Non-admitted patient emergency department care NMDS 2012-13

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Identifying and definitional attributes

Metadata item type: Data Set Specification

METEOR identifier: 474371

Registration status: Health!, Superseded 07/02/2013

DSS type: National Minimum Data Set (NMDS)

Scope: The scope of the Non-admitted patient emergency department care national minimum data set specification (NAPEDC NMDS) is non-admitted patients registered for care in emergency departments in selected public hospitals that are classified as either Peer Group A or B in the Australian Institute of Health and Welfare's Australian Hospital Statistics publication from the preceding financial year (see also Scope links with other metadata sets in the Comments section below).

Patients who were dead on arrival are in scope if an emergency department clinician certified the death of the patient. Patients who leave the emergency department after being triaged and then advised of alternative treatment options are in scope.

The scope includes only physical presentations to emergency departments. Advice provided by telephone or videoconferencing is not in scope, although it is recognised that advice received by telehealth may form part of the care provided to patients physically receiving care in the emergency department.

The care provided to patients in emergency departments is, in most instances, recognised as being provided to 'non-admitted' patients. Patients being treated in emergency departments may subsequently become 'admitted' (including admission to a short stay unit, admission to elsewhere in the emergency department, admission to another hospital ward, or admission to hospital-in-the-home). All patients remain in scope for this collection until they are recorded as having physically departed the emergency department, regardless of whether they have been admitted. For this reason there is an overlap in scope of this NMDS and the Admitted patient care national minimum data set (APC NMDS).

Collection and usage attributes

Statistical unit: Emergency department stay.

Guide for use: The definition of a 'short stay unit' is as per clause C48 of the National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services (NPA IPHS), as follows:

a) Designated and designed for the short term treatment, observation, assessment and reassessment of patients initially triaged and assessed in the emergency department (ED);

b) Have specific admission and discharge criteria and policies;

c) Designed for short term stays no longer than 24 hours;

d) Physically separated from the ED acute assessment area;

e) Have a static number of beds with oxygen, suction, patient ablution facilities; and

f) Not a temporary ED overflow area nor used to keep patients solely awaiting an inpatient bed nor awaiting treatment in the ED.

Collection methods:

National reporting arrangements

State and territory health authorities provide the data to the Australian Institute of Health and Welfare for national collation, on a quarterly basis within one month of the end of a reporting period and an annual basis within three months of the reporting period.

The Institute and the Commonwealth Department of Health and Ageing will agree on a data quality and timeliness protocol. Once cleaned, a copy of the data and a record of the changes made will be forwarded by the Institute to the Commonwealth Department of Health and Ageing. A copy of the cleaned data for each jurisdiction should also be returned to that jurisdiction on request.

Periods for which data are collected and nationally collated

Quarterly and financial year. Extraction of data for each quarter or year should be based on the date of the end of the emergency department stay. For example, a presentation that commences at 11pm on 30 June and ends at 2am 1 July is not in scope for the April to June quarter.

Implementation start date: 01/07/2012

Implementation end date: 30/06/2013

Comments:

Scope links with other metadata sets

Episodes of care for admitted patients are reported through the Admitted patient care NMDS.

National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services

The scope for reporting against the National Emergency Access Target is all hospitals reporting to the NAPEDC NMDS (Peer groups A, B and other) as at August 2011 (when the Agreement was signed). For the duration of the Agreement, hospitals that have not previously reported to the NAPEDC NMDS can come into scope, subject to agreement between the jurisdiction and the Commonwealth.

Source and reference attributes

Submitting organisation: National Health Information Management Principal Committee

Relational attributes

Related metadata references:

Supersedes Non-admitted patient emergency department care NMDS 2011-12
Health!, Superseded 30/01/2012

Has been superseded by Non-admitted patient emergency department care NMDS 2013-14
Health!, Superseded 11/04/2014

See also National Partnership Agreement on Improving Public Hospital Services: National Emergency Access Target
Health!, Standard 21/11/2013

See also Non-admitted patient emergency department care DSS 1 January 2012-30 June 2012
Health!, Retired 30/01/2012

Metadata items in this Data Set Specification

Seq No.	Metadata item	Obligation	Max occurs
-	Emergency department stay—physical departure date, DDMMYYYY	Mandatory	1
-	Emergency department stay—physical departure time, hhmm	Mandatory	1
-	Emergency department stay—presentation date, DDMMYYYY	Mandatory	1
-	Emergency department stay—presentation time, hhmm	Mandatory	1

Seq No.	Metadata item	Obligation	Max occurs
-	Emergency department stay—transport mode (arrival), code N	Mandatory	1
-	Emergency department stay—type of visit to emergency department, code N	Mandatory	1
-	Emergency department stay—waiting time (to commencement of clinical care), total minutes NNNNN	Conditional	1

Conditional obligation:

This data item is to be recorded if the patient has one of the following Episode end status values recorded:

- Admitted to this hospital (either short stay unit, hospital in the home or non-emergency department hospital ward);
- Non-admitted patient emergency department service episode completed —departed without being admitted or referred to another hospital;
- Non-admitted patient emergency department service episode completed —referred to another hospital for admission;
- Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed;
- Died in emergency department as a non-admitted patient;
- Dead on arrival, emergency department clinician certified the death of the patient.

-	Episode of care—funding eligibility indicator (Department of Veterans' Affairs), code N	Mandatory	1
-	Establishment—organisation identifier (Australian), NNX[X]NNNNN	Mandatory	1
-	Non-admitted patient emergency department service episode—clinical care commencement date, DDMMYYYY	Conditional	1

Conditional obligation:

This data item is to be recorded if the patient has one of the following Episode end status values recorded:

- Admitted to this hospital (either short stay unit, hospital in the home or non-emergency department hospital ward);
- Non-admitted patient emergency department service episode completed —departed without being admitted or referred to another hospital;
- Non-admitted patient emergency department service episode completed —referred to another hospital for admission;
- Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed;
- Died in emergency department as a non-admitted patient;
- Dead on arrival, emergency department clinician certified the death of the patient.

Seq No.	Metadata item	Obligation	Max occurs
-	Non-admitted patient emergency department service episode—clinical care commencement time, hhmm ***Conditional obligation:*** This data item is to be recorded if the patient has one of the following Episode end status values recorded: • Admitted to this hospital (either short stay unit, hospital in the home or non-emergency department hospital ward); • Non-admitted patient emergency department service episode completed —departed without being admitted or referred to another hospital; • Non-admitted patient emergency department service episode completed —referred to another hospital for admission; • Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; • Died in emergency department as a non-admitted patient; • Dead on arrival, emergency department clinician certified the death of the patient.	Conditional	1
-	Non-admitted patient emergency department service episode—episode end date, DDMMYYYY	Mandatory	1
-	Non-admitted patient emergency department service episode—episode end status, code N	Mandatory	1
-	Non-admitted patient emergency department service episode—episode end time, hhmm	Mandatory	1
-	Non-admitted patient emergency department service episode—service episode length, total minutes NNNNN	Mandatory	1
-	Non-admitted patient emergency department service episode—triage category, code N ***Conditional obligation:*** This data item is to be recorded for patients who have one of the following Type of visit values recorded: • Emergency department presentation; • Return visit, planned; • Pre-arranged admission; • Patient in transit.	Conditional	1
-	Non-admitted patient emergency department service episode—triage date, DDMMYYYY ***Conditional obligation:*** This data item is to be recorded for patients who have one of the following Type of visit values recorded: • Emergency department presentation; • Return visit, planned; • Pre-arranged admission; • Patient in transit.	Conditional	1

Seq No.	Metadata item	Obligation	Max occurs
-	Non-admitted patient emergency department service episode—triage time, hhmm	Conditional	1

Conditional obligation:

This data item is to be recorded for patients who have one of the following Type of visit values recorded:

- Emergency department presentation;
- Return visit, planned;
- Pre-arranged admission;
- Patient in transit.

-	Patient—compensable status, code N	Mandatory	1
-	Person—area of usual residence, geographical location code (ASGC 2011) NNNNN	Mandatory	1
-	Person—area of usual residence, statistical area level 2 (SA2) code (ASGS 2011) N(9)	Mandatory	1
-	Person—country of birth, code (SACC 2011) NNNN	Mandatory	1
-	Person—date of birth, DDMMYYYY	Mandatory	1

DSS specific information:

This field must not be null.

National Minimum Data Sets:

For the provision of state and territory hospital data to Commonwealth agencies this field must:

- be less than or equal to Admission date, Date patient presents or Service contact date
- be consistent with diagnoses and procedure codes, for records to be grouped.

-	Person—Indigenous status, code N	Mandatory	1
-	Person—person identifier, XXXXXX[X(14)]	Mandatory	1
-	Person—sex, code N	Mandatory	1