Non-admitted patient emergency department care NMDS 2013-14

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Non-admitted patient emergency department care NMDS 2013-14

Identifying and definitional attributes

Metadata item type:	Data Set Specification
METEOR identifier:	509116
Registration status:	Health, Superseded 11/04/2014
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 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 and nursing unit manager 24 hours per day 7 days per week.
	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 NMDS and the Admitted patient care national minimum data set (APC NMDS).
	Excluded from the scope of the NMDS is:
	Care provided to patients in General Practitioner co-located units.

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:	01/07/2013
Implementation end date:	30/06/2014

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	Episodes of care for admitted patients are reported through care NMDS.	the Admitted	patient
	National Health Reform Agreement—National Partnership Agen Public Hospital Services	greement on l	mproving
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.			s at reement, ne into
Glossary items			
Glossary terms that are relevant to this National minimum data set are included here.			uded
	Admission		
	Compensable patient		
	Emergency department		
	Registered nurse		
	<u>Triage</u>		
	Urgency related groups		
Source and reference	e attributes		
Submitting organisation: Independent Hospital Pricing Authority			
Relational attributes			
Related metadata references:	Supersedes Activity based funding: Emergency department care DSS 2013-2014 Independent Hospital Pricing Authority, Superseded 01/03/2013		
	Supersedes <u>Non-admitted patient emergency department ca</u> <u>Health</u> , Superseded 07/02/2013	are NMDS 201	<u>12-13</u>
	Has been superseded by <u>Non-admitted patient emergency of NMDS 2014-15</u> <u>Health</u> , Superseded 13/11/2014	lepartment ca	<u>re</u>
Metadata items in thi	s Data Set Specification		
Seq Metadata item No.		Obligation	Max occurs
 <u>Address</u>—Australian po {<u>NNNN</u>} 	<u>stcode, Australian postcode code (Postcode datafile)</u>	Mandatory	1
	stay—additional diagnosis, code X[X(8)]	Conditional	2
Conditional obligat	ion:		
	only required to be reported when at least one additional for the emergency department stay.		
- Emergency department	stay—diagnosis classification type, code N.N	Conditional	1
Conditional obligat	ion:		
	only required to be reported when a principal diagnosis diagnosis has been reported.		

Scope links with other metadata sets

Comments:

Seg Metadata item Ν

Obligation Max rs

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
-	Emergency department stay—principal diagnosis, code X[X(8)]	Conditional	1
	Conditional obligation:		
	The reporting of this data element is conditional for those attendances where the value recorded for <i>Non-admitted patient emergency department service episode end status</i> 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 death.		
-	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
-	Emergency department stay—urgency related group, URG (v1.3) code [X]N[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

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 nonemergency 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.

-	Non-admitted patient emergency department service episode—clinical care commencement time, hhmm	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. 		
-	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 conject onicode - enicode and time	Mandaton	1

- <u>Non-admitted patient emergency department service episode end time</u>. Mandatory <u>hhmm</u>
- <u>Non-admitted patient emergency department service episode</u>___service episode Mandatory 1
 <u>length, total minutes NNNNN</u>

Conditional 1

Seq No.	Metadata item	Obligation	Max occurs
-	$\frac{\text{Non-admitted patient emergency department service episode}{$	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. 		
-	Non-admitted patient emergency department service episode—triage date, DDMMYYYY	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. 		
-	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, 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	

- Person—sex, code N

Mandatory 1