Non-admitted patient emergency department care DSS 2014-15

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Identifying and definitional attributes

Metadata item type: Data Set Specification

METEOR identifier: 567462

Registration status: Health!, Superseded 04/02/2015

DSS type: Data Set Specification (DSS)

Scope: The scope of the Non-admitted patient emergency department care data set specification (NAPEDC DSS) is patients registered for care in emergency departments in public hospitals where the emergency department meets the following criteria:

- Purposely designed and equipped area with designated assessment, treatment and resuscitation areas.
- Ability to provide resuscitation, stabilisation and initial management of all emergencies.
- Availability of medical staff in the hospital 24 hours a day.
- Designated emergency department nursing staff 24 hours a day, 7 days a week, and a designated emergency department nursing unit manager.

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 the scope of this DSS and the Admitted patient care national minimum data set (APC NMDS).

Excluded from the scope of the DSS are:

- Care provided to patients in General Practitioner co-located units;
- Where only a clerical service is provided to people supporting a pre-arranged admission; and
- Where people are awaiting transit to another facility and receive no clinical care.

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 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. 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: 01/07/2014

Implementation end date: 30/06/2015

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.

Glossary items

Glossary terms that are relevant to this data set specification are included here.

Admission

Compensable patient

Emergency department

Registered nurse

Triage

Urgency related groups

Source and reference attributes

Submitting organisation: Independent Hospital Pricing Authority

Relational attributes

Related metadata references:

Has been superseded by Non-admitted patient emergency department care DSS 2015-16
Health!, Superseded 02/12/2015

See also Non-admitted patient emergency department care NMDS 2014-15
Health!, Superseded 13/11/2014

Metadata items in this Data Set Specification

Seq No.	Metadata item	Obligation	Max occurs
-	Address—Australian postcode, Australian postcode code (Postcode datafile) {NNNN}	Mandatory	1
-	Emergency department stay—additional diagnosis, code X[X(8)] ***Conditional obligation:*** This data element is only required to be reported when at least one additional diagnosis is present for the emergency department stay.	Conditional	2
-	Emergency department stay—diagnosis classification type, code N.N ***Conditional obligation:*** This data element is only required to be reported when a principal diagnosis and/or an additional diagnosis has been reported.	Conditional	1
-	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
-	Emergency department stay—principal diagnosis, code X[X(8)] ***Conditional obligation:*** The reporting of this data element is conditional for those attendances where the value recorded for *Non-admitted patient emergency department service episode—episode end status* is reported as either: Code 4 - Did not wait to be attended by a health care professional; Code 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; or Code 7 - Dead on arrival, emergency department clinician certified the death of the patient.	Conditional	1
-	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—urgency related group major diagnostic block, code N[AA]	Mandatory	1

Seq No.	Metadata item	Obligation	Max occurs
-	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:

- Code 1 - Admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward);
- Code 2 - Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital;
- Code 3 - Non-admitted patient emergency department service episode completed - referred to another hospital for admission;
- Code 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed;
- Code 6 - Died in emergency department as a non-admitted patient;
- Code 7 - 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:

- Code 1 - Admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward);
- Code 2 - Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital;
- Code 3 - Non-admitted patient emergency department service episode completed - referred to another hospital for admission;
- Code 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed;
- Code 6 - Died in emergency department as a non-admitted patient;
- Code 7 - 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: • Code 1 - Admitted to this hospital (either short stay unit, hospital-in-the-home or non-emergency department hospital ward); • Code 2 - Non-admitted patient emergency department service episode completed - departed without being admitted or referred to another hospital; • Code 3 - Non-admitted patient emergency department service episode completed - referred to another hospital for admission; • Code 5 - Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed; • Code 6 - Died in emergency department as a non-admitted patient; • Code 7 - 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: • Code 1 - Emergency presentation; • Code 2 - Return visit, planned; • Code 3 - Pre-arranged admission; • Code 4 - 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: • Code 1 - Emergency presentation; • Code 2 - Return visit, planned; • Code 3 - Pre-arranged admission; • Code 4 - 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:

- Code 1 - Emergency presentation;
- Code 2 - Return visit, planned;
- Code 3 - Pre-arranged admission;
- Code 4 - Patient in transit.

-	Patient—compensable status, code N	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
-	Record—identifier, X[X(79)]	Mandatory	1