Victorian Emergency Minimum Dataset (VEMD) User Manual

22nd Edition 2017–18

Section 3 Data definitions

Download from the Department of Health and Human Services web site at:
https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems

Published By:	The Department of Health and Human Services, Victoria
Authorised By:	The Victorian Government 50 Lonsdale Street, Melbourne
Version:	1.0

Contents

SECTION 3: Data Definitions

This section provides the specifications for each VEMD data item. Within each part, data items are sequenced in alphabetical order.

Sites and software vendors should be aware that this manual describes the data as submitted to DHHS, not as stored internally in a site's system. Sites should map from their internally stored values to the values specified for VEMD.

Data Definition Structure

Specification

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

Administration

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

Data Items

Activity When Injured

Specification

Definition

The type of activity being undertaken by the person, at the moment the injury occurred.

Reported 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	Includes	Excludes
S	Sports (sport as means of leisure or income)	Physical exercise with a described functional element such as: golf, riding, jogging, skiing, school athletics, swimming, trekking, water skiing.	Leisure (L)
L	Leisure	Hobby activities; leisure time activities with an entertainment element such as being at a cinema, a dance or party; participating in activities of a voluntary organisation.	Sports (S)
W	Working for income	Paid work for salary (manual) (professional), bonus and other types of income; transportation (time) to and from such activities.	Voluntary work (L) Sports (S)
E	Education	Formal education, learning activities, such as: attending school session or lesson, university, undergoing education.	
C	Other work	Unpaid domestic duties such as: caring for children and relatives, cleaning, gardening, household maintenance, cooking. Other duties for which income is not gained, such as: unpaid work in family business.	Voluntary work (L)
N	Being nursed, cared for	Care of infant by parent, patient by nurse.	
V	Vital activity, resting, sleeping, eating	Personal hygiene, other personal activity	
O	Other specified activity		
U	Unspecified activity		

Reporting guide	Report the first appropriate code listed in the table which best characterises the type of activity being undertaken by the person at the time when the injury occurred, on the basis of the information available at the time the information is recorded. If two or more categories are judged to be equally appropriate, select the code which is sequenced first in the code list. Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.	
Validations	**E310**	Activity When Injured Code Invalid
	E391	The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements
Related items	This section	Body Region Description of Injury Event Human Intent Injury Cause Nature of Main Injury Place where Injury Occurred.
	Section 4	Primary Diagnosis Injury Surveillance

Administration

Purpose	To facilitate injury research.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
Definition source	Department of Health and Human Services	**Code set source**	Department of Health and Human Services

Advance Care Plan Alert

Specification

Definition

An alert, flag or similar that is obvious to any treating team across the health service that indicates:

- an advance care plan is on file, and/or
- substitute 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 plan alert
2	Presence of an advance care plan alert
3	Presence of a substitute decision maker alert
4	Presence of both an advance care plan alert and a substitute decision maker alert

Reporting guide

An advance care plan alert will be identified by an alert identifying any of the following:

- A completed Refusal of Treatment Certificate
- A formally documented advance care plan
- Other advance care planning documentation (documentation of a person's future wishes such as a written letter 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 substitute decision maker alert will be identified by an alert, flag or similar identifying any of the following:

- Medical Enduring Power of Attorney
- Enduring Power of Guardianship which includes consent to health care
- Guardian appointed by VCAT with powers to consent to health care
- Nomination in writing of a person responsible
- Identification of the 'person responsible' as per the 'person responsible hierarchy'
- Nominated Person under the Mental Health Act (Vic) 2014

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

Validations

E406 Advance Care Plan Alert invalid

Administration

Purpose To enable monitoring of advance care planning uptake

Principal data users DHHS

Collection start 1 July 2017 **Version** 1 (Effective 01.07.17)

Definition source DHHS **Code set source** DHHS

Ambulance at Destination Date

Specification

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

Administration

Purpose	Analysis of reception of patients via ambulance into the ED		
Principal data users	Ambulance Victoria; Department of Health and Human Services.		
Collection start	1 July 2014	**Version**	1 (Effective 01.07.14) 2 (Effective 01.07.17)
Definition source	Department of Health and Human Services	**Code set source**	Department of Health and Human Services

Ambulance at Destination Time

Specification

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

Administration

Purpose	Analysis of reception of patients via ambulance into the ED		
Principal data users	Ambulance Victoria; Department of Health and Human.		
Collection start	1 July 2014	**Version**	1 (Effective 01.07.14) 2 (Effective 01.07.17)
Definition source	Department of Health and Human Services	**Code set source**	Department of Health and Human Services

Ambulance Case Number

Specification

Definition	Unique identifier issued by Ambulance Victoria (AV) for each ambulance transport occasion.
Reported for	All ED presentations arriving by ambulance
Code Set	A valid Ambulance Case Number
	Alternate Codes
	Ambulance Case Number not available due to:
	B – Industrial action (for example: bans, strikes)
	U – Not provided by Ambulance Officer
	If the patient arrives via an interstate ambulance service, Ambulance Case Number should be either:
	ACT, NSW, NT, QLD, SA, TAS or **WA**
Validations	**E392** Invalid Ambulance Case Number

Administration

Purpose	Analysis of ambulance service delivery:		
Principal data users	Ambulance Victoria; Monash Injury Research Institute; Department of Health and Human Services		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.02) 3 (Effective 01.07.03) 4 (Effective 01.07.04) 5 (Effective 01.09.07) 6 (Effective 01.07.11) 7 (Effective 01.07.12) 8 (Effective 01.07.13) 9 (Effective 01.07.17)
Definition source	Department of Health and Human Services	**Code set source**	Department of Health and Human Services

Ambulance Handover Complete Date

Specification

Definition

The date when:

- clinical information has been given to the ED clinician; and
- the patient has been moved from the ambulance stretcher to the hospital bed, care area or waiting room.

Reported for

All ED patients arriving by ambulance. Non-Emergency Patient Transport vehicles arriving at the ED are included.

Reporting Guide

Handover may be provided to ED clinicians (including a nurse or doctor) when the patient is transferred to a hospital bed, care area or waiting room.

Paramedics may need to retrieve some ambulance equipment prior to completion of handover.

'Ambulance handover complete' is recorded as the actual time that has been confirmed by the ED clinician and ambulance paramedics.

'Ambulance handover complete' time does not include:

- Paramedics watching how a patient is managed in the ED subsequent to handover
- Cleaning of equipment and re-stocking of ambulance vehicle.
- Completion of VACIS following ambulance handover complete.

ED staff are responsible for entering the time into the ED information system. Paramedics are responsible for entering the time into VACIS.

Validations

E399	Ambulance Handover Complete Date/Time Invalid

Related Items

This section:	Ambulance at Destination Date Ambulance at Destination Time Ambulance Case Number Ambulance Handover Complete Time
Section 2:	Ambulance Handover Complete Date/Time fields

Administration

Purpose Analysis of handover of patients from Ambulance Victoria to ED

Principal data users Ambulance Victoria; Department of Health and Human Services.

Collection start	1 July 2014	**Version**	1 (Effective 01.07.14) 2 (Effective 01.07.17)
Definition source	Department of Health and Human Services	**Code set source**	Department of Health and Human Services

Ambulance Handover Complete Time

Specification

Definition

The time when:

- clinical information has been given to the ED clinician; and
- the patient has been moved from the ambulance stretcher to the hospital bed, care area or waiting room.

Reported for

All ED patients arriving by ambulance. Non-Emergency Patient Transport vehicles arriving at the ED are included.

Reporting Guide

A valid 24-hour time (0000 to 2359)

Handover may be provided to ED clinicians (including a nurse or doctor) when the patient is transferred to a hospital bed, care area or waiting room.

Paramedics may need to retrieve some ambulance equipment prior to completion of handover.

'Ambulance handover complete' is recorded as the actual time that has been confirmed by the ED clinician and ambulance paramedics.

'Ambulance handover complete' time does not include:

- Paramedics watching how a patient is managed in the ED subsequent to handover
- Cleaning of equipment and re-stocking of ambulance vehicle.
- Completion of VACIS following ambulance handover complete.

ED staff are responsible for entering the time into the ED information system. Paramedics are responsible for entering the time into VACIS.

Validations

E399	Ambulance Handover Complete Date/Time Invalid

Related Items

This section:	Ambulance at Destination Date Ambulance at Destination Time Ambulance Case Number Ambulance Handover Complete Date
Section 2:	Ambulance Handover Complete Date/Time fields

Administration

Purpose

Analysis of handover of patients from Ambulance Victoria to ED

Principal data users

Ambulance Victoria; Department of Health and Human Services.

Collection start

1 July 2014

Version

1 (Effective 01.07.14)

2 (Effective 01.07.17)

Definition source

Department of Health and Human Services.

Code set source

Department of Health and Human Services.

Arrival Date

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.

Validations

E025	Duplicate Attendance
E086	Medicare IRN and Date of Birth Combination Invalid
E089	Medicare IRN and Date Of Birth Combination Invalid
E093	Sex Indeterminate and Age Less Than 90 Days
E095	Date of Birth Invalid
E103	Invalid Combination of Date Of Birth, Arrival Date and Country Of Birth
E155	Arrival Date/Time Invalid
E167	Triage Date/Time Before Arrival Date/Time
E219	Length Of Stay Greater Than 10 Days
E340	Departure Date/Time Less Than or Equal To Arrival Date/Time
E350	Length Of Stay Greater Than 4 and Less Than 10 Days
E351	Potentially Excessive Time to Initiation of Patient Management
E389	Triage Category 1 patient – Excessive Time to Initiation of Patient Management
E395	Clinical Decision to Admit Date/Time Before Arrival Date/Time

Related items

This section	Arrival Time
Section 2	Length of Stay
	Registration
	Time to Initiation of Patient Management

Administration

Purpose
Used in the calculation of various derived items, including:
Age at admission
Length of Stay
Time to Initiation of Patient Management

Principal data users
Monash Injury Research Institute; Department of Health and Human Services.

Collection start
1 July 1995

Version
1 (Effective 01.07.95)
2 (Effective 01.07.02)
3 (Effective 01.07.16)

Definition source
Department of Health and Human Services.

Code set source
Department of Health and Human Services.

Arrival Time

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.

Validations

E025	Duplicate Attendance
E095	Date of Birth Invalid
E103	Invalid Combination of Date Of Birth, Arrival Date and Country Of Birth
E155	Arrival Date/Time Invalid
E167	Triage Date/Time Before Arrival Date/Time
E219	Length Of Stay Greater Than 10 Days
E340	Departure Date/Time Less Than or Equal To Arrival Date/Time
E350	Length Of Stay Greater Than 4 and Less Than 10 Days
E351	Potentially Excessive Time to Initiation of Patient Management
E372	Age Invalid
E389	Triage Category 1 patient – Excessive Time to Initiation of Patient Management
E395	Clinical Decision to Admit Date/Time Before Arrival Date/Time

Related items

This section	Arrival Time
Section 2	Length of Stay. Registration Time to Initiation of Patient Management

Administration

Purpose

Used in the calculation of various derived items:

Age at admission: Arrival Date/Time and Date of Birth

Length of Stay: Arrival Date/Time and Departure Date/Time

Time to Initiation of Patient Management

Principal data users

Monash Injury Research Institute; Department of Health and Human Services.

Collection start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.02) 3 (Effective 01.07.16) 4 (Effective 01.07.17)
Definition source	Department of Health and Human Services.	**Code set source**	Department of Health and Human Services.

Arrival Transport Mode

Specification

Definition The type of transport the patient utilised to arrive at the Emergency Department

Reported for Every Emergency Department presentation.

Code set

Code	Descriptor
1	Air ambulance - fixed wing aircraft (Excludes helicopter - Code 2)
2	Helicopter
3	Road Ambulance service
6	Community/public transport (includes council / philanthropic services)
8	Police vehicle
9	Undertaker
10	Ambulance service - private ambulance car - AV contracted
11	Ambulance service - private ambulance car - hospital contracted
99	Other

Reporting guide For journeys involving more than one transport mode, select the mode of transport in which the greater distance of the journey was undertaken.

For example:

Most patients transported by air require road transportation to and/or from the transferring hospital. Where the air transport involves the greater distance, select code 1 or 2 as appropriate.

Validations

E125 Arrival Transport Mode Invalid

E142 Dead on Arrival Combination Invalid

E397 Ambulance at Destination Date/Time and Arrival Transport Mode invalid

Related items

Section 2
- Ambulance at Destination
- Ambulance Handover Complete

Section 3
- Ambulance at Destination Date
- Ambulance at Destination Time
- Ambulance Handover Complete Date
- Ambulance Handover Complete Time

Administration

Purpose Analysis of transport service utilisation and coordination.

Principal data users Ambulance Victoria; Monash Injury Research Institute; Department of Health and Human Services.

Collection start 1 July 1995

Version
- 1 (Effective 01.07.95)
- 2 (Effective 01.07.97)
- 3 (Effective 01.07.99)
- 4 (Effective 01.07.03)

Definition source 1 July 1995

Code set source Department of Health & Human Services.

Body Region

Specification

Definition

The region of the body where the injury was sustained.

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).

There are two sets of Body Region codes based on whether or not the Nature of Main Injury code indicates that the injury is due to a foreign body.

Foreign body - 'any object or substance found in an organ or tissue in which it does not belong under normal circumstances, such as a bolus of food in the trachea or a particle of dust in the eye' (Mosby's Medical, Nursing & Allied Health Dictionary, 6th Edition, Mosby Inc, 2002, p. 699)

Code set 1

Body Region – Foreign body injury

Code	Descriptor
F1	Eye
F2	Ear
F3	Nose
F4	Respiratory tract (excludes nose - use code F3)
F5	Digestive tract
F6	Genitourinary tract
F7	Soft tissue

Reporting guide

Must be reported if Nature of Main Injury is '14 Foreign Body'

Select the first appropriate category

Excludes:

Non-foreign body injury (refer to Body Region-Non foreign body injury.)

Code set 2

Body Region – Non-Foreign body injury

Code	Descriptor
1	Head (includes ear; excludes face – use code 2)
2	Face (excludes eye, use code 22)
3	Neck
4	Thorax
5	Abdomen
6	Lower back (includes loin)
7	Pelvis (includes ano genital and perineum)
8	Shoulder
9	Upper arm
10	Elbow
11	Forearm
12	Wrist

13	Hand (includes fingers)
14	Hip
15	Thigh
16	Knee
17	Lower leg
18	Ankle
19	Foot (includes toes)
20	Unspecified body region
21	Multiple injuries involving more than one body region
22	Body Region not applicable

Reporting guide

Must be reported if Nature of Main Injury is not '14 - Foreign Body'

Select the first appropriate category.

Excludes:
Foreign Body injury (refer to Body Region-Foreign body injury).

Each injury code in the Primary Diagnosis field is matched in the Nature of Main Injury and Body Region matrix. For valid combinations, refer to the VEMD Editing Matrix at: VEMD reference files

Validations

E286 Body Region Code Invalid.

E320 Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid.

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

Related items

This section	Activity When Injured
	Description of Injury Event
	Human Intent
	Injury Cause
	Nature of Main Injury
	Place Where Injury Occurred
Section 4	Primary Diagnosis
	Injury Surveillance
	Nature of Main Injury and Body Region

Administration

Purpose To facilitate injury research.

Principal data users Monash Injury Research Institute; Department of Health and Human Services.

Collection start 1 July 1995

Version 1 (Effective 01.07.95)

2 (Effective 01.07.97)

Definition source Department of Health and Human Services

Code set source Department of Health and Human Services, NHDD, modified

Campus Code

Specification

Definition	Indicates the hospital campus at which the Emergency Department presentation occurred.	
Reported for	Every Emergency Department presentation. The Campus Code table is located at: Reference files This table is updated as required throughout the year. The codes contained in the Campus Code Table will be amended occasionally as new hospitals open and others close. These changes will be documented in the HDSS Bulletin.	
Validations	**E010**	Non VEMD Hospital
	E050	Campus Code Invalid
	E137	Transfer Destination / Source Equals Campus Code
	E233	Unregistered Short Stay Observation Unit
Related items	This section	Transfer Destination
		Transfer Source

Administration

Purpose	To identify the reporting hospital.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.97) 3 (Effective 01.07.99)
Definition source	Department of Health and Human Services.	**Code set source**	Department of Health and Human Services.

Clinical Decision to Admit Date

Specification

Definition	Date of clinical decision to admit the patient to a bed in this campus.	
Reported for	Presentations where a clinician has decided that a patient is to be admitted to this campus.	
Validations	**393**	Clinical Decision to Admit Date/Time and Departure Status Combination Invalid
	394	Departure Date/Time Before Clinical Decision to Admit Date/Time
	395	Clinical Decision to Admit Date/Time Before Arrival Date/Time
	396	Clinical Decision to Admit Date/Time Invalid
Related items	This section	Arrival Date/Time
		Clinical Decision to Time
		Departure Date/Time
		Departure Status
	Section 2	Date/Time Fields

Administration

Purpose	To record the date/time of the clinical decision to admit the patient and support compliance with the National Health Reform Agreement.		
Principal data users	Department of Health and Human Services.		
Collection start	1 July 2014	**Version**	1 (Effective 01.07.14)
Definition source	Department of Health and Human Services.	**Code set source**	Department of Health and Human Services.

Clinical Decision to Admit Time

Specification

Definition	Time of clinical decision to admit the patient to a bed at this campus.	
Reported for	Presentations where a clinician has decided that a patient is to be admitted to this campus.	
Reporting guide	A valid 24-hour time (0000 to 2359)	
Validations	**393**	Clinical Decision to Admit Date/Time and Departure Status Combination Invalid
	394	Departure Date/Time Before Clinical Decision to Admit Date/Time
	395	Clinical Decision to Admit Date/Time Before Arrival Date/Time
	396	Clinical Decision to Admit Date/Time Invalid
Related items	This section	Arrival Date/Time
		Clinical Decision to Time
		Departure Date/Time
		Departure Status
	Section 2	Date/Time Fields

Administration

Purpose	To record the date/time of the clinical decision to admit the patient and support compliance with the National Health Reform Agreement.		
Principal data users	Department of Health and Human Services.		
Collection start	1 July 2014	**Version**	1 (Effective 01.07.14)
			2 (Effective 01.07.17)
Definition source	Department of Health and Human Services.	**Code set source**	Department of Health and Human Services.

Compensable Status

Specification

Definition Whether or not a patient is a compensable patient.

Reported for Every Emergency Department presentation.

Code Set

Code	Descriptor
1	Transport Accident Commission.
2	Department of Veterans' Affairs.
3	Work Safe.
4	Common Law, Public liability, Other compensable, Service personnel.
5	Ineligible not compensable.
6	Medicare patient/Overseas eligible/Ineligible hospital exempt.
7	Compensable status unknown.

Reporting guide Select the first appropriate category.

E079 Compensable Status and DVA Number Combination Invalid

E145 Compensable Status Invalid

Related items

This section

- DVA Number
- Family Name
- Given Name
- Medicare Number
- Medicare Suffix

Administration

Purpose Analysis and monitoring.

Principal data users Monash Injury Research Institute; Department of Health and Human Services; Department of Veterans' Affairs; Work Safe; Transport Accident Commission; Medicare.

Collection start 1 July 1995

Version 1 (Effective 01.07.95)

Definition source Department of Health and Human Services

NHDD (METeOR ID# 270100)

Code set source Department of Health and Human Services.

Country of Birth

Specification

Definition	The country in which the patient was born.	
Reported for	Every Emergency Department presentation.	
Reporting guide	Select the code which describes the patient's Country of Birth as precisely as possible.	
Code set	**Country of Birth code set is at**: Reference files	
Validations	**E100**	Country of Birth Invalid.
	E102	Unusual Country of Birth.
	E103	Invalid Combination of Date Of Birth, Arrival Date and Country Of Birth.
	E107	Aboriginal or Torres Strait Islander Origin But Not Australian Born.

Administration

Purpose	Country of Birth is important in the study of access to services by different population sub-groups. This item is required for analysis of service utilisation, need for services and epidemiological studies		
Principal data users	Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
			2 (Effective 01.07.07)
			3 (Effective 01.07.09)
			4 (Effective 01.07.12)
			5 (Effective 01.07.17)
Definition source	NHDD	**Code set source**	ABS Standard Australian Classification of Countries (SACC), 2016, DHHS modified

Date of Birth

Specification

Definition	Patient's date of birth.
Reported for	Every Emergency Department presentation.
Reporting guide	**Unknown Date of Birth:** If the patient's date of birth is unknown, this should be estimated. If the patient's approximate age is known, then the Date of Birth should be estimated using the approximate age to calculate an estimated year of birth. Sentinel dates should not be used.

Validations

E086	Medicare IRN and Date of Birth Combination Invalid
E089	Medicare IRN and Date Of Birth Combination Invalid
E092	Sex Indeterminate with Age Greater Than or Equal To 90 Days
E093	Sex Indeterminate and Age Less Than 90 Days
E095	Date of Birth Invalid
E103	Invalid Combination of Date Of Birth, Arrival Date and Country Of Birth
E263	Diagnosis Code and Age Incompatible
E265	Diagnosis Code and Age — Check
E297	Injury Cause Code and Age Incompatible
E302	Human Intent Code and Age Incompatible
E355	Type of Usual Accommodation and Age Combination Invalid.
E372	Age Invalid.

Related items

Section 2: Age

Section 3: Date of Birth Accuracy Code.

Administration

Purpose	Used in the calculation of derived items.		
Principal data users	Monash Injury Research Institute, Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
Definition source	NHDD	**Code set source**	Department of Health and Human Services.

Date of Birth Accuracy Code

Specification

Definition

A code representing the accuracy of the components of a date:

- day
- month
- year

Reported for

Every Emergency Department presentation.

Value Domain

Value domain consists of a combination of three codes, each of which denotes the accuracy of one date component:

Code Set

Code	Descriptor
A	The referred date component is accurate.
E	The referred date component is not known but is estimated.
U	The referred date component is not known and not estimated.
This data element contains three positional components (DMY) that reflect the order of the date components in the format (DDMMYYYY) of the reported *Date of Birth.*	
Component	**Descriptor**
1st – D	Refers to the accuracy of the day component.
2nd – M	Refers to the accuracy of the month component.
3rd – Y	Refers to the accuracy of the year component.

Reporting Guide

Any combination of the values A, E, U representing the corresponding level of accuracy of each date component of the reported date.

Where possible, report the accuracy of each date component. However, where software systems allow the collection of a binary value for Date of Birth Accuracy (that is the system has an 'Estimated Date of Birth' check box or similar) values such as 'AAA' and 'EEE' will be acceptable.

It is understood that the Date of Birth Accuracy Code will be reported as 'AAA' unless the date has been flagged as an estimated date. It is not necessary to validate the Date of Birth provided by every patient unless there is a reasonable suspicion that the date provided is not correct. Where there is a question over the date provided, or where the patient is unable or unwilling to provide their date of birth, the date should be estimated and flagged as such.

If the date of birth is provided by a reliable source (for example the patient or close relative) and is known as accurate then the date accuracy indicator should be reported as 'AAA'.

If the patient's approximate age is known, then the Date of Birth should be estimated using the approximate age to calculate an estimated year of birth. Sentinel dates should not be used. The Date of Birth Accuracy code would be reported as 'UUE', that is the day and month are 'unknown' and the year is 'estimated'.

A Year component value of U – Unknown is not acceptable.

Where the date part is accurate or estimated, the date part cannot be '00'. Where the date part is unknown, the date part may be '00' or 'NN'.

Examples:

Valid combinations include:	DOB Accuracy = 'AAA', DOB='03/11/1956'
	DOB Accuracy = 'EEE', DOB='03/11/1956'
	DOB Accuracy = 'UUE', DOB='00/00/1945'
	DOB Accuracy = 'UUE', DOB='01/01/1945'
Invalid combinations include:	DOB Accuracy = 'AAA', DOB='00/00/1956'
	DOB Accuracy = 'AAA', DOB='00/06/1956'
	DOB Accuracy = 'EEE', DOB='00/00/1956'
	DOB Accuracy = 'UUE', DOB='00/00/0000'
	DOB Accuracy = 'UEE', DOB='00/00/1956'

Validations	**E383**	Invalid Date of Birth Accuracy Code	
Related items	**See**	Section 3	Date of Birth
		Section 2:	Age

Administration

Purpose	Required to derive age for demographic analyses and for analysis by age at a point of time.		
Principal data users	Multiple internal and external research users.		
Collection start	1 July 2008		
Definition source	NHDD (Department of Health and Human Services modified)	**Value Domain source**	NHDD 294429

Departure Date

Specification

Definition

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

Reported for

Every Emergency Department presentation.

Reporting guide

- If Departure Status is Ward Setting or Procedure Room at this Campus (Departure Status Codes 3, 14, 15, 18, 22, 25, 26, 27, and 28) 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.

Validations

E025	Duplicate Attendance
E210	Departure Date/Time Invalid
E212	Departure Date/Time Before Nurse Initiation of Patient Management Date/Time.
E213	Departure Date/Time Before First Seen By Doctor Date/Time
E217	Departure Date Conflicts with VEMD File Name
E219	Length Of Stay Greater Than 10 Days
E340	Departure Date/Time Less Than or Equal To Arrival Date/Time.
E350	Length Of Stay Greater Than 4 and Less Than 10 Days
E374	Departure Date/Time Before Seen By Mental Health Practitioner Date/Time
394	Departure Date/Time Before Clinical Decision to Admit Date/Time

Related items	Section 2	Date/Time Fields
		Length of Stay
		Verification/Certification of death
	Section 3	Departure Time
		Departure Status.

Administration

Purpose

Included in the calculation of various derived items:

- Length of Stay
- Length of Treatment.

Principal data users

Monash Injury Research Institute; Department of Health and Human Services for calculation of National Emergency Access Target (NEAT). NB Departure Status 30 is the only exclusion for the NEAT calculation.

Collection start	1 July 1995	**Version**	1	(Effective 01.07.95)
			2	(Effective 01.07.02)
			3	(Effective 01.07.06)
			4	(Effective 01.07.12)

Definition source

NHDD METeOR ID# 322597

Departure Status

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
Procedure room at this campus:	
27	Cardiac catheter laboratory
28	Other operating theatre/procedure room
Ward Setting at this hospital campus:	
15	Intensive Care Unit – this campus
22	Coronary Care Unit – this campus
25	Mental Health Observation/Assessment Unit
3	Emergency Department (ED) Short Stay Unit
14	Medical Assessment and Planning Unit
26	Other Mental Health Bed – this Campus
18	Ward not elsewhere described
Transfers to another hospital campus:	
17	Mental Health bed at another Hospital Campus
20	Another Hospital Campus – Intensive Care Unit
21	Another Hospital Campus – Coronary Care Unit
19	Another Hospital Campus
Returning to usual residence:	
23	Mental health residential facility
24	Residential care facility
12	Correctional/Custodial Facility
1	Home

Reporting guide

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.

Reporting guide (Cont'd)

Procedure room at 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)
Ward setting at this hospital campus	
15	**Intensive Care Unit – this campus** Patient is transferred to a registered ICU bed at this campus. Excludes: • Coronary Care Unit (use 22) Refer to: Section 2 Intensive Care Unit
22	**Coronary Care Unit – this campus** Patient is transferred to a registered CCU bed at this campus. Excludes: • Intensive Care Unit (use 15) Refer to: Section 2 Coronary Care Unit
25	**Mental Health Observation/Assessment Unit** Includes registered: • Psychiatric Assessment and Planning Unit (PAPU) • Mental Health Short Stay Observation Unit Excludes: • Other Mental Health Bed at this campus (use 26) • Short Stay Observation Unit (use 3) • Medical Assessment and Planning Unit (use 14).

Reporting guide (cont'd)

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. 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).
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.

Reporting guide (cont'd)

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).
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.

Reporting guide (cont'd)

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'.

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

Related items

This section	Transfer Destination
	Referred to on Departure

		Reason for Transfer
		Departure Transport Mode
		Diagnosis - Primary Diagnosis
		Clinical Decision to Admit date/time
	Section 4	Clinician Date Time and Departure Status
		Dead on Arrival
		Departure Status and Referred to on Departure
		Primary Diagnosis

Administration

Purpose

To identify and monitor the status and location of patients on departure from the ED.

Define patients for performance measures calculation.

Principal data users

Monash Injury Research Institute; Department of Health and Human Services.

Collection start	1 July 1995	**Version**	1	(Effective 01.07.95)
			2	(Effective 01.07.00)
			3	(Effective 01.07.01)
			4	(Effective 01.07.02)
			5	(Effective 01.07.03)
			6	(Effective 01.07.06)
			7	(Effective 01.07.08)
			8	(Effective 01.07.09)
			9	(Effective 01.07.11)
Definition source	NHDD	**Code set source**	Department of Health and Human Services.	

Departure Time

Specification

Definition

The time the patient physically 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 Ward Setting or Procedure Room at this Campus (Departure Status Codes 3, 14, 15, 18, 22, 25, 26, 27, and 28) 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.

Validations

E025	Duplicate Attendance
E210	Departure Date/Time Invalid
E212	Departure Date/Time Before Nurse Initiation of Patient Management Date/Time.
E213	Departure Date/Time Before First Seen By Doctor Date/Time
E217	Departure Date Conflicts with VEMD File Name
E219	Length Of Stay Greater Than 10 Days
E340	Departure Date/Time Less Than or Equal To Arrival Date/Time
E350	Length Of Stay Greater Than 4 and Less Than 10 Days.
E374	Departure Date/Time Before Seen By Mental Health Practitioner Date/Time.
E395	Departure Date/Time Before Clinical Decision to Admit Date/Time

Related items

Section 2	Date/Time fields
	Length of Stay
Section 3	Departure Date
	Verification/Certification of Death
	Departure Status

Administration

Purpose

Included in the calculation of various derived items:

- Length of Stay
- Length of Treatment.

Principal data users

Monash Injury Research Institute; Department of Health and Human Services for calculation of National Emergency Access Target (NEAT). NB Departure Status 30 is the only exclusion for the NEAT calculation.

Collection start

1 July 1995

Version

1 (Effective 01.07.95)

2 (Effective 01.07.02)

3 (Effective 01.07.06)

4 (Effective 01.07.12)

5 (Effective 01.07.17)

Definition source

NHDD METeOR ID# 322597

Departure Transport Mode

Specification

Definition

The type of transport used to transfer the patient from the Emergency Department to another hospital.

Reported for

Presentations where Departure Status code is 17, 19, 20 and 21.

Must remain blank if Departure Status code is **not** 17, 19, 20 and 21 (Conditional mandatory).

Code Set

Code	Descriptor
1	Air ambulance - fixed wing aircraft (Excludes helicopter - Code 2)
2	Helicopter
3	Ambulance Service – MICA
4	Ambulance Service - road car
6	Community / philanthropic services (e.g. hospital volunteer drivers)
7	Private car
8	Police vehicle
10	Ambulance Service - private ambulance car - AV contracted
11	Ambulance Service - private ambulance car - hospital contracted
19	Other

Reporting guide

Item should be blank if patient has not been transferred to another hospital.

For journeys involving more than one transport mode, select the mode of transport in which the greater distance of the journey was undertaken.

Validations

E255 Departure Transport Mode Invalid

Related items

This section

- Departure Status
- Transfer Destination
- Reason for Transfer

Administration

Purpose

Analysis of transport utilisation.

Principal data users

Monash Injury Research Institute Department of Health and Human Services.

Collection start

1 July 1995

Version

1 (Effective 01.07.95)

2 (Effective 01.07.97)

3 (Effective 01.07.00)

4 (Effective 01.07.02)

Definition source

Department of Health and Human Services.

Code set source

Department of Health and Human Services.

Description of Injury Event

Specification

Definition

Patient's personal account or description of injury event provided at triage.

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).

Reporting Guide

Data entry prompts in software assist collection of the required components to describe the event.

Ensure that no identifying details are included in this text field.

Data entry staff should be aware that this text is sent to VEMD.

This field is a free text field and must not be auto filled with a defined code set value**.**

Data entry prompts

Briefly and concisely describe the injury event using the prompts. Information should be incorporated into a single description of the injury event for data transmission:

Location

Specific location of the person at the time the injury occurred.

For example, in the bathroom of own home, workshop or local shops.

Activity

Specific activity the person was undertaking at the time the injury occurred.

For example, playing, working on a forklift or playing competition netball.

Product

Specific product involved in the injury (where applicable).

For example, 50mls brand name X medicine, wooden pallet or football.

Safety Equipment

Safety devices in use or absent at the time the injury occurred (where applicable).

For example, wearing steel capped work boots, not wearing seatbelt, child resistant cap was on bottle or mouthguard worn.

Additional Information to Include:

Nature of the injuries

What caused the injuries (subject)

Any other relevant information.

Validations

E290	Description of Injury Event Invalid
E391	The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements

Related items

This section	Activity When Injured
	Body Region
	Diagnosis-Primary Diagnosis

	Human Intent
	Injury Cause
	Nature of Main Injury
	Place Where Injury Occurred.
Section 4	Primary Diagnosis
	Injury Surveillance

Administration

Purpose	To clarify the injury event (vital for identifying the interventions) and provide additional information relevant to the injury (product type, brand name, safety precautions.). The narrative is very important to identify injury event features not captured by the coded data.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.02)
Definition source	Department of Health and Human Services.	**Code set source**	Department of Health and Human Services.

Diagnosis - Additional Diagnoses 1 and 2

Specification

Definition	Additional diagnoses are those which: Existed at the time of presentation Arose while patient was in the Emergency Department Are expected to affect treatment plan or length of stay in the Emergency Department.
Reported for	Mandatory if Primary Diagnosis is 'Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment'. Optional for all other Emergency Department presentations.
Reporting guide	Additional diagnoses give information on factors which can result in increased length of stay, more intensive treatment or the use of greater resources. Additional diagnosis can include diseases, conditions, injuries, poisoning, signs, symptoms, abnormal findings, complaints or other factors influencing the patient's health status. In cases requiring mandatory assignment due to Primary Diagnosis of 'Z099', the Additional Diagnosis 1 provides information regarding the specific condition under review during the Emergency Department presentation. Code Z099 – 'Attendance for Follow up (includes injections)/Review following earlier treatment' may not be reported in either Additional Diagnosis field. Additional Diagnoses should correlate with and must be substantiated by clinical documentation. **Diagnosis code format:** Diagnosis codes must be submitted in ICD-10-AM format. Ensure any punctuation (decimal points or obliques) are removed from ICD-10-AM codes before submission, as codes with punctuation will not be accepted. The VEMD diagnosis reference file (VEMD Library File) can be downloaded from: VEMD reference files Only codes detailed in the VEMD Library File will be accepted. For diagnoses not detailed in this list please contact the HDSS Help Desk for assistance (for further contact details: refer to Section 1).

Validations	**E261**	Diagnosis Code Invalid
	E262	Diagnosis Code and Sex Incompatible
	E263	Diagnosis Code and Age Incompatible
	E264	Diagnosis Code and Sex — Check
	E265	Diagnosis Code and Age — Check
	E341	Primary Diagnosis Equals ‘Z099’ but Additional Diagnosis Blank
	E390	Additional Diagnosis 1 or 2 equals ‘Z099’
Related items	This section	Diagnosis-Primary Diagnosis
	Section 2	Diagnosis

Administration

Purpose	To facilitate epidemiological studies and other research		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995		
Definition source	Department of Health and Human Services	**Code set source**	Department of Health and Human Services

Diagnosis - Primary Diagnosis

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'.

Optional for presentations with Departure Status '10 – Left after clinical advice regarding treatment options'. or '30 – Left after clinical advice regarding treatment options – GP Co-Located Clinic'.

Reporting guide

Primary Diagnosis must be substantiated by clinical documentation.

Dead on Arrival

If the Departure Status is '8 – Dead on Arrival'; the Primary Diagnosis must be 'R99 – Death of unknown cause' or 'R959 Sudden Infant Death Syndrome (SIDS)'.

Injury or Poisoning

If the Primary Diagnosis code is an injury, poisoning or other consequence of an external cause (VEMD diagnosis codes beginning with S or T); ensure that the corresponding Nature of Main Injury and Body Region combination is correct. Refer to the VEMD Editing Matrices for valid combinations and completion of Injury Surveillance fields optional/mandatory indicator.

VEMD reference files

Follow up Attendance

If the Primary Diagnosis code is 'Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment', an Additional Diagnosis 1 code is mandatory. The Additional Diagnosis 1 code must identify the condition under review.

Diagnosis code format:

Diagnosis codes must be submitted in ICD-10-AM format. Ensure any punctuation (decimal points or obliques) are removed from ICD-10-AM codes before submission, as codes with punctuation will not be accepted. The VEMD diagnosis reference file (VEMD Library File) can be downloaded from: VEMD reference files

Only codes detailed in the VEMD Library File will be accepted. For diagnoses not detailed in this list please contact the HDSS Help Desk for assistance (for further contact details: refer to Section 1).

See Section 1 Contact Details

VEMD Editing Matrices and

VEMD Library File at: VEMD reference files

Validations	**E142**	Dead on Arrival Combination Invalid
	E260	Primary Diagnosis Blank
	E261	Diagnosis Code Invalid
	E262	Diagnosis Code and Sex Incompatible
	E263	Diagnosis Code and Age Incompatible
	E264	Diagnosis Code and Sex — Check
	E265	Diagnosis Code and Age — Check
	E320	Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid.
	E341	Primary Diagnosis Equals 'Z099' but Additional Diagnosis Blank.
	E342	Invalid Combination between Primary Diagnosis and Departure Status
	E391	The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements

Related items	This section	Activity When Injured. Diagnosis- Additional Diagnosis 1 & 2 Body Region Description of Injury Event Human Intent Injury Cause Nature of Main Injury Place Where Injury Occurred
	Section 2	Diagnosis
	Section 4	Dead on Arrival. Injury Surveillance Primary Diagnosis

Administration

Purpose	To facilitate epidemiological studies and other research.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.98) 3 (Effective 01.07.99) 4 (Effective 01.07.02) 5 (Effective 01.07.12) 6 (Effective 01.07.16) 7 (Effective 01.07.17)
Definition source	Department of Health and Human Services.	**Code set source**	Department of Health and Human Services.

DVA Number

Specification

Definition The Department of Veterans' Affairs file number applicable for the patient.

Reported for Presentations with Compensable Status of '2 - Department of Veterans' Affairs' (Conditional mandatory).

Reporting guide The DVA number is obtained from the patient.

Layout

Part 1	State identifier. Valid codes: Q, N, V, T, S or W. ACT is included in N (NSW) and NT with S (SA).
Part 2	War Group Code, (Alphanumeric characters) may be up to 3 characters.
Part 3	Serial Number (numeric characters) may be 2 to 6 characters in length.
Part 4 (Optional)	Spouse or Dependent Identifier, may be 1 character in length.

Valid Format (see also above layout and following examples):

- only alphabetic and numeric characters and spaces are permitted
- alphabetic characters must be in uppercase
- a maximum of six numeric characters is permitted
- trailing spaces (to the right) are permitted
- spaces between characters are not permitted.

Examples:

N123456, VX123456, WXX123A or QXXX1B

Validations

E078	DVA Number Invalid
E079	Compensable Status and DVA Number Combination Invalid

Related items

This section	Compensable Status
	Family Name
	Given Name

Administration

Purpose Required for analysis of service utilisation by eligible veterans and war widow(er)s.

Principal data users Department of Veterans' Affairs; Department of Health and Human Services; Monash Injury Research Institute.

Collection start 1 July 2000 **Version** 1 (Effective 01.07.00)

Definition source NHDD **Code set source** DVA

Family Name

Specification

Definition	The family name of the DVA patient
Reported for	Presentations with Compensable Status of '2 - Department of Veterans' Affairs'
Reporting guide	The family name of the patient
Valid Format	Permitted characters First character: A to Z (upper case) Subsequent characters: A to Z (upper case), space, apostrophe, hyphen
Validations	**E405** Compensable Status and Family Name Combination Invalid
Related items	This section: Compensable Status DVA Number Given Name

Administration

Purpose	To facilitate payment by DVA			
Principal data users	Department of Veterans' Affairs			
Collection start	1 July 2017	**Version**	1	(Effective 01.07.17)
Definition source	DHHS	**Code set source**	-	

First Seen By Doctor Date

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

Must complete First Seen By Doctor Date/Time if both Nurse Initiation of Patient Management Date/Time AND Seen by Mental Health Practitioner Date/Time are blank,

except where Departure Status is one of the following, leave blank

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

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

Related items

See	This section	First Seen By Doctor Time.
		Nurse Initiation of Patient Management Date
		Nurse Initiation of Patient Management Time
		Seen by Mental Health Practitioner Date
		Seen by Mental Health Practitioner Time
	Section 2	Date / Time Fields
		Length of Stay
		Time to Initiation of Patient Management.
	Section 4	Clinician Date/Time and Departure Status
		Dead on Arrival

Administration

Purpose

Used in the calculation of various derived items:

Length of Treatment

Time to Initiation of Patient Management.

Principal data users

Monash Injury Research Institute; Department of Health and Human Services.

Collection start 1 July 1995 **Version** 1 (Effective 01.07.95)

Definition source	DHHS	**Code set source**	DHHS

First Seen By Doctor Time

Specification

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

Administration

Purpose	Used in the calculation of various derived items: Length of Treatment Time to Initiation of Patient Management.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
Definition source	DHHS	**Code set source**	DHHS

Given Name(s)

Specification

Definition	The given name/s of the DVA patient
Reported for	Presentations with Compensable Status of '2 - Department of Veterans' Affairs'
Reporting guide	The given name/s of the patient
Valid Format	Permitted characters: First character: A to Z (upper case) Subsequent characters: A to Z (upper case), space, apostrophe, hyphen
Validations	**E404** Compensable Status and Given Name Combination Invalid
Related items	This section: Compensable Status DVA Number Family Name

Administration

Purpose	To facilitate payment by DVA			
Principal data users	Department of Veterans' Affairs			
Collection start	1 July 2017	**Version**	1	(Effective 01.07.17)
Definition source	DHHS	**Code set source**	-	

Human Intent

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

Reporting guide

Family member

The *Family Violence Protection Act 2008* definition of 'family member' includes:

- a current or former spouse or domestic partner;
- a person who has, or has had, an intimate personal relationship with the relevant person;
- a current or former relative;
- a child who normally lives or has lived with the relevant person; and
- a child of a person who has, or has had, an intimate personal relationship with the perpetrator of violence.

Note: Intimate partner includes a current or former spouse or domestic partner.

Select the first appropriate category, which best characterises the role of intent in the occurrence of the injury on the basis of the information available at the time it is recorded. If two or more categories are judged to be equally appropriate, select the one listed first in the code set.

Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.

Validations	**E300**	Human Intent Code Invalid
	E302	Human Intent Code and Age Incompatible
	E391	The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements

Related items	Section 3	Nature of Main Injury
		Body Region
		Description of Injury Event
		Injury Cause
		Place Where Injury Occurred
		Activity When Injured
	Section 4	Primary Diagnosis
		Injury Surveillance

Administration

Purpose	To facilitate injury / poisoning research.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
			2 (Effective 01.07.03)
			3 (Effective 01.07.16)
Definition source	NHDD	**Code set source**	NHDD, modified

Indigenous Status

Specification

Definition

An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives.

Reported for

Every Emergency Department presentation.

Code Set

Code	Descriptor
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
8	Question unable to be asked
9	Patient refused to answer

Reporting guide

This information must be collected for every emergency department presentation and updated each time the patient represents to the hospital for care.

Patient is baby or child

The parent or guardian should be asked about the Indigenous Status of the child. If the mother of a newborn baby has not identified as being of Aboriginal or Torres Strait Islander descent, hospital staff should not assume the baby is non-Aboriginal; the father may be of Aboriginal or Torres Strait Islander descent.

Code 8 Question unable to be asked should only be used under the following circumstances:

- When the patient's medical condition prevents the question of Indigenous Status being asked; or
- In the case of an unaccompanied child who is too young to be asked their Indigenous Status.

Note: Systems must not be set up to input a default code.

For further information refer to the National best practice guidelines for collecting Indigenous status in health data sets available on the AIHW website at: http://www.aihw.gov.au/guidelines-for-collecting-indigenous-status/

Validations

E105 Indigenous Status Invalid.

E107 Aboriginal or Torres Strait Islander Origin But Not Australian Born.

E360 Indigenous Status and Preferred Language Mismatch.

Administration

Purpose	To: • enable planning and service delivery, and monitoring of indigenous health at state and national level • facilitate application of specific funding arrangements.		
Principal data users	Funding and Information Policy Branch, Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.99) 3 (Effective 01.07.05) 4 (Effective 01.07.08)
Definition source	NHDD METeOR ID # 291036	**Code set source**	NHDD, Department of Health and Human Services modified, CCDS

Injury Cause

Specification

Definition

Event, circumstances or condition associated with the occurrence of injury, poisoning or adverse effect.

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	Motor vehicle - driver
2	Motor vehicle - passenger
3	Motorcycle - driver
4	Motorcycle - passenger
5	Pedal cyclist - rider or passenger
6	Pedestrian
7	Horse related (fall from, struck or bitten by)
8	Other transport-related circumstance
9	Fall - low (same level or less than 1 metre, or no information on height)
10	Fall - high (greater than 1 metre)
11	Submersion or drowning - swimming pool
12	Submersion or drowning - other
13	Other threat to breathing (includes strangulation, asphyxiation)
14	Fire, flames, smoke
15	Scalds (hot drink, food, water, other fluid, steam, gas or vapour)
16	Contact burn (hot object or substance)
17	Poisoning - medication
18	Poisoning - other or unspecified substance
19	Firearm
20	Cutting, piercing object
21	Dog related
22	Other animal related (Excludes dog - use code 21; horse - use code 7)
23	Struck by or collision with person
24	Struck by or collision with object
25	Machinery
26	Electricity
27	Hot conditions (natural origin, includes sunlight)
28	Cold conditions (natural origin)
29	Other specified external cause
30	Unspecified external cause

Reporting guide	Select the first appropriate category.	
	Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.	
Validations	**E295**	Injury Cause Code Invalid
	E297	Injury Cause Code and Age Incompatible
	E391	The Primary Diagnosis for this record requires the completion of all Injury Surveillance data elements
Related items	Section 3	Nature of Main Injury
		Body Region
		Description of Injury Event
		Human Intent
		Place Where Injury Occurred
		Activity When Injured
	Section 4	Primary Diagnosis
		Injury Surveillance

Administration

Purpose	To facilitate injury / poisoning research.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
			2 (Effective 01.07.97)
Definition source	Department of Health and Human Services.	**Code set source**	Department of Health and Human Services.

Interpreter Required

Specification

Definition The patient's need for an interpreter, as perceived by the patient or person consenting for the patient.

Reported for Every Emergency Department presentation.

Code Set

Code	Descriptor
1	Yes
2	No
9	Not Stated / Inadequately Described.

Reporting guide

Preferred Language to be asked before Interpreter Required.

If the Preferred language is English, Interpreter Required can be assumed to be '2 – No'.

This information must:

- Be checked for every Emergency Department presentation
- Not be set up to a default code on computer systems
- Be collected on, or as soon as possible after, arrival.

The standard question is:

[Do you] [Does the person] [Does (name)] require an interpreter?

The question:

'Do you require an interpreter?' is asked to determine patient need for an interpreter, not the capacity of the hospital to provide an interpreter.

1 Yes

Use code 1 if the patient indicates they need an interpreter.

2 No

Use code 2 if the patient indicates they do not need an interpreter or where the Preferred Language is English.

9 Not Stated / Inadequately Described.

Use code 9 if neither Yes nor No can be accurately ascertained.

Includes where the Preferred Language is:

- 0002 Not Stated; or

0000 Inadequately described.

Patient is unable to consent (for example: baby, child or elderly)

Where a person is not able to consent for themselves (for example baby, child or elderly) then the need for an interpreter is recorded for the person who is consenting. For example a guardian or someone with enduring power of attorney.

Validations	**E358**	Interpreter Required - Invalid
	E359	Invalid Combination of Interpreter Required and Preferred Language
Related items	Section 3	Country of Birth Indigenous Status Preferred Language.

Administration

Purpose	For planning and to form the basis for future funding allocation for Culturally and Linguistically Diverse (CALD) hospital service provision.		
Principal data users	Multiple internal and external data users.		
Collection start	1 July 2003	**Version**	1 (Effective 01.07.03)
Definition source	Department of Health and Human Services.	**Code set source**	CCDS

Locality

Specification

Definition	Geographic location (suburb/town locality for Australian residents, country for overseas residents) of usual residence of the person (not postal address).
Reported for	Reported for every Emergency Department presentation
Code set	Refer to the Postcode/Locality reference file available from: Reference files
Reporting guide	Australia Post web site listing of postcodes and localities is available from: http://www.auspost.com.au/ The DHHS file excludes non-residential postcodes. Locality must be blank if the Postcode is 1000 or 9988. Where the Postcode is 8888 (overseas), report the country the patient lives in, in Locality. The country code must be one that corresponds with a code against the listing of 8888 (overseas) codes in the Postcode/Locality/SLA reference file, available at: Reference files
Validations	**E115** Postcode/Locality Combination Invalid
Related items	Section 3 Postcode Section 4 Locality/Postcode

Administration

Purpose	To enable calculation (with Postcode field) of the patient's appropriate Statistical Local Area (SLA) which enables: Analysis of service utilisation and need for services. Identification of patients living outside Victoria. Identification of patients living outside Australia for the Reciprocal Health Care Agreement (RHCA).		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection Start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.99) 3 (Effective 01.07.04) 4 (Effective 01.07.09)
Definition source	Department of Health and Human Services	**Code set source**	ABS National Locality Index (Cat. No. 1252) (Department of Health and Human Services modified)

Medicare Number

Specification

Definition

Personal identifier allocated by Medicare Australia to eligible persons under the Medicare scheme.

Reported for

All patients except in the circumstances covered under Medicare Suffix.

Reporting guide

The patient's Medicare Number and individual reference number (IRN), issued by Medicare Australia.

Valid:

- First character can only be a: 2, 3, 4, 5, or 6
- Numeric or all blanks
- Check digit (ninth character) is the remainder of the following equation:[(1st digit * 1) + (2nd digit * 3) + (3rd digit * 7) + (4th digit * 9) +(5th digit * 1) + (6th digit * 3) + (7th digit * 7) + (8th digit * 9)] / 10

Invalid:

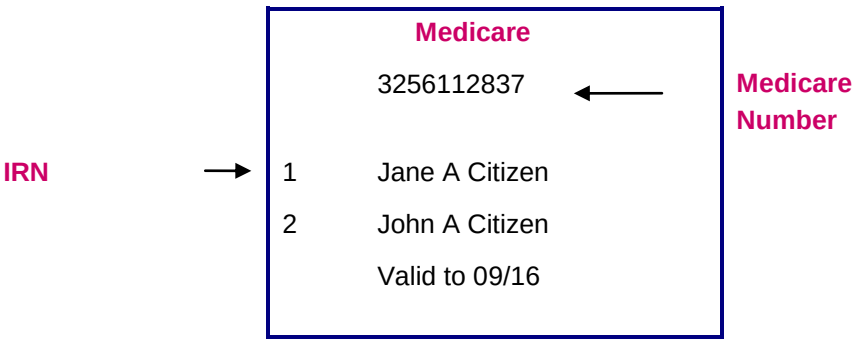
Special characters (for example, $, #)

Alphabetic characters

Zero-filled (if the Medicare Number is not available or not applicable, the Medicare Number must be left blank)

Note: Deletion record

Eleven 9s in the Medicare Number field denote a deletion record, refer Section 5



Medicare Number from the Medicare card, the eleventh character being the IRN (the number printed on the Medicare Card, to the left of the printed name of the patient).

Neonates

For neonates who have not yet been added to the family Medicare Card, and therefore have no IRN, there are two reporting options:

1. mother's/family's Medicare Number in the first ten characters and a zero (0) as the eleventh character

2. mother/family Medicare Number in the first ten characters and the mother's IRN as the eleventh character.

Validations

E081 Medicare Number Invalid

	E086	Medicare IRN and Date of Birth Combination Invalid
	E087	Medicare Suffix Invalid
	E089	Medicare IRN and Date Of Birth Combination Invalid
	E364	Medicare Last Digit Zero; Suffix Not 'BAB'
Related items	This section	Compensable Status
		Medicare Suffix
	SECTION 5	Deletion of records

Administration

Purpose	To assist in monitoring continuity of care across hospitals. Ensure eligibility for publicly funded health care.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection Start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.99)
Definition source	NHDD (METeOR ID # 270101)	**Code set source**	Medicare Australia

Medicare Suffix

Specification

Definition

First three characters of the patient's first given name (as it appears on the Medicare card).

Reported for

All emergency department presentations

Code set

Characters should be:

The first three characters of the patient's first given name in upper case

Note:

If the patient's name has only two characters type a space for the third character.

Characters permitted:

- Upper case alphas
- Space as second and third characters
- Space as third character
- Hyphen or apostrophe as second character or hyphen or apostrophe as third character.

If Medicare Number is unavailable or the patient is not eligible for a Medicare Number, leave the Medicare Number blank (not zero-filled) and enter the appropriate suffix:

Alternative Codes	Descriptor
C-U	Card unavailable/Not applicable.
N-E	Not eligible for Medicare
P-N	Prisoner

Reporting Guide

Unnamed neonate:

For unnamed neonates where the family has a Medicare Number, report an alternative code of 'BAB'. The Medicare Number issued to the mother/ family must also be reported with an 11th character of '0' or the mother's IRN.

Prisoners:

Prisoners are treated and funded as public patients

Validations

E087	Medicare Suffix Invalid
E357	Type of Usual Accommodation and Medicare Suffix Combination Invalid
E364	Medicare Last Digit Zero; Suffix Not 'BAB'

Related items

This section	Compensable Status Medicare Number.

Administration

Purpose To ensure the patient is an eligible Medicare patient.

Principal data users Monash Injury Research Institute; Department of Health and Human Services.

Collection start 1 July 1999 **Version** 1 (Effective 01.07.99)

Definition source Department of Health and Human Services **Code set source**

Nature of Main Injury

Specification

Definition The patho-physical nature of the injury primarily responsible for the patient's presentation at the Emergency Department.

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

Code	Descriptor	Body Region
+	Non-foreign body injury requires 'Body Region – Non-foreign body' code, see Section 3 – Data Definitions (Body Region – Non-foreign body).	
#	Foreign body injury requires 'Body Region – Foreign Body' code, see Section 3 – Data Definitions (Body Region – Foreign Body).	

Reporting guide

Select the first appropriate category.

Select the item, which best characterises the nature of the injury responsible for the patient's presentation on the basis of the information available at the time it is recorded.

If two or more categories are judged to be equally appropriate, select the one that is sequenced first in the above code list. It is more significant to code a major injury, if present, rather than a minor injury.

If a major injury has been sustained (e.g. fractured femur), along with one or more minor injuries (e.g. some small abrasions), the major injury should be coded in preference to coding 'multiple injuries'.

As a general rule, any injury, which on its own would be unlikely to have led to the presentation, may be regarded as minor.

All diagnosis codes beginning with either an 'S' or 'T' are injury codes. Each injury code in the Primary Diagnosis field is matched in the Nature of Main Injury and Body Region matrix. The fields must be completed **unless** completion of injury surveillance data elements is flagged as optional for that particular S or T code. (refer to the VEMD Editing Matrices) For valid combinations, refer to the NoMI/Body Region Matrix (stored as the VEMD Editing Matrix) at: Reference files

Validations

E281 Nature of Main Injury Invalid

E320 Nature of Main Injury, Body Region and Primary Diagnosis Combination Invalid

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

Related items

This section

- Activity When Injured
- Body Region
- Description of Injury Event
- Diagnosis – Primary Diagnosis
- Human Intent
- Injury Cause
- Place Where Injury Occurred

Section 4

- Primary Diagnosis
- Injury Surveillance

Administration

Purpose	To facilitate injury research.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
			2 (Effective 01.07.97)
			3 (Effective 01.07.99)
			4 (Effective 01.07.02)
			5 (Effective 01.07.04)
Definition source	Department of Health and Human Services	**Code set source**	Department of Health and Human Services

Nurse Initiation of Patient Management Date

Specification

Definition

The date on which a nurse initiated management of the patient, according to an established clinical pathway, protocol or guidelines.

Reported for

Mandatory for all presentations where a nurse has initiated management of the patient.

Optional for presentations where patient management has been initiated by a doctor or mental health practitioner.

Reporting guide

Must complete Nurse Initiation of Patient Management Date where a nurse initiates management of a patient according to an established clinical pathway, protocol, set of guidelines, or accepted clinical practice,

Established clinical pathways, protocols, guidelines, or accepted clinical practice, are not necessarily documented but are agreed procedures of the emergency department.

Where patient management is initiated by a doctor or mental health practitioner, this should be reported in the relevant seen by ….date field.

Excludes

- Observations taken to monitor a patient leading to a clinical decision regarding commencement of a clinical pathway, protocol, set of guidelines, or accepted clinical practice, do not represent initiation of patient management, however once a clinical pathway, protocol, set of guidelines or accepted clinical practice, has been determined, patient management may be initiated by the taking of observations.
- Placement of a patient in a cubicle and/or routine initial assessment and/or observations does not, on its own, constitute initiation of patient management.
- The process of re-triage is a continuation of the triage process and does not constitute initiation of patient management.

Refer: to Initiation of Patient Management – Case Studies in Section 2

Where a valid date has been entered in Nurse Initiation of Patient Management Date, a valid time must be entered in Nurse Initiation of Patient Management Time

Validations

E180	Nurse initiation of patient management date/time invalid
E181	Nurse initiation of patient management date/time before triage date/time.
E182	Clinician date/time and Departure status combination invalid
E351	Potentially excessive time to initiation of patient management
E389	Triage Category 1 patient – Excessive Time to Initiation of Patient Management

Related items

This section	Nurse Initiation of Patient Management Time.
Section 2	Time to Initiation of Patient Management.
Section 4	Clinician Date/Time and Departure Status

Administration

Purpose

Used in the calculation of Time to Initiation of Patient Management.

Principal data users	Department of Health and Human Services		
Collection start	1 July 2009	**Version**	1 (Effective 01.07.09)
Definition source	Department of Health and Human Services (VEMD Technical Reference Group)	**Code set source**	

Nurse Initiation of Patient Management Time

Specification

Definition

The time at which a nurse initiated management of the patient, according to an established clinical pathway, protocol or guidelines.

Reported for

All presentations where a valid date has been entered in Nurse Initiation of Patient Management Date

Reporting guide

A valid 24-hour time (0000 to 2359)

Nurse initiation of patient management occurs at the start of the occasion of contact between the patient and nurse/s when this protocol is implemented.

Validations

E180	Nurse initiation of patient management date/time invalid
E181	Nurse initiation of patient management date/time before triage date/time.
E182	Clinician date/time and Departure status combination invalid
E351	Potentially excessive time to initiation of patient management
E389	Triage Category 1 patient – Excessive Time to Initiation of Patient Management

Related items

This section	Nurse Initiation of Patient Management Date
Section 2	Time to Initiation of Patient Management
Section 4	Clinician Date/Time and Departure Status

Administration

Purpose

Used in the calculation of Time to Initiation of patient management.

Principal data users

Department of Health and Human Services.

Collection start	1 July 2009	**Version**	1 (Effective 01.07.09)
			2 (Effective 01.07.17)
Definition source	Department of Health and Human Services (VEMD Technical Reference Group)		

Patient Identifier

Specification

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

Administration

Purpose	To ensure hospitals have the ability to identify specific patient presentations.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
Definition source	Department of Health and Human Services.		

Place Where Injury Occurred

Specification

Definition The specific physical location of the person at the time the injury occurred.

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	Includes	Excludes
H	Home	House, home premises, farm house, non-institutional place of residence, apartment, boarding house, caravan park (resident), private: driveway to home, garage, garden/yard or home, path to home, swimming pool in private house, garden.	Institutional place of residence (I), Abandoned or derelict house (O) Home under construction and not yet occupied (C).
I	Residential institution	Children's home, orphanage, home for the sick, nursing home, old people's home, hospice, military camp, reform school, prison, pensioners home, dormitory.	Hospital (M).
S	School, day care centre, public administration area	Building (including adjacent grounds) used by the general public or by a particular group of the public such as: assembly hall, public hall, church, clubhouse, court house, post office, day care centre, preschool, youth centre, gallery, library, museum, cinema, theatre, opera house, concert hall, dance hall, school (public or private), college, university, institution for higher education, movie house, kindergarten, campus.	Hospital (M), Recreation area (P), Athletics and sports area (A), Trade or service area (T), Building under construction (C), Residential institution (I).
M	Medical hospital	Hospital	Hospice, nursing home (I).
A	Athletics and sports area	Cricket ground, football, hockey field, riding school, basketball court, golf course, stadium, skating rink, tennis, squash court, swimming pool.	
R	Road, street or highway	Freeway, footpath, motorway, pavement, road.	Private driveway (H).
T	Trade or service area	Bank, petrol station, supermarket, airport, cafe, casino, garage (commercial), gas station, hotel, market, office building, radio or television station, restaurant, service station, shop (commercial), shopping mall, station (bus/rail), warehouse.	Garage in private home (H).

Code set (cont'd)

Code	Descriptor	Includes	Excludes
C	Industrial or construction area	Any building under construction, industrial yard, workshop, dry dock, dock yard, factory building/ premises, gasworks, oil rig & other offshore installation, power station (coal/nuclear/oil), shipyard.	Mine, quarry, tunnel under construction (Q).
Q	Mine or quarry	Mine or quarry tunnel under construction	
F	Farm	Farm buildings and land, ranch	Farm house & home premises of farm (H).
P	Place for recreation	Public park, amusement park	Athletics and sports area (A).
O	Other specified place	Forest, beach, pond, abandoned or derelict house, campsite, canal, caravan site NOS, desert, dock NOS, harbour, hill, lake, marsh, military training ground, mountain, parking lot & parking place, prairie, public place NOS, railway line, river, sea, seashore, stream, swamp, water reservoir, zoo.	
U	Unspecified place		

Reporting guide

Report the code which best characterises the location where the patient was situated at the time the injury occurred, on the basis of the information available at the time it is recorded.

If two or more categories are equally appropriate, select the code sequenced first in above code list.

Refer to Section 4 – Business Rules (Injury Surveillance) for examples of how the Injury Surveillance fields should be utilised.

Validations

E305 Place Where Injury Occurred Invalid.

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

Related items

Section 3
- Nature of Main Injury
- Body Region
- Description of Injury Event
- Human Intent
- Injury Cause
- Activity When Injured

Section 4
- Primary Diagnosis
- Injury Surveillance

Administration

Purpose To facilitate injury research.

Principal data users Monash Injury Research Institute; Department of Health and Human Services.

Collection start 1 July 1995 **Version** 1 (Effective 01.07.95)

Definition source Department of Health and Human Services **Code set source** NHDD, modified

Postcode

Specification

Definition	Postcode in which the person usually resides (not postal address).
Reported for	Every Emergency Department presentation.
Code set	Refer to the Postcode/Locality reference file available from: Reference files
Reporting guide	Australia Post web site listing of postcodes and localities is available from: http://www.auspost.com.au/ The DHHS file excludes non-residential postcodes listed in the Australia Post file. Common variations of locality spellings, as used in Melway references and the Australian Bureau of Statistics National Locality Index (Cat. No. 1252), are included in the DHHS file. Locality must be blank if the Postcode is 1000 or 9988. Where the Postcode is 8888 (overseas), report the country the patient lives in, in Locality. The country code must be one that corresponds with a code against the listing of 8888 (overseas) codes in the Postcode/Locality/SLA reference file, available at: Reference files
Validations	**E115** Postcode/Locality Combination Invalid.
Related items	This section Locality Section 4 Postcode/Locality

Administration

Purpose	To enable calculation (with Locality field) of the patient's appropriate Statistical Local Area (SLA) which enables: Analyses of service utilisation and need for services. Identification of patients living outside Victoria. Identification of patients living outside Australia for the Reciprocal Health Care Agreement (RHCA). Analysis of service utilisation and epidemiological studies.
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.
Collection start	1 July 1995
Definition source	Department of Health and Human Services **Code set source** Australia Post

Preferred Language

Specification

Definition

The language (including sign language) most preferred by the patient for communication. This may be a language other than English even where the person can speak fluent English.

Reported for

Every Emergency Department presentation.

Code set

Refer to HDSS website 'Preferred language code set' at:

Reference files

This information must:

- be checked for every emergency presentation
- be collected on, or as soon as possible after, arrival.

Ask the standard question:

What is [your] [the person's] preferred language?

Patient is unable to consent (for example baby, child or elderly):

Where a person is not able to consent for themselves (for example baby, child or elderly) then the language of the person who is consenting will be recorded. For example a parent/guardian or someone with enduring power of attorney.

8000 - Australian Indigenous languages, NEC

Includes:

- All Australian Indigenous languages not shown separately on the code list.

0002 - Not Stated

Includes:

- Patients who are not able to respond to this question during their admission (for example unconscious).
- Unaccompanied child, who is too young to identify preferred language.

Validations

E110	Preferred Language Invalid.
E359	Invalid Combination of Interpreter Required and Preferred Language.
E360	Indigenous Status and Preferred Language Mismatch.
E361	Preferred Language is Unspecified.

Administration

Purpose

This item is an indicator of ethnicity and assists multilingual service planning and provision.

Principal data users

Monash Injury Research Institute; Department of Health and Human Services.

Collection start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.95) 3 (Effective 01.07.12)
Definition source	NHDD	**Code set source**	ABS Australian Standard Classification of Languages (ASCL), 2011 version

Reason for Transfer

Specification

Definition Reason for transfer of a patient to another hospital or health service

Reported for Presentations with Departure Status of 17, 19, 20 and 21 (Conditional mandatory).

Code Set

Code	Descriptor
1	ICU bed not available
2	CCU bed not available
3	General bed not available
4	Specialty not available
5	Previous patient of destination hospital
6	Insured/Compensable
7	Patient preference
9	Other reason

Reporting guide Select the first appropriate category.

E245 Reason for Transfer Code Invalid

Related items

This section
- Departure Status
- Departure Transport Mode
- Transfer Destination.

Administration

Purpose To monitor the reasons for patient transfer between hospitals.

Principal data users Monash Injury Research Institute; Department of Health and Human Services

Collection start 1 July 1995

Version 1 (Effective 01.07.95)
2 (Effective 01.07.97)

Definition source Department of Health and Human Services

Code set source Department of Health and Human Services

Referred By

Specification

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

Reported for Every Emergency Department presentation

Code Set

Code	Descriptor
0	Staff from this campus
1	Self, family, friends
2	Local medical officer, includes local GP/Doctor
4	Private specialist
6	Staff from another campus (includes both admitted and non-admitted transfers. Also record Transfer Source)
8	Correctional Officer / Police
14	Nurse on Call
15	Other Nurse
16	Mental health telephone assessment/advisory line
17	Telephone advisory line, not otherwise specified
18	Other mental health staff
19	Other
20	Other community services staff

Reporting guide

6 Staff from another campus

Includes:

- admitted and non-admitted transfers
- record transfer Source

8 Correction Officer / Police

Includes:

- prison hospitals

The Commonwealth does not recognise these as hospitals. Therefore admission from, or separation to, such facilities are not an inter-hospital transfer.

14 Nurse on Call

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

Excludes:

- District Nurse, Nurse Practitioner and Nurses employed within Aged Care Residential Care Facility (both high and low level care), Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility.
- Unspecified telephone advisory line/service (report code 17)

Mental Health telephone advisory service where this is specifically named by the patient (report code 16)

Reporting guide (cont)

15 Other Nurse

Includes:

District Nurse, Nurse Practitioner and Nurses employed within Aged Care Residential Care Facility (both high and low level care), Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility.

Excludes:

Personal Care Attendants (PCA), Nurse on Call, and nurses within this hospital or other acute care facility.

16 Mental Health telephone assessment/advisory line

Includes:

- Suicide help line
- Mental health area phone triage

Excludes:

- Unspecified telephone advisory line/service (report code 17)
- Nurse on call where this is specifically named by the patient (report code 14).

17 Telephone advisory line, not otherwise specified

Patient indicated that they had been advised by a telephone advisory or referral service to present to the Emergency Department. Patient unable to advise the specific telephone service involved.

Excludes:

- Nurse on call where this is specifically named by the patient (report code 14).
- Mental Health telephone advisory service where this is specifically named by the patient (report code 16)

18 Other mental health staff

Includes:

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

Excludes:

- Triage/help line workers.

19 Other

Includes:

- armed forces hospitals

These are not recognised by the Commonwealth and therefore admission from, or separation to, such facilities are not an inter-hospital transfer.

20 Other community services staff

Excludes

- Mental Health services staff such as crisis assessment teams (report 18)
- Continuing care services.

Validations	**E130**	Referred By Invalid
	E136	Referred By and Transfer Source Combination Invalid
Related items	This section	Arrival Transport Mode
		Transfer Source

Administration

Purpose	Analysis of referral patterns.		
Principal data users	Department of Health and Human Services		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
			2 (Effective 01.07.97)
			3 (Effective 01.07.01)
			4 (Effective 01.07.02)
			5 (Effective 01.07.03)
			6 (Effective 01.07.08)
			7 (Effective 01.07.09)
Definition source	Department of Health and Human Services	**Code set source**	Department of Health and Human Services.

Referred to on Departure

Specification

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

Reported for Every Emergency Department presentation.

Code Set

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

Reporting guide

1 Review in Emergency Department – scheduled

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

2 Review in Emergency Department – as required

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

3 Outpatients

Patient has been referred to an outpatient clinic for further care, treatment and/or follow up

4 Local medical officer (LMO)

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

5 Medical Specialist

Medical Specialist

Excludes:

- Allied health personnel, Dentist (report code 6-Other specialist health practitioner).

Reporting guide (cont'd)

6 Other specialist health practitioner

Includes:

- Allied health personnel, Dentist.

Excludes:

- Mental health staff (report code 11 Mental Health community service)

7 Home nursing service

Includes:

- Royal District Nursing Service (RDNS)

9 Aged Care Assessment Service (ACAS)

Used where a patient is referred to an ACAS in order to assess eligibility for access to Community Aged Care Packages or residential aged care.

The core objective of ACAS is to comprehensively assess the needs of frail older people and to facilitate access to available services appropriate to their needs. In meeting this objective, ACAS also determine eligibility for Commonwealth subsidised residential aged care (including residential respite), Community Aged Care Packages and some flexible care services, including Extended Aged Care at Home (EACH).

Where a patient is referred to any other aged care specific service the appropriate code should be used (e.g. if a referral is made to a geriatrician then use code '5 – Medical Specialist')

10 Alcohol and Drug Treatment Service (A&D Services)

Used when a patient is referred to an Alcohol and Drug Treatment Service (including Counselling, Residential Withdrawal, Rehabilitation and Supported Accommodation).

11 Mental Health community service

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

- **Crisis assessment and treatment (CAT) services.**
  These operate 24 hours a day and provide urgent community-based assessment and short-term treatment interventions to people in psychiatric crisis. CAT services have a key role in deciding the most appropriate treatment option and in screening all potential inpatient admissions. CAT services provide intensive community treatment and support, often in the person's own home, during the acute phase of illness as an alternative to hospitalisation. CAT services also provide a service to designated hospital emergency departments through an onsite presence.
- **Continuing care services.**
  These are the largest component of adult community based services. They provide non-urgent assessments, treatment, case management, support and continuing care services to people with a mental illness in the community. The length of time case management services are provided to a person varies according to clinical need. Continuing care services may be involved with people for extended periods of time or may provide more episodic care. Continuing care clinicians frequently liaise with, and refer to, generalist services including general practitioners for ongoing support and provision of

services to people with a mental illness.

Excludes:

Mental Health service provision in the admitted setting

12 Other community service

Includes:

- Rape crisis centre

16 No referral

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

17 Not known

18 Other

19 Not Applicable

Patient has either:

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

Validations

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

Related items

Section 4	Dead on arrival Departure Status and Referred to on Departure

Administration

Purpose To promote and monitor the coordination of patient care.

Principal data users Monash Injury Research Institute; Department of Health and Human Services.

Mental Health and Drugs Division Department of Health and Human Services.

Collection start 1 July 1995

Version

1	(Effective 01.07.95)
2	(Effective 01.07.97)
3	(Effective 01.07.03)
4	(Effective 01.07.04)
5	(Effective 01.07.09)

Definition source Department of Health and Human Services.

Code set source Department of Health and Human Services.

Seen By Mental Health Practitioner Date

Specification

Definition

The date the patient was first attended to by a Mental Health Practitioner.

Reported for

All Emergency Department presentations where the patient is seen by a mental health practitioner.

Reporting guide

Complete where the patient is seen by a Mental Health practitioner at any stage during the ED presentation,

except where Departure Status is one of the following, leave blank

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

Where a valid date has been entered in First Seen By Mental Health Practitioner Date, a valid time must be entered in First Seen By Mental Health Practitioner Time.

Validations

E373	Seen By Mental Health Practitioner Date/Time Before Arrival Date/Time.
E374	Departure Date/Time Before Seen By Mental Health Practitioner Date/Time.
E375	Seen By Mental Health Practitioner Date/Time Invalid.
E388	Seen By Mental Health Practitioner Date/Time Before Triage Date/Time

Related items

This section	First Seen By Doctor Date. First Seen By Doctor Time. Nurse Initiation of Patient Management Date Nurse Initiation of Patient Management Time Seen by Mental Health Practitioner Time.
Section 2	Mental Health Practitioner Date/Time Fields
Section 4	Clinician Date/Time and Departure Status

Administration

Purpose

To facilitate service planning for and monitoring of access and service provision to emergency department patients in need of mental health treatment or assessment.

Principal data users

Department of Health and Human Services

Collection start	1 July 2006	**Version**	1 (Effective 01.07.06)
Definition source	Department of Health and Human Services.	**Code set source**	Department of Health and Human Services.

Seen By Mental Health Practitioner Time

Specification

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

Administration

Purpose	To facilitate service planning for and monitoring of access and service provision to emergency department patients in need of mental health treatment or assessment.		
Principal data users	Department of Health and Human Services.		
Collection start	1 July 2006	**Version**	1 (Effective 01.07.06)
Definition source	Department of Health and Human Services.	**Code set source**	Department of Health and Human Services.

Sex

Specification

Definition The sex of the person

Reported for Every Emergency Department presentation

Code Set

Code	Descriptor
1	Male
2	Female
3	Indeterminate
4	Other

Reporting guide

A person's sex is usually described as either being male or female. Some people may have both male and female characteristics. Sex is assigned at birth and is relatively fixed.

A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment or transgender reassignment. However, throughout the process, which may be over a considerable period of time, a person will identify with a specific gender allowing sex to clearly be recorded as either Male or Female.

In some cases an individual may choose to report their gender when sex is being requested.

3 Indeterminate

Code '3 – Indeterminate' should be used for infants with ambiguous genitalia, where the biological sex, even following genetic testing, cannot be determined. This code should not generally be used on data collection forms completed by the respondent.

Code 3 can only be used for infants aged less than 90 days.

4 Other

Includes:

- An intersex person, who because of a genetic condition was born with reproductive organs or sex chromosomes that are not exclusively male or female and who identifies as being neither male nor female
- A non-intersex person who identifies as neither male nor female

Excludes: Transgender, transsexual and chromosomally indeterminate individuals who identify with a particular sex (male or female).

Validations	**E090**	Sex Invalid
	E092	Sex Indeterminate with Age Greater Than or Equal To 90 Days
	E093	Sex Indeterminate and Age Less Than 90 Days
	E262	Diagnosis Code and Sex Incompatible
	E264	Diagnosis Code and Sex — Check
	E370	Sex Code 'Other'

Administration

Purpose	Analysis of service utilisation and epidemiological studies.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1999	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.03) 3 (Effective 01.07.04) 4 (Effective 01.07.17)
Definition source	NHDD METeOR ID# 287316	**Code set source**	NHDD

Transfer Destination

Specification

Definition

Identification of the hospital campus to which a person is transferred following departure from this hospital campus.

Reported for

Presentations where Departure Status is 17, 19, 20 and 21 irrespective of whether they were admitted or not admitted at the sending hospital (Conditional mandatory).

Reporting guide

Victorian hospital

If a patient is transferred to a Victorian hospital, report a valid Campus Code. The Campus table is available at: Reference files

This table is updated as required throughout the year.

Hospital identifier for interstate/overseas hospital

Compile a code according to the following convention:

First character

9 For all interstate and overseas hospitals.

Second Character

State/overseas identifier

0 Queensland
1 New South Wales
2 Tasmania
3 South Australia
4 Western Australia
5 ACT
6 Northern Territory
7 New Zealand
8 Other overseas

Third Character

Hospital type

0 Major specialist/teaching
1 Other public acute
2 Extended care
3 Private
5 Psychiatric (public only)
6 Rehabilitation (public only)
9 Other healthcare accommodation (for example early parenting centres.

Fourth character

7 For all interstate and overseas hospitals.

Example:

An extended care hospital in New South Wales would be coded 9127.

Forensic Hospitals (prisons) and Armed Forces Hospitals:

These are not generally recognised as hospitals by the Commonwealth.

Multiple campus hospital transfers:

The VEMD is a 'campus' based collection.

Where the patient transfers to another campus of the same hospital (different site identifier):

- Departure Status is 17, 19, 20 and 21
- Transfer Destination is Campus Code.

Unknown Transfer Destination:

It is expected that the sending hospital is aware of the specific receiving hospital to which the patient is being transferred.

- Unknown Transfer Destination of 9999 will result in a rejection.

Validations	**E137**	Transfer Destination / Source Equals Campus Code
	E235	Transfer Destination Code Invalid
Related items	This section	Departure status.
		Campus Code
		Transfer Source

Administration

Purpose	Analysis of patient transfer patterns.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.97) 3 (Effective 01.07.99)
Definition source	Department of Health and Human Services	**Code set source**	Department of Health and Human Services

Transfer Source

Specification

Definition

Identification of the hospital campus from which the person has been transferred.

Reported for

Presentations where Referred By is '6 – Staff from Another Campus', except if from a nursing home within such a facility (Conditional mandatory).

Reporting guide

This item includes all patients who were transferred, whether admitted or not admitted at the transferring hospital and identifies the precise acute health care facility from which the patient was transferred to your hospital.

Item should be blank if patient has not been transferred or if transfer is from a nursing home.

Victorian hospital

If a patient is transferred from a Victorian hospital, report a valid Campus Code. The Campus code table is available at: Reference files

This table is updated as required throughout the year.

Hospital identifier for interstate/overseas hospital

Compile a code according to the following convention:

First character	9	For all interstate and overseas hospitals.
Second Character	State/overseas identifier	
	0	Queensland
	1	New South Wales
	2	Tasmania
	3	South Australia
	4	Western Australia
	5	ACT
	6	Northern Territory
	7	New Zealand
	8	Other overseas
Third Character	Hospital type	
	0	Major specialist/teaching
	1	Other public acute
	2	Extended care
	3	Private
	5	Psychiatric (public only)
	6	Rehabilitation (public only)
	9	Other healthcare accommodation (for example early parenting centres.
Fourth character	7	For all interstate and overseas hospitals.

Example:

An extended care hospital in New South Wales would be coded 9127

Forensic Hospitals (prisons) and Armed Forces Hospitals:

These are not generally recognised as hospitals by the Commonwealth.

Multiple campus hospital transfers:

The VEMD is a 'campus' based collection.

Where the patient is transferred from another campus of the same hospital (different campus code):

- Referred By is '6 – Staff from Another Campus'
- Transfer Source is Campus Code.

Where the patient is transferred from another campus of the same hospital (same campus code):

- Referred By is '0 – Staff from this campus'
- Transfer Source is blank

Unknown Transfer Source:

It is expected that the sending hospital is aware of the specific hospital from which the patient was transferred. Unknown Transfer Source of 9999 will result in a rejection.

See Section 3 Campus Code

Validations	**E135**	Transfer Source Code Invalid
	E136	Referred By and Transfer Source Combination Invalid
	E137	Transfer Destination / Source Equals Campus Code
	E371	Transfer Source Equals '9999 – Unknown'
Related items	This section	Referred By.
		Campus Code

Administration

Purpose	Analysis of patient transfer patterns.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	Version	1 (Effective 01.07.95)
			2 (Effective 01.07.97)
			3 (Effective 01.07.99)
Definition source	Department of Health and Human Services	Code set source	Department of Health and Human Services

Triage Category

Specification

Definition Classification according to urgency of need for medical and nursing care, using the National Triage Scale.

Reported for Every Emergency Department presentation.

Code set

Code	Descriptor
1	Resuscitation
2	Emergency
3	Urgent
4	Semi urgent
5	Non urgent
6	Dead on arrival

Reporting guide

The Triage Category is to be allocated by an experienced registered nurse or medical practitioner.

It is imperative that the VEMD accurately reflects the demand placed on Emergency Department services, therefore, once a patient is triaged, to one of the VEMD triage categories, the presentation must be recorded within the VEMD in all instances. This applies even when the patient did not wait for treatment to commence OR if registration was commenced but not completed.

Changes in triage category:

It is recognised that triage categories may alter during a presentation.

The following guideline should be followed when a patient changes Triage Category during an emergency presentation:

- If the triage category of a patient is altered during their presentation, the original Triage Category is to be submitted to the VEMD (regardless of whether the re-categorisation is higher or lower)
- Changes in Triage Categories may be recorded locally but should not be submitted to the VEMD; only the original Triage Category should be reported.

6 - Dead on arrival:

This item is collected for VEMD purposes. It is not included in the National Triage Scale.

Refer Section 4 – Business Rules (Dead On Arrival).

Validations

E142	Dead on Arrival Combination Invalid.
E175	Triage Category Invalid.
E351	Potentially Excessive Time to Initiation of Patient Management.
E366	Departure Status and Triage Category Combination Invalid.
E386	Unexpected Combination between Triage Category and Type of Visit
E389	Triage Category 1 patient – Excessive Time to Initiation of Patient Management

Related items

This section	Arrival Date
	Arrival Time
	First Seen By Doctor Date/Time
	Nurse Initiation of Patient Management Date/Time
	Seen by Mental Health Practitioner Date/Time
	Triage Date
	Triage Time
Section 2	Triage
	Initiation of Patient Management Time to Initiation of Patient Management
Section 4	Dead on Arrival

Administration

Purpose

To identify and monitor the urgency of a patient's presentation and corresponding time to initiation of patient management.

Principal data users

Monash Injury Research Institute; Department of Health and Human Services.

Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
Definition source	Australasian College for Emergency Medicine	**Code set source**	Australasian College for Emergency Medicine; Department of Health and Human Services NHDD

Triage Date

Specification

Definition	Date the patient was first seen by a Triage nurse/doctor.	
Reported for	Every Emergency Department presentation.	
	See Section 2:	Date / Time Fields
		Time to initiation of patient management.
Validations	**E165**	Triage Date/Time Invalid
	E167	Triage Date/Time Before Arrival Date/Time
	E181	Nurse Initiation of Patient Management Date/Time Before Triage Date/Time
	E196	First Seen By Doctor Date/Time Before Triage Date/Time
	E387	Triage Date/Time after Departure Date/Time
	E388	Seen By Mental Health Practitioner Date/Time Before Triage Date/Time
	E400	Triage Date/Time before Ambulance at Destination Date/Time
Related items	This section	Triage Time

Administration

Purpose	• Used in the calculation of various derived items		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
Definition source	NHDD	**Code set source**	NHDD

Triage Time

Specification

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

Administration

Purpose	Used in the calculation of various derived items.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95)
Definition source	Department of Health and Human Services	**Code set source**	Department of Health and Human Services.

Type of Usual Accommodation

Specification

Definition Type of accommodation in which the patient usually lives.

Reported for Every Emergency Department presentation.

Code set

Code	Descriptor
1	Private Residence, living alone.
2	Private Residence, living with other(s).
3	Residential aged care facility - includes both high care (nursing home) and low care (hostel).
4	Boarding/rooming house/hostel or hostel type accommodation (not including aged care hostel).
5	Community-based residential supported living facility or other supported accommodation (includes group home for people with disabilities, supported residential services, specialised alcohol/other drug treatment residence).
6	Psychiatric Hospital.
7	Other Hospital Setting.
8	Homeless Person's Shelter.
9	Shelter/refuge (not including homeless person's shelter).
10	Public place (homeless).
11	Prison/Remand Centre/ Youth Training centre.
18	Unknown/unable to determine.
19	Other accommodation, not elsewhere classified.

Reporting guide

'Usual' is defined as the type of accommodation the person has lived in for the most amount of time over the past three months prior to presentation.

If a person stays in a particular place of accommodation for four or more days a week over the period, that place of accommodation would be the person's type of usual accommodation.

In practice, receiving an answer strictly in accordance with the above definition may be difficult to achieve. The place the person perceives as their usual accommodation will often prove to be the best approximation.

2 Private Residence, living with other(s)

Includes: family or friends. Intended to capture those who would provide support on discharge.

Reporting guide (cont'd)

3 Residential aged care facility -includes both high care (nursing home) and low (hostel) care.

Includes: nursing home beds in acute and sub/acute care hospitals.

5 Community-based residential supported living facility or other supported accommodation

Includes:

- Community-based residential supported accommodation specifically targeted at people with psychiatric disabilities which provide 24-hour support/rehabilitation on a residential basis
- Group homes for people with disabilities, cluster apartments where a support worker lives on-site, community residential apartments, congregate care arrangements. Support is provided by staff on either a live-in or rostered basis, and they may or may not have 24-hour supervision and care
- Other supported accommodation facilities such as hostels for people with disabilities and Residential Services/Facilities. These facilities provide board and lodging and rostered care workers provide client support services.

The intent of code 5 is to capture accommodation where there is some support available. Where there is no support available i.e. the hostel or other facility provides accommodation only, code 4 should be allocated.

6 Psychiatric Hospital

Includes alcohol/other drug treatment units in psychiatric hospitals

7 Other Hospital Setting

Includes respite and palliative care facilities.

Validations

E354	Type of Usual Accommodation Invalid.
E355	Type of Usual Accommodation and Age Combination Invalid.
E356	Type of Usual Accommodation and Departure Status Combination Invalid.
E357	Type of Usual Accommodation and Medicare Suffix Combination Invalid.

Related items

This section	Date of Birth Locality Postcode.

Administration

Purpose To assist in the evaluation of acute / residential care interface issues and the implementation of strategies to address these issues.

Principal data users Department of Health and Human Services.

Collection start	1 July 2003	**Version**	1 (Effective 01.07.03)
Definition source	Department of Health and Human Services.	**Code set source**	Department of Health and Human Services.

Type of Visit

Specification

Definition The reason the patient presented to the Emergency Department.

Reported for Every Emergency Department presentation.

Code Set

Code	Descriptor
1	Emergency presentation
2	Return visit – planned
8	Pre-arranged admission – clerical, nursing, clinical
10	Dead on arrival

Reporting guide

Select the **first** appropriate category from the following hierarchy of options.

1 Emergency Presentation

Attendance requiring acute unscheduled care.

Includes:

Presentation due to an actual or suspected new clinical condition; OR

An unplanned presentation for a continuing actual or suspected condition; OR

Privately referred or privately treated patient,

2 Return Visit - Planned

Includes:

Planned return to the ED as a result of a previous ED presentation or return visit. The return visit may be for planned follow-up treatment or as a consequence of test results indicating need for further treatment or as a result of a care plan initiated at discharge; **OR**

Outpatient appointment for a planned presentation.

Excludes:

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

8 Pre-arranged Admission-clerical, nursing, clinical.

Includes:

Presentation at the ED for clerical, nursing or medical processes to be undertaken. Admission has been arranged by the referring medical officer and a ward bed allocated.

10 Dead on Arrival

Patient is pronounced dead by a medical practitioner before (or without) being brought into the ED or where the patient is bought into the ED but there is no intent to resuscitate.

Validations

E140 Type of Visit Invalid.

E142 Dead on Arrival Combination Invalid.

	E386	Unexpected Combination between Triage Category and Type of Visit
Related Items	**Section 4**	Dead on Arrival

Administration

Purpose	Analysis of service utilisation.		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.03) 2 (Effective 01.07.16)
	NHDD, METeOR ID# 270362	**Code set source**	Department of Health and Human Services, NHDD, modified.

Unique Key

Specification

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

Administration

Purpose	To uniquely identify every ED presentation		
Principal data users	Monash Injury Research Institute; Department of Health and Human Services.		
Collection start	1 July 1995	**Version**	1 (Effective 01.07.95) 2 (Effective 01.07.98) 3 (Effective 01.07.99)
Definition source	Department of Health and Human Services	**Code set source**	Hospital generated.