Government of **Western Australia**
Department of **Health**
Information and System Performance

Data Quality Statement
EMERGENCY DEPARTMENT DATA COLLECTION

Summary details	
Background / history	The Emergency Department Data Collection (EDDC) is a comprehensive data set of all presentations to emergency departments (ED) at public hospitals in WA. In addition to data specifically related to episodes of care within ED, the collection also includes demographic data and data required under the Australian Health Care Agreement.
Purpose	The EDDC is used to provide data for several state and national ED data requirements. This includes national reporting for: • Non-Admitted Patient Emergency Department Care National Minimum Data Set (NAPEDC NMDS) • The Activity Based Funding Dataset Specification (ABF DSS) • National Health Funding Body (NHFB). The EDDC also provides local reporting for health service planning and management, budget allocation, resource utilisation, state and national performance monitoring and reporting, parliamentary questions' ministerial questions, freedom of information requests and research projects.
Governance - Legal and Policy - Data stewardship - Data custodianship	The EDDC is mandated by the System Manager functions. **Data Steward:** Assistant Director General **Data Custodian:** Principal Data Management Officer
Data collection	**Collection Methodology:** Administrative **Collection Method:** Direct Access
Type of data collected	The EDDC is a local administrative data collection that captures data relating to services provided to patients within public hospital emergency departments, contracted health entities and emergency services provided in smaller hospitals without a designated ED.
Scope of data	**Inclusions:** • Information related to episodes of care in emergency departments (e.g. triage category, presentation date and time) • Demographic data (e.g. name, date of birth) • Data required under the Australian Health Care Agreement (e.g. whether an interpreter service was required) **Exclusions:** • Episodes of non-admitted patient care provided in outpatient clinics or hospital inpatient departments

<table>
<tr><td>Frequency/timing</td><td>Data is sourced from approved core enterprise information systems according to the following data schedules:
EDIS (metropolitan sites plus Bunbury sites):
• Daily automated electronic data capture and load into the EDD repository for the previous two days (48 hours), commencing at 2:00am in turn from all EDIS sites.
• Monthly, Quarterly, Annual – manual electronic data capture and load into the EDDC repository for the previous month between the 3rd and 5th of the month (for Feb, Mar, May, Jun, Sept, Nov, Dec)
webPAS (rural sites):
• Daily automated electronic extract and load into the EDDC repository, for the previous 7 days
• Monthly, Quarterly, Annual – manual electronic data capture and load into the EDDC repository for the previous month between the 3rd and 5th day of the month (for Feb, Mar, May, Jun, Sept, Nov, Dec)
• Extract also includes Medicare Number, Department of Veteran Affairs (DVA) fields and Pay Class fields for Armadale and Rockingham Hospitals who are not on EDIS
• This extract also includes Admitted Episode Number for all EDIS sites
webPAS (St John of God Midland Public Hospital):
• Daily automated electronic extract and load into the EDDC repository, for the previous 28 days
Meditech (JHC):
• Monthly automated electronic extract which provides data for the month, two months prior. Extract is provided and loaded by the 5th of every month. EDDC extracts the Medicare Number, Department of Veteran Affairs (DVA) fields and Pay Class fields
TOPAS:
• Monthly automated electronic extract and load into the EDDC repository for the previous month for EDIS sites. Extract is provided and loaded by the 5th of every month. EDDC extracts the Medicare Number, Department of Veteran Affairs (DVA) fields and Pay Class fields.
Peel Health Campus (PHC):
• Weekly, manually sent electronic extract which EDDC provides to IDM to load every Tuesday morning. Extract contains 7 days data (previous Monday to Sunday)
• Monthly refresh manually sent electronic extract by the 12th of the month, which EDDC provides to IDM to load. Extract contains data for the previous month.</td></tr>
<tr><td>Quality</td><td>EDDC includes data from 2000/2001 but not from all hospitals. Data from Joondalup Health Campus is available from 2004/2005, and Peel Health Campus from 2006/2007.</td></tr>
<tr><td>Further information</td><td>E: DataRequests.EDDC@health.wa.gov.au
EDDC Data Dictionary</td></tr>
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Data Variables – Emergency Department Collection

Data Variables							
Variable	**Variable description**	**Definition**	**Type**	**Length**	**Permitted Values**	**Collection requirements**	**Additional notes**
pres_dt	Presentation datetime	The Date and Time that the patient arrives at the ED.	Date DD/MM/YYYY HH:MM:SS	19	Any valid date and time value.	Mandatory	This is the date and time that the patient arrives in the ED. The arrival date cannot be missing. The earlier of the ARRIVAL_DATETIME and the TRIAGE_DATETIME is used to derive PRESENTATION_DATETIME, which is the datetime used as the reference period for local reporting. OTHER NOTES This field in most systems is populated when a new record is opened to begin patient triage. In some instances, patients may be queued up waiting for triage. To better record ARRIVAL_DATETIME, hospitals should consider a ticket system that records the date when the ticket is pulled. The systems should be able to take in this date… or at the very least, the clerk should be able to take the date from the ticket.
base_address	Address	The address provided for the patient's place of usual residence.	Character	50	Free text; Must contain Alpha numerics Only. No symbols permitted.	Mandatory	The patient's home address at the time of their presentation to the ED cannot be missing. The house number, street name and street type should be on the first of two address lines to be sent. Suburb is to be recorded separately. Non-residential addresses for accounts or billing purposes (e.g. PO Boxes) are not acceptable as residential addresses. Every effort should be made to collect the patient's actual residential address. Under Activity Based Funding arrangements, the patient physical address may play an important role in funding calculations. If the patient is an overseas visitor, their permanent residential address overseas should be recorded, not their local temporary address. The country of residence should be entered into the suburb line for overseas residential addresses. In these cases, suburbs are not required. Please note overseas residential addresses should have the postcode of 8888. If the patient is homeless or does not have a fixed permanent address, 'NFPA' – No Fixed Permanent Address should be entered. If a patient does not know there address, or refuses to provide an address then 'UNKNOWN' should be entered into the base address. If a patient is a current inmate of a prison, the base address should contain the name of the correctional facility. Patients whose usual place of residence is a Residential Aged Care

							Service (e.g. nursing home or aged care hostel) should have the nursing home or hostel's address as their residential address
age	Age	Patient's age at time of ED presentation, derived from patient date of birth.	Character	5	Any valid value	Mandatory	There is a data quality edit concerning patient's with an age greater than 120
rfc_gen _code	Sex	Patient's gender. The biological distinction between male and female.	Character	5	1 Male 2 Female 3 Indeterminate 9 Not stated/Inadequately described	Mandatory	Gender cannot be missing. The term "sex" refers to the biological differences between males and females, while the term gender refers to the socially expected/perceived dimensions of behaviour associated with males and females that are masculinity and femininity. The National Health Data Dictionary advises that the correct terminology for this data element is sex, There are three categories for this data element — male, female and indeterminate. The latter category should only be used for neonates whose sex cannot be determined at birth. This includes babies diagnosed with gynandrous, hermaphroditism, ovotestis, pseudohermaphroditism (male) (female) and pure gonadal dysgenesis. These persons may have either male and female sex organs or structural aberrations of the sex chromosomes Information collection for transsexuals and people with transgender issues should be treated in the same manner. To avoid problems with edits, transsexuals undergoing a sex change operation should have their current (biological) sex at time of the ED presentation recorded as the sex of the episode of care.
aborigin ality	Indigenous status	Patient's Indigenous status. Whether a person identifies as being of Aboriginal or Torres Strait Islander Origin.	Character	5	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 Not Aboriginal or Torres Strait Islander origin 9 Unknown	Mandatory	Indigenous identification is extremely important in health data collections throughout Australia. It is used not only to direct funds into Aboriginal and Torres Strait Islander medical programs, but also to identify causes of peri natal and adult morbidity and mortality within the indigenous population. An Aboriginal or Torres Strait Islander is a person who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community within which he or she lives. There are three components to this definition: descent, self-identification and community acceptance. All three should be satisfied for a person to be Aboriginal or Torres Strait Islander. However, it is not possible in the hospital setting to ascertain descent or community acceptance. If a person identifies himself or herself as Aboriginal or

							Torres Strait Islander, then assign the most appropriate code. Persons who self-identify as another ethnicity (e.g. Caucasian, Afro-American, Polynesian, Asian or Indian) must be recorded as Neither Aboriginal nor Torres Strait Islander. EXAMPLES 1. A person who identifies as a Torres Strait Islander attends the Royal Perth Hospital ED.
neat_adm	Admission to hospital	Patient was Admitted to ward/other admitted patient unit, Admitted to an ED Observation Ward or Admitted to Hospital in the home.	Numeric	2	0 patient was not admitted 1 patient was admitted	Derived	Used to sum total patient admissions from the ED.
neat_attend	ED presentation	Patient attended the emergency department and was later discharged.	Numeric	2	Requires a valid discharge date/time 0 not a valid ED attendance 1 patient attended the ED and was subsequently discharged	Derived	Requires a valid discharge date/time.
discharge_date	Discharge from hospital	The Date that the patient is discharged from the ED.	Date DD/MM/YYYY	6	Any valid date and time value.	Mandatory	The date that the patient is physically discharged from ED. Discharge date and time cannot be missing. If the patient is subsequently admitted to this hospital (including those who are admitted and subsequently die before leaving the emergency department), then record the date the patient's emergency department non-admitted clinical care is completed. If the service episode is completed without the patient being admitted, then record the date the patient's emergency department non-admitted clinical care is completed. If the service episode is completed and the patient is referred to another hospital for admission, then record the date the patient's emergency department non-admitted clinical care is completed. If the patient did not wait, then record the date the patient leaves the emergency department or was first noticed as having left. If the patient left at their own risk, then record the date the patient leaves the emergency department or was first noticed as having left. If the patient died in the emergency department as a non-admitted patient, then record the date the patient was certified dead. If the patient was dead on arrival, then record the date the patient was

							certified dead. If the patient was registered, advised of another health-care service, and left the emergency department without being attended by a health-care professional, then record the date the patient leaves the emergency department. Records that are missing a discharge date are excluded from National reporting and will not receive funding from the Commonwealth. It is therefore imperative that all records including patients that did not wait have a discharge date.
neat_died	Death	Patient Died in ED	Numeric	2	0 patient did not die 1 patient died in ED	Derived	Used to sum total patient deaths inside the ED.
client_identifier	UMRN	Patient unique identifier	Character	10		Mandatory	Can be used for linkage purposes.
first_forename	Name	Patient's given name	Character	50	Free text; Must contain Alpha numerics Only. No symbols permitted	Mandatory	N/A
surname	Surname	Patient's surname	Character	50	Free text; Must contain Alpha numerics Only. No symbols permitted	Mandatory	N/A
dob	Date of birth	Patient’s date of birth	Date DD/MM/YYYY	8	Any valid date value	Mandatory	Date of Birth is used to derive the age of the patient for use in demographic analysis. It also assists in the unique identification of patients if other identifying information is missing or in question, and may be required for the derivation of other metadata items The Date of Birth should always be given in day, month and full year (DDMMYYYY). The day range is 01-31 (depending on the month), the month range is 01-12 and the century range is 18, 19 or 20. Age is not to be sent on electronic files as it is a calculated field and that is performed by the EDDC. It is important to be as accurate as possible when completing the birth date. It is recognised that some patients do not know the exact date of their birth. When the exact date of birth is unknown, please estimate the person’s age and record the date of birth as follows: AGE 75 YEARS DATE OF BIRTH 01/07/1942 AGE 30 YEARS DATE OF BIRTH 01/07/1987 EXAMPLES Patient’s date of birth is 10th of July 1950. 1. Patient’s estimated age is 14 years old and they present to the ED in

							October 2019. 2. A female patient gives birth and the baby is delivered at midnight on the 19th of October 2017.
est_cod e	Establishme nt code	A unique code identifying the establishment/hospital that the patient attended.	Numeric	5	As per the list of numeric codes allocated to hospitals and other health-related locations/establishments by the WA DOH (eg. 101 = Royal Perth Hospital).	Assigned	A list of in-scope hospitals/establishments is provided in Appendix A The establishments listed are hospitals or health services that are required by law report their Emergency Department activity to the EDDC. Each organisation must only have one Establishment Code assigned. Establishment Allocation Establishment Codes are assigned by HMDS. If your Establishment is new and you require allocation in order to report data to HMDS, please contact HMDS to arrange allocation of a unique code. Updated establishment lists are uploaded to the Morbidity intranet periodically for HSPs to access throughout the year. CHEs and other Private Hospitals are sent updated copies of the Establishment Lists via MyFT as and when required. EXAMPLES 1. A patient attended the Royal Perth Hospital ED. 2. A patient attended the Morowa Hospital ED.
tri_code	Triage code	Patient's triage category assessment. The urgency of a patient's need for medical and nursing care, as represented by a code.	Character	5	1 Resuscitation: immediate (within seconds) 2 Emergency: within 10 minutes 3 Urgent: within 30 minutes 4 Semi-urgent: within 60 minutes 5 Non-urgent: within 120 minutes 6 Dead On Arrival 7 Direct Admit 8 Inpatient	Mandatory	Triage category cannot be missing. Emergency patients are triaged to assess the urgency of their symptoms?. Triage categories can be changed after initial assessment of a patient, but it is important to note that a triage code change will affect reporting related to whether the patient was seen within the recommended time. Patients who require unplanned services, who have contacted a general practitioner and have been directed to the hospital by the GP, are considered emergency patients. This type of care is unplanned in that the illness or injury was sudden and the services unplanned, thus the Triage protocol should be followed. In some cases, a telephone service can be used as a substitute for face to face contact with the patient because of special circumstances, for example the distance required to travel to a service provider, and this may be counted as a presentation. For this activity to be included in reporting, the service must have been provided by a clinician, the telephone call must have been longer than five minutes, a triage code of 1 to 5 must be recorded and the patient must be clerically registered. If patients who are referred to After Hours GP Clinics are recorded in the

							ED system (what do you mean IF?? If they attend the ED, regardless of what happens to them, they should be recorded in the system), the following coding should be used: Triage code 5 should be entered, the episode end status should be entered as referred to After Hours GP Clinic and the patient should be clerically registered where possible. Dead On Arrival Patients who are dead on arrival and require some service from ED clinicians are to be recorded. In capturing the data: - Triage should be entered as Dead on arrival - Episode end status entered as Dead on arrival; and - Visit type is entered as Dead on arrival. - Have you recorded this information in the DISPOSAL CODE and VISIT TYPE variables? Should at least refer the reader to the place where the info is recorded. - Should perhaps also say that if patient is DOA but does not require anything from ED, they are usually taken straight to the morgue and should not be recorded in the ED system. Double check with Chris! Direct Admission Direct admission patients who require some service from ED Clinicians are to be recorded. In capturing the data: -Triage should be entered as Direct admission -Episode end status entered as admitted; and -Visit Type entered as Direct Admission Direct Admissions are not normally recorded in the ED. Inpatient If an admitted patient attends the ED for a procedure, such as having an intravenous cannula re-sited, and this activity is captured in the ED electronic system the following data should be entered -Triage should be entered as an inpatient -Episode end status as Returned to ward or HITH; and -Visit type entered as Current inpatient or HITH -This approach will enable the patient to be identified as being a current inpatient and the activity can be removed from mainstream ED reporting.
disposal_code	Disposal code	The outcome of a patient's ED attendance. Also known as Episode End Status,	Character	5	1 Admitted to ward/other admitted patient unit 2 ED service event completed; departed under own care	Mandatory	Departure Status cannot be missing.

		Disposition or Emergency Discharge Status.			3 Transferred to another hospital for admission 4 Did not wait to be attended by medical officer 5 Left at own risk 6 Died in ED 7 Dead on arrival, not treated in ED 8 Referred to After Hours General Practitioner 9 Unknown 10 Admitted to ED Observation Ward 11 Admitted to Hospital in the Home 12 Admitted from Hospital at the Home 13 Nursing Home 14 Returned to Hospital in the Home 15 Returned to Rehabilitation in the Home 16 Returned to Hospital at the Home 17 Transferred from Hospital in the Home 18 Transferred from Rehabilitation in the Home 19 Discharged after admission 20 Reversal		
destination	Departure destination	Where did the patient go after the completion of treatment.	Character	TBA	1 Did not wait 2 Left at own risk 3 Nursing Home/Hostel 4 Transferred 5 Mortuary 6 Admitted 7 Other hospital 8 Home 9 Unknown 10 Other 11 Admitted to ED Observation Ward	Mandatory	Mapping of departure destination is currently being overhauled, For EDIS, the element currently captures the ward that the patient goes to once a patient has been admitted. If a patient is being transferred, some EDIS sites will specify which hospital the patient is going to, some do not. For webPAS hospitals, this field is only completed when a patient is transferred to another hospital. On transfer, the establishment code of the hospital will be populated in this field
vis_type	Type of visit to ED	Patient's reason for visiting the ED.	Character	5	1 Emergency Presentation 2 Return Visit - Planned	Mandatory	N/A

					3 Unplanned Return visit 4 Outpatient/Outpatient Clinic 5 Privately Referred: Non Admitted Patient 6 Prearranged Admission: Clerical Only 7 Pre-Arranged Admission: Nursing and Clerical 8 Pre-Arranged Admission: Full Clinical 9 Patient In Transit 10 Dead On Arrival 11 Health Direct Referral 12 GP Referral 13 Referral From Another Hospital 14 Referral from another facility 15 Transfer from other hospital 16 Direct Admission 17 No access to GP 18 Not Stated/Unknown 19 Hospital in the Home 20 Rehabilitation in the Home 21 Hospital at the Home		
arriv_type	Arrival type	Patient's mode of arrival at the ED.	Character	5	1 Private transport 2 Public transport 3 Ambulance 4 Hospital transport 5 Police/Correctional Services 6 Helicopter rescue 7 Royal Flying Doctor Service 8 Other 9 Not Stated/Unknown 10 Taxi	Mandatory	This field provides information regarding how they arrived at the ED. If a patient is transported by Royal Flying Doctor Service to an airport and then taken to hospital by ambulance, the Royal Flying Doctor Service should be coded as it takes priority over other forms of transport.
rfc_ref_code	Referral source	The person or agency responsible for the referral of the patient to the ED.	Character	5	1 Appointment 2 GP – Letter 3 GP – No letter 4 Self/relative 5 Clinic	Mandatory	Referral source was not recorded at sites utilising HCare. For all other feeder information systems, referral source cannot be missing.

					6 Other hospital 7 Other 8 Health Direct 9 No GP access 10 Recalled medical staff 11 Unknown 12 Nursing Home 13 Hospital in the Home 14 Mental Health		
diag	Primary diagnosis	Patient's principal diagnosis upon completion of the ED service event.	Character	TBA	(A00-B99) Infectious diseases (C00-D48) Neoplasms (D50-D89) Diseases of blood (E00-E90) Endocrine disorders (F00-F99) Mental disorders (G00-G99) Diseases of nervous system (H00-H59) Diseases of eye & adnexa (H60-H95) Diseases of ear & mastoid process (I00-I99) Diseases of circulatory system (J00-J99) Diseases of respiratory system (K00-K93) Diseases of digestive system (L00-L99) Diseases of skin (M00-M99) Diseases of musculoskeletal system (N00-N99) Diseases of genitourinary system (O00-O99) Complications of pregnancy (P00-P96) Conditions of perinatal period (Q00-Q99) Congenital anomalies (R00-R99) Symptoms/signs and ill-defined conditions (S00-T98) Injury and poisoning	Derived	Derived from Primary Diagnosis. Groupings based on AIHW grouping as per Emergency department care 2016–17: Australian hospital statistics report.

					(U00-U49) Codes for special purposes (U90-U90) Healthcare associated infections (V00-X59) Accidents (X60-Y09) Intentional Self Harm and Assaults (Y10-Y36) Events of undetermined intent and legal intervention and operations of war (Y40-Y89) Complications of medical and surgical care and sequelae of morbidity and mortality (Y90-Y91) Supplementary factors related to causes of morbidity and mortality classified elsewhere (Y95-Y98) Supplementary factors related to causes of morbidity and mortality classified elsewhere (Z00-Z99) Supplementary classifications		
symptom	Symptom	Patient's primary symptom upon presentation to the ED. Also known as Presenting Problem. The clinical interpretation of the problem or concern that is the main reason for seeking health care from the ED.	Character	5		Mandatory	Different symptom codes are used at different hospitals. There is one set of codes used at hospitals which use the EDIS feeder information system, one set for hospitals which use WebPAS and one set for St John of God Midland Public Hospital. Peel Health Campus does not record symptom codes. All three sets of codes are listed in Appendix C.<-- ditto Symptom may be missing. Note that the EDIS symptom list is an amalgamation of symptom codes used across all EDIS hospitals in WA. Duplication of codes and/or descriptors may occur because: • codes may have been made inactive; • different sites may have created different codes for the same symptom descriptor; and • different sites may use the same code for different descriptors.
mdc	Major diagnostic category	Patient's Major Diagnostic Category (MDC) upon completion of the ED service event.	Character	2	1 Diseases and disorders of the nervous system 2 Diseases and disorders of the eye 3 Diseases and disorders of the ear, nose and throat	Mandatory	This data element is not available for all EDDC records. Data were only collected at Peel Health Campus (PHC) and HCare sites between what dates??, but the variable has since been superseded.

					4 Diseases and disorders of the respiratory system 5 Diseases and disorders of the circulatory system 6 Diseases and disorders of the digestive system 7 Diseases and disorders of the hepatobiliary system and pancreas 8 Diseases and disorders of musculoskeletal system and connective tissue 9 Diseases and disorders of the skin, subcutaneous tissue and breast 10 Endocrine, nutritional and metabolic diseases and disorders 11 Diseases and disorders of the kidney and urinary tract 12 Diseases and disorders of the male reproductive system 13 Diseases and disorders of the female reproductive system 14 Pregnancy, childbirth and the puerperium 15 Newborns and other neonates with conditions originating in the perinatal period 16 Diseases and disorders of blood & blood forming organs & immunological disorders 17 Myeloproliferative diseases and disorders, and poorly differentiated neoplasms 18 Infectious and parasitic diseases 19 Mental diseases and disorders 20 Substance use and substance induced organic mental disorders 21 Injuries, poisonings and toxic effects of drugs		

					22 Burns 23 Factors influencing health status and other contacts with health services 24 Ungrouped 99 Unknown		
dob	Subset date of birth	Subset of the patients date of birth.	Date MM/YYYY	6	Any valid date value	Derived	
sa1	SA1	A designated region representing the smallest unit for the release of Census data used for describing a location, as represented by a code.	Numeric	11		Derived	