Section 4 – Business rules

Victorian Emergency Minimium Dataset (VEMD) manual

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Contents

Introduction

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

Clinician Date/Time and Departure Status

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

Departure Status		Seen by Mental Health Practitioner Date/Time	Nurse Initiation of Patient Management Date/Time	First Seen by Doctor Date/Time
8	Dead on Arrival	Blank	Blank	Time patient's death was certified
10	Left after Clinical Advice regarding treatment options	Blank	Blank	Blank
11	Left at own risk, without treatment	Blank	Blank	Blank
30	Left after clinical advice regarding treatment options – GP Co-Located Clinic	Blank	Blank	Blank
Refer to Section 6: E182 - Seen by Clinician date/time and Departure status combination invalid				

Dead on Arrival

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

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

OR

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

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

If the Departure Status is dead on arrival then the following fields MUST contain these values:

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

All other mandatory fields should also be reported.

If the Departure Status is NOT dead on arrival then the following fields MUST NOT contain these values:

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

See: Section 2: Death – Verification and Certification

See: Section 6: E142 Dead on Arrival

Departure Status and Referred to on Departure

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

If Departure Status is:		Referred to on Departure must be:
Departure Before Treatment Completed:		
11	Left at own risk, without treatment	19
10	Left after clinical advice regarding treatment options	1 – 18
30	Left after clinical advice regarding treatment options – GP Co-Located Clinic	1 – 18
5	Left at own risk, after treatment started	19
7	Died within ED	19
8	Dead on arrival	19
Theatre/procedure setting at this hospital		
27	Cardiac catheter laboratory	19
28	Other procedure room or operating theatre	19
Ward Setting at this Hospital Campus:		
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
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	1 – 18
24	Residential care facility includes nursing home, hostel.	1 – 18
12	Correctional/Custodial Facility	1 – 18
1	Home	1 – 18

Injury Surveillance

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

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

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

- As many Injury Surveillance fields as were collected prior to the patient's departure
- Departure Status of 10, 11 or 30
- No Diagnosis codes for Departure Status 11
- Diagnosis optional for Departure Status 10 or 30

Injury surveillance fields (including Description of Injury Event) are not permitted with any primary diagnosis that is not an injury code (starting with either 'S' or 'T').

The VEMD Editing Matrix lists S and T codes and flags those where completion of the Injury Surveillance fields is optional. Refer https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files

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

Examples:

1. Poisoning as child ingested 8 paracetamol tablets (cardboard packet of brand X) found in bathroom cabinet while playing in the bathroom at home.
2. Crush injury to foot, wooden pallet dropped onto foot whilst working at a construction site, wearing safety boots with steel capped toes at the time.
3. Shop assistant received contusion to cheek, punched in face by angry customer at the local shopping centre.

	Example 1	Example 2	Example 3
Primary Diagnosis	[Use code T391] Poisoning, paracetamol	[Use code S978] Crush injury of foot	[Use code S0080] Contusion of cheek
Nature of Main Injury	[Use code 20] Poisoning, toxic effect	[Use code 9] Crushing injury	[Use code 1] Superficial
Body Region	[Use code 22] Body Region not applicable	[Use code 19] Foot	[Use code 2] Face
Description of Injury Event	Poisoning as child ingested 8 paracetamol tablets (cardboard packet of brand X) found in bathroom cabinet while playing at home	Crush injury to foot, wooden pallet dropped onto foot whilst working at a construction site, safety boots with steel capped toes	Shop assistant received contusion to cheek, punched in face by angry customer at the local shopping centre

Injury Cause	[Use code 17] Poisoning - medication	[Use code 24] Struck by or collision with object	[Use code 23] Struck by or collision with person
Human Intent	[Use code 1] Non-intentional harm	[Use code 1] Non-intentional harm	[Use code 17] neglect, maltreatment, assault by other/unknown
Place Where Injury Occurred	[Use code H] Own home, bathroom	[Use code C] Construction site	[Use code T] Shopping centre
Activity When Injured	[Use code L] Leisure	[Use code W] Working for income	[Use code W] Working for income

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

For example:

- 'Tripped on tree root in back yard. TBSB Dr Jacob' becomes

  'Tripped on tree root in back yard'

- 'James presented with third overdose this week' becomes

  'Patient presented with third overdose this week.'

Hospitals and software vendors should contact HDSS Helpdesk if they have any further queries.

VEMD Editing Matrices

The VEMD Editing Matrices provide a reference showing valid combinations between Primary Diagnosis injury codes and particular injury surveillance fields.

The VEMD Editing Matrix is on the HDSS Website at https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/reference-files

Interpreter Required and Preferred Language

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

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

Validations	E359	Invalid Comb Int Req/Pref Lang
Related Items	Section 3	Interpreter Required Preferred Language Refer to Preferred Language code set at: HDSS website

Left Without Treatment

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

Field	Value
Departure Date / Time	Date and Time the patient left the ED
Departure Status	'10 – Left after clinical advice regarding treatment options', '11 - Left at Own Risk, Without Treatment', or '30 – Left after Clinical advice regarding treatment options – GP Co-Located clinic'
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 • '19 – Not Applicable'
Injury Surveillance Fields (all pertinent validations and business rules still applied). All or any of the Injury Surveillance fields can be submitted for any episode where the Departure Status is: 10 – Left after Clinical Advice regarding Treatment Option, 30 - Left after Clinical advice regarding treatment options – GP Co-Located clinic OR 11- Left at Own Risk, Without Treatment.	
Activity When Injured	
Body Region	
Description of Main Injury	
Human Intent	Optional
Injury Cause	
Nature of Main Injury	
Place Where Injury occurred	

Locality / Postcode

There are two categories of Postcode/Locality errors:

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

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

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

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

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

Rejected (validation 115) if there is not an exact match for both Locality and Postcode.

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

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

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

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

Nature of Main Injury and Body Region

Valid combinations for Nature of Main Injury and Body Region:

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

For further information, refer to the VEMD Editing Matrices on the HDSS website.

Primary Diagnosis

A Primary Diagnosis is MANDATORY unless Departure Status equals:

- 30 Left after clinical advice regarding treatment options – GP Co-Located Clinic (Primary Diagnosis optional); or
- 10 Left after clinical advice regarding treatment options (Primary Diagnosis optional); or
- 11 Left at own risk, without treatment (Primary Diagnosis must be blank)

If Departure Status equals:

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

Transfer to another Hospital Campus

If a patient is transferred to another hospital campus for continuing treatment the following fields MUST contain these values (all other fields should be completed as appropriate):

Field	Value
Departure Date / Departure Time	Date and Time the patient left the ED
Departure Status	17 - Mental Health bed at another Hospital campus 20 - Another Hospital Campus - Intensive Care Unit 21 - Another Hospital Campus - Coronary Care Unit 19 - Another hospital campus (excludes for Mental Health and ICU or CCU transfer)
Departure Transport Mode	Select the appropriate Mode of Transport: 1 – Air Ambulance 2 – Helicopter 3 – Ambulance Service – MICA 4 – Ambulance Service – Road Car 6 – Community / Philanthropic Service 7 – Private Car 8 – Police Vehicle 10 – Ambulance Service – private ambulance car – AV contracted 11 – Ambulance Service – hospital contracted 19 – Other
Reason for Transfer	Select the appropriate Reason for Transfer: 1 – ICU bed not available 2 – CCU bed not available 3 – General bed not available 4 – Specialty not available 5 – Previous patient of destination hospital 6 – Insured / Compensable 7 – Patient preference 9 – Other Reason
Referred to on Departure	19 – Not Applicable
Transfer Destination	Hospital code of destination hospital

Departure Status and transfer fields

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

- Not Null, **OR**
- Null.

Departure Status	Transfer Destination	Reason for Transfer	Departure Transport Mode
17,19,20,21	Valid Campus Code	Not Null	Not Null
1,3,5,7,8,10,11,12,14, 15,18,22,23,24,25,26,27,28,30	Null	Null	Null

Referred by and Transfer Source

Valid combinations for Referred By and Transfer Source

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