exist in the Patient Location code set.

Remedy Check the Patient Location code, correct as appropriate and re-submit the record.

See Section 3: Patient Location

E409 Patient location and service type combination invalid (new)

Effect REJECTION

Problem Either:

- The Patient Location has been reported and the Service Type is 1 – General Emergency Presentation; or
- The Patient Location has not been reported and the Service Type is 2 – Telehealth.

Remedy Check the Service Type and the Patient Location, correct as appropriate and re-submit the record.

See Section 3: Patient Location

Service Type

E410 Service type invalid (new)

Effect REJECTION

Problem The Service Type code reported 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 3: Service Type

E411 Departure status and service type combination invalid (new)

Effect **REJECTION**

Problem The Departure Status code is:

- T1, T2, T3, T4, T5, T6, or T7 – Telehealth but the Service Type is 1 – General Emergency Presentation, OR
- not T1, T2, T3, T4, T5, or T6 and the Service Type is 2 – Telehealth.

Remedy Check the Service Type, correct as appropriate and re-submit the record.

See Section 3: Departure Status

Service Type

E412 Unregistered Mental Health and AOD Hub (new)

Effect **REJECTION**

Problem The Departure Status is reported as 31 – Mental Health and AOD Hub Short Stay Unit, but the Campus does not have an approved Mental Health and AOD Hub.

Remedy Check the Departure Status, correct as appropriate and re-submit the record.

If you believe the campus does have an approved Mental Health and AOD Hub Short Stay Unit contact the HDSS Helpdesk.

See Section 3: Departure Status

E125 Arrival transport mode invalid (amend)

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

E260 Primary diagnosis blank (amend)

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.

[No change to remainder of item]

E356 Type of usual accommodation and departure status combination invalid (amend)

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. ~~It is unlikely that a patient with an identified Type of Usual Accommodation of 11 would have a Departure Status other than 12 indicating the patient remains in custodial care.~~

Remedy Correct as appropriate and re transmit.

E366 Departure status and triage category combination invalid (amend)

Effect	**WARNING**
Problem	The Departure Status of the record 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 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, 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

E182 First Seen By Treating Clinician Date/Time and Departure Status Combination Invalid (change to function only)

Clinician Date/Time and Departure Status (amend)

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				

Departure Status and Referred to on Departure (amend)

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 campus:		
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

Left Without Treatment (amend)

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', or '30 – Left after Clinical advice regarding treatment options – GP Co-Located clinic' '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
First Seen By Treating Nurse	Blank
First Seen By Treating Nurse	Blank
Procedure	Blank
Referred To On Departure	If Departure Status = 10 or 30 • Any code between 1 and 18 If Departure Status = 11 or T1 • '19 – Not Applicable'

Primary Diagnosis (amend)

A Primary Diagnosis is MANDATORY unless Departure Status is:

- 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 Hub Short Stay Unit (Primary Diagnosis is 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 is:

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

Departure Status and transfer fields (amend)

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

Amend Human Intent code set

Section 3 Data definitions

Human intent (amend)

Specification

Definition

Clinician's assessment of the most likely human intent in the occurrence of the injury or poisoning.

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 Matrices).

Code Set

Code	Descriptor
1	Non-intentional harm
~~**2**~~	~~Intentional self-harm~~
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
18	Intentional self-harm - non-suicidal self-injury
19	Intentional self-harm - suicide attempt
20	Intentional self-harm, suicidal intent cannot be determined

[No change to remainder of item]

Section 6 Validation reports and validations

E300 Human intent code invalid (change to function only)

E302 Human intent code and age incompatible (amend)

Effect	**WARNING**
Problem	There is an invalid combination of the Human Intent code and the patient's age If Human Intent is: ~~'2 - Intentional Self-harm': age should be greater than 10 years~~ 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

E391 The primary diagnosis for this record requires the completion of all Injury Surveillance data elements (change to function only)

Amend reporting guide for Advance Care Directive Alert

Section 3 Data definitions

Advance Care Directive Alert (amend)

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 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 alert

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 goals of patient care form, resuscitation plan, or limitation of treatment order meet the requirements for this data item when combined with a record of the discussion of the person's preferences for future care.~~

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 ~~health care~~ 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
- ~~Nominated Person under the Mental Health Act (Vic) 2014~~
- ~~Support person appointment~~

Advance care planning: have the conversation: A strategy for Victorian health services 2014-2018 (the Strategy) www.health.vic.gov.au/acp

Updated file naming convention for 2019-20 submissions

Section 5 Compilation and submission

File Naming Convention (amend)

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

File Naming Convention	AAAABnna.txt		
Where	AAAA	=	Campus Code **Example** **9999**
	B	=	Version of the dataset (last digit) (2019-20 is version 24. Code '4' will be used)
	nn	=	Month of Transmission (example 07=July)
	a	=	Data Submission Indicator **Example** **1st July submission 07a** **2nd July submission 07b** **3rd July submission 07c** Must be consecutive, with no gaps, commencing with 'a' for the first submission for the month.
Extract: 9999407a.txt			

Updated VEMD library file and editing matrices 2019-20

The VEMD library file and editing matrices for 2019-20 will be provided at a later date. This edition will include the following modification.

Code	Description	VEMD description
O021	Missed abortion	Missed abortion, miscarriage
O033	Spontaneous abortion, incomplete, with other and unspecified complications	Abortion/miscarriage, incomplete with complications unspecified
O034	Spontaneous abortion, incomplete, without complication	Abortion/miscarriage, incomplete without complications
O039	Spontaneous abortion, complete or unspecified, without complication	Abortion/miscarriage, complete and/or spontaneous

Updated File structure

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 the Mandatory Items Key (Table 2) for the conditions under which they become mandatory.

Table 1- Data Item Format

Key	Data Item	Max Characters	Layout/Code Set
1	Campus Code	4	XXXX
1	Unique Key	9	XXXXXXXXX
1	Patient Identifier	10	XXXXXXXXXX
2	Medicare Number	11	NNNNNNNNNNN or blank
1	Medicare Suffix	3	XXX
14	DVA Number	9	See Section 3
1	Sex	1	1, 2, 3, 4
1	Date of Birth	8	DDMMYYYY
1	Date of Birth Accuracy Code	3	XXX
1	Country of Birth	4	XXXX
1	Indigenous Status	1	1, 2, 3, 4, 8, 9
1	Interpreter Required	1	1, 2, 9
1	Preferred Language	4	XXXX
1	Locality	22	XXXXXXXXXXXXXXXXXXXXXX
1	Postcode	4	NNNN
1	Type of Usual Accommodation	2	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 18, 19
1	Arrival Transport Mode	2	1, 2, 3, 6, 8, 9, 10, 11, 99 or blank
1	Referred By	2	0, 1, 2, 4, 6,14,15,16,17,18 19,20,21,22
3	Transfer Source	4	XXXX or blank

Key	Data Item	Max Characters	Layout/Code Set
1	Type of Visit	2	1, 2, 8, 10
1	Compensable Status	1	1, 2, 3, 4, 5, 6, 7
4	Ambulance Case Number	10	See Section 3
1	Arrival Date	8	DDMMYYYY
1	Arrival Time	4	HHMM
1	Triage Date	8	DDMMYYYY
1	Triage Time	4	HHMM
1	Triage Category	1	1, 2, 3, 4, 5, 6
8	Nurse Initiation of Patient Management Date	8	DDMMYYYY or blank
8	Nurse Initiation of Patient Management Time	4	HHMM or blank
9	First Seen by Doctor Date	8	DDMMYYYY or blank
9	First Seen by Doctor Time	4	HHMM or blank
8	Seen by Mental Health Practitioner Date	8	DDMMYYYY or blank
8	Seen by Mental Health Practitioner Time	4	HHMM or blank
13	Procedure	89	XX (x30) (Not collected from 1 July 2016)
12	Clinical Decision to Admit Date	8	DDMMYYYY or blank
12	Clinical Decision to Admit Time	4	HHMM or blank
1	Departure Date	8	DDMMYYYY
1	Departure Time	4	HHMM
1	Departure Status	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, T6, T7
5	Transfer Destination	4	XXXX or blank
1	Referred to on Departure	2	1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 16, 17, 18, 19
5	Reason for Transfer	1	1, 2, 3, 4, 5, 6, 7, 9 or blank
6	Departure Transport Mode	2	1, 2, 3, 4, 6, 7, 8, 10, 11, 19 or blank

Key	Data Item	Max Characters	Layout/Code Set
15	Primary Diagnosis	5	VEMD subset of ICD-10-AM Codes
11	Additional Diagnosis 1	5	VEMD subset of ICD-10-AM Codes
	Additional Diagnosis 2	5	VEMD subset of ICD-10-AM Codes
7	Nature of Main Injury	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
7	Body Region	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 or blank
7	Description of Injury Event	250	Free text
7	Injury Cause	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
7	Human Intent	2	1, 2, 12, 13, 14, 15, 16, 17, 6, 8, 9 or blank
7	Place Where Injury Occurred	1	H, I, S, A, R, T, C, Q, F, M, P, O, U or blank
7	Activity When Injured	1	S, L, W, E, C, N, V, O, U or blank
16	Ambulance at Destination Date	8	DDMMYYYY or blank
16	Ambulance at Destination Time	4	HHMM or blank
16	Ambulance Handover Complete Date	8	DDMMYYYY or blank
16	Ambulance Handover Complete Time	4	HHMM or blank
17	Advance Care Directive Alert	1	1, 2, 3, 4 or blank
14	Given Name	15	See Section 3 XXXXXXXXXXXXXXX or blank
14	Family Name	25	See Section 3 XXXXXXXXXXXXXXXXXXXXXXXXX or blank
1	Service Type	1	1, 2
18	Patient Location	4	XXXX or blank

Mandatory Items Key (Table 2)

Key	Descriptor
1	Mandatory item
2	Mandatory if Medicare Suffix does not equal C-U, N-E or P-N
3	Mandatory if Referred By = 6
4	Should be reported if Arrival Transport Mode = 1, 2, 3, 10 or 11
5	Mandatory if patient is transferred to another hospital campus. Departure status is: 17 - Mental Health bed at another Hospital Campus 19 - Another Hospital Campus (excludes for Mental Health and ICU or CCU transfer) 20 - Another Hospital Campus - Intensive Care Unit 21 - Another Hospital Campus - Coronary Care Unit
6	Mandatory where Departure Status code is not 10 – Left after clinical advice regarding treatment options, 11 – Left at own risk, without treatment, or 30 – Left after clinical advice regarding treatment options – GP Co-Located Clinic. Blank for Departure Status codes 10 11 or 30
7	See Section 4 – Business Rules, Injury Surveillance.
8	Blank if Departure Status = 8, 10, 11, or 30
9	Blank where Departure Status = 10 – Left after clinical advice, regarding treatment options, 11- Left at own risk, without treatment, or 30- Left after clinical advice regarding treatment options - GP Co-Located Clinic.
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 DHHS
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 = 2

Attachment 1: Service type and data items

Table 3: Service type and applicable data items

VEMD 2019-20 data item	Service Type 1- General Emergency Presentation	Service Type 2- Teleheatlh
Activity When Injured	C	C
Additional Diagnosis 1	O	O
Additional Diagnosis 2	O	O
Advance Care Directive Alert	M	M
Ambulance at Destination Date	C	N
Ambulance at Destination Time	C	N
Ambulance Case Number	C	N
Ambulance Handover Complete Date	C	N
Ambulance Handover Complete Time	C	N
Arrival Date	M	M
Arrival Time	M	M
Arrival Transport Mode	M	N
Body Region	C	C
Campus Code	M	M
Clinical Decision to Admit Date	C	N
Clinical Decision to Admit Time	C	N
Compensable Status	M	M
Country of Birth	M	M
Date of Birth	M	M
Date of Birth Accuracy Code	M	M
Departure Date	M	M
Departure Status	M	M
Departure Time	M	M
Departure Transport Mode	C	N
Description of Injury Event	C	C
DVA Number	C	C
Family Name	C	C
First Seen by Doctor Date	C	C
First Seen by Doctor Time	C	C
Given Name	C	C
Human Intent	C	C
Indigenous Status	M	M
Injury Cause	C	C
Interpreter Required	M	M
Locality	M	M
Medicare Number	C	C

VEMD 2019-20 data item	Service Type 1- General Emergency Presentation	Service Type 2- Teleheatlh
Medicare Suffix	M	M
Nature of Main Injury	C	C
Nurse Initiation of Patient Management Date	C	C
Nurse Initiation of Patient Management Time	C	C
Patient Identifier	M	M
Patient Location	N	M
Place Where Injury Occurred	C	C
Postcode	M	M
Preferred Language	M	M
Primary Diagnosis	C	C
Reason for Transfer	C	N
Referred By	M	N
Referred to on Departure	M	M
Seen by Mental Health Practitioner Date	C	C
Seen by Mental Health Practitioner Time	C	C
Service Type	M	M
Sex	M	M
Transfer Destination	C	N
Transfer Source	C	N
Triage Category	M	M
Triage Date	M	M
Triage Time	M	M
Type of Usual Accommodation	M	M
Type of Visit	M	M
Unique Key	M	M

Table 4: Key

Key	Descriptor
M	Mandatory
C	Conditional
O	Optional
N	Not collected (leave blank)