##

Emergency Department Data Collection

ACT Government Health Directorate

### Background

The primary purpose of collecting Emergency Department data in ACT is to:

* Assist clinicians in the management of patients; and
* Enable comparisons of performance in respect to access to services, quality clinical outcomes, patient management, customer satisfaction and cost effectiveness.

Each record in the collection represents a presentation to an emergency department.

### ED coverage

* The Emergency Department Data Collection (EDDC) commenced in 2000, but is only available through the Master Linkage Key from July 2005.

There are two participating Emergency Departments in the ACT, one at each public hospital (Canberra and Calvary).

### Diagnosis coding

The ACT Admitted Patient Data Collection has diagnoses coded by trained clinical information managers who choose diagnoses from the Australian clinical version of the International Classification of Diseases (ICD). The EDDC, on the other hand, has diagnoses recorded by medical, nursing or clerical personnel at the point of care. These personnel are not trained in clinical coding. The diagnoses are selected by keyword searching or tables of a limited set of diagnoses. The codes are assigned to the chosen diagnosis using tables built into the computer database program.

Other points to note are:

* There are two different computer programs used in ACT EDs. Different programs use different classifications to record the diagnosis, including ICD-9, ICD-10, or SNOMED CT (see <https://nehta.org.au/aht/>). If you intend analysing ED diagnoses, you need to determine the codes from each of these classifications that relate to the disease or symptom grouping to be studied.
* Variation in computer programs and management practices at EDs may lead to variation in diagnosis coding practices. Some disease categories are not available in some programs but may be in others.
* Symptoms can be, and often are, selected as diagnoses.
* Diagnoses can be very specific or very broad. For example, someone with the same symptoms might be assigned a diagnosis of "influenza" or "viral infection".

### Other limitations

* The other main source of primary care in Australia is general practice services. Because of variability in GP service availability, limited consultation hours and variation in bulk billing practices, ED activity may be very sensitive to availability of GP services.
* Emergency Departments have different visit types, the most common being an "Emergency Visit".

### Tips for using Emergency Department data in linkage studies

* The EDDC has substantial limitations. These limitations must be considered when planning a study using ED data, and in particular, when interpreting and presenting the data
* Data are available from all public hospitals in the ACT.
* Access to data from Canberra and Calvary hospitals needs to be sought separately. Please see the CHeReL website ‘Apply for linked data’ page for more information (<http://www.cherel.org.au/apply-for-linked-data>) or speak to the CHeReL Research Project Manager (cherel.mail@moh.health.nsw.gov.au).

### Data custodian – Canberra Hospital

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## Variable information

| Variable | Description/Notes | Codes |
| --- | --- | --- |
| Date of birth  | Full date of birth will only be supplied if sufficient justification is supplied that age is insufficient. Date of birth may otherwise be supplied as MMYYYY. |  |
| Age  | The age of the patient in years |  |
| Sex | Gender of the patient | 1 = Male2 = Female3 = Indeterminate9 = Not stated/inadequately described |
| Indigenous status | Whether the person is Aboriginal or Torres Strait Islander, based on the person’s own self-report | 1 = Aboriginal but not Torres Strait Islander origin2 = Torres Strait Islander but not Aboriginal origin3 = Both Aboriginal and Torres Strait Islander origin4 = Neither Aboriginal nor Torres Strait Islander origin9 = Unknown or not stated |
| Country of birth | The country in which the patient was born | Codes are according to the Standard Australian Classification of Countries (SACC) issued by the Australian Bureau of Statistics [http://www.abs.gov.au/ausstats/abs@.nsf/mf/1269.0](http://www.abs.gov.au/ausstats/abs%40.nsf/mf/1269.0) |
| Marital status | Current marital status of the patient | 1 = Never married2 = Widowed3 = Divorced4 = Separated5 = Married (including de facto)6 = Not stated/inadequately described |
| State of residence | The Australian state in which the patient usually resides | 0 = not applicable, o/s, at sea. no fixed address1 = NSW2 = Vic3 = Qld4 = SA5 = WA6 = Tas7 = NT8 = ACT9 = Other/Territories |
| Postcode of residence | The postcode of the patient’s usual place of residence | The following codes are also valid:9999 = No Further Information Available (NFIA) ACT - 2600-2620; 2900-2915. Postcodes 2600, 2611, 2618, 2619, 2620 are shared with NSWNSW - 2000 - 2599; 2618 – 2899VIC - 3000 - 3999QLD – 4000-4999SA – 5000-5999WA – 6000-6999TAS – 7000-7999NT – 0800-0899O/S – null or 9999 |
| Statistical Local Area of residence  | The geographical boundary assigned to the patient’s area of residence | Codes are according to the Australian Standard Geographical Classification (ASGC) issued by the Australian Bureau of Statistics [http://www.abs.gov.au/ausstats/abs@.nsf/mf/1216.0](http://www.abs.gov.au/ausstats/abs%40.nsf/mf/1216.0) |
| Hospital Identifier | The specific hospital reporting the ED episode of care. | 82 = Canberra Hospital83 = Calvary Public Hospital -Bruce |
| Insurance status | Indicates whether the person receiving the service is insured or not insured at the time. This variable is not intended to indicate whether or not the person utilises hospital benefit entitlements. | 1 = Hospital insurance 2 = No hospital insurance 9 = Unknown |
| Arrival date and time  | Date and time at which the person presents for the service | DDMMYYY and HH:MM (24 hour format) |
| Triage date and time | Date and time at which the person is assessed by a Triage nurse  | DDMMYYY and HH:MM (24 hour format) |
| Triage category | Triage is the process used to classify patients according to the urgency of their needs for medical and nursing care  | 1 = Resuscitation -Immediate (within seconds)2 = Emergency - Within 10 mins3 = Urgent - Within 30 mins4 = Semi urgent - Within 60mins5 = Non urgent - Within 120 mins9 = Did not wait to be triaged |
| Seen date and time  | Date and time at which the person is first seen for medical care/assessment | DDMMYYY and HH:MM (24 hour format) |
| Mode of arrival | Mode of transport by which the person arrives | 01 = ACT Ambulance02 = Ambulance (Services)03 = Air Ambulance04 = NSW Ambulance05 = Bicycle06 = Clinic car07 = Community / public transport08 = Hospital transport09 = Motor bike10 = Other including undertakers11 = Private car12 = Police vehicle13 = Taxi14 = Walk15 = Correctional services vehicle99 = Other/unknown |
| Type of visit | The reason the person presents to the Emergency Department | 01 = Emergency presentation02 = Return visit03 = Pre-arranged admission04 = Patient in transit05 = Dead on arrival |
| Referral source | Source from which the person was referred to this service | 01 = Self, family, friends02 = Community based specialist03 = Outpatients04 = Community based GP05 = Residential Aged Care facility06 = Other ACT hospital07 = Non-ACT hospital08 = Mental health team09 = Community health centre or service10 = Other community services11 = Prison12 = Police13 = Ambulance14 = Health First call centre17 = Defence hospital18 = Canberra Hospital19 = Calvary Public hospital98 = Unspecified99 = Other/unknown |
| ICD-10-AM Edition  | International Classification of Diseases Edition and Version of diagnosis codes | 1 = ICD-10-AM Ed 12 = ICD-10-AM Ed 23 = ICD-10-AM Ed 34 = ICD-10-AM Ed 45 = ICD-10-AM Ed 56 = ICD-10-AM Ed 6 7 = ICD-10-AM Ed 7  |
| Diagnosis  | The diagnosis or condition established after assessment to be responsible for the person presenting to the Emergency Department.If the person is admitted as an inpatient it is the equivalent of the admission diagnosis. | ICD Edition and Version as noted in “ICD-10-AM Edition” variable |
| Departure status | The status of the person at separation from the Emergency Department | 1 = Admitted this hospital (includes units or beds in ED)2 = Non-admitted patient ED service episode completed - departed without being admitted or referred to another hospital3 = Referred to another hospital for admission4 = Did not wait to be attended by a health care professional5 = Left at own risk after being seen – before episode completed6 = Died in ED as a non-admitted patient7 = Dead on arrival, not treated in ED9 = Unknown incl. un-mappable codes  |
| Ready date and time | Date and time at which the person is ready for departure | DDMMYYY and HH:MM (24 hour format) |
| Actual departure date and time | For the admitted patient this refers to the time the person is either 1) transferred to a ward or other unit or 2) leaves the ED for transfer to another unit. For non-admitted patients this refers to the time at which the assessment and initial treatment is completed and/or they physically leave the department | DDMMYYY and HH:MM (24 hour format) |