

health

Proposals for Revisions to the Victorian Emergency Minimum Dataset (VEMD) for 1 July 2012

November 2011

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Executive Summary

Each year the Department of Health (DH) reviews the data elements and format of the Victorian Emergency Minimum Dataset (VEMD). This review seeks to ensure that the emergency department data collection supports the Department's state and national reporting obligations, assists DH planning and policy development, and incorporates appropriate feedback from data providers on improvements.

This document has been produced to invite comment and stimulate discussion on the proposals outlined below. If you would like to comment on any of the proposals, please see the introduction section on how to do so.

In order to be accepted into the VEMD proposals need to demonstrate clear business justification and be fully costed, meaning funding streams will need to be identified and confirmed. Final acceptance of all proposals is dependent on the Executive Director, Hospital and Health Service Performance (based upon recommendations by the Annual Changes Governance Committee).

The proposed revisions for the Victorian Emergency Minimum Dataset (VEMD) for 1 July 2012 are summarised below. They include (but are not limited to) the:

1. Addition of new data element
 - i. Alcohol Involvement in Injury
2. Modification to the Specification of Ambulance Case Number
3. Addition of new edits and modifications to existing edits

For further information on the revisions process and timetable contact the HDSS Help Desk on 9096 8141.

Introduction

The VEMD Proposals Process

The Proposal document is being distributed to all Victorian hospitals, to patient management system suppliers known to have Victorian clients, and to a range of industry bodies. It outlines proposals for changes to the VEMD as at the time of its release in November 2011. This should not be regarded as a complete list of changes to be made for 2012-13. Items in this publication are not guaranteed to change or to change in the form suggested here; nor does the absence of an item from this publication indicate it will not change from 1 July 2012. Confirmed changes will be published in the document *Specification for Revisions to the VEMD for 1 July 2012*, expected to be published in December 2011.

It is expected that release of these proposals will stimulate discussion within the health industry. Prompt feedback is sought on these proposals. Hospitals and software suppliers should review this document and assess the feasibility of the proposals. All are invited to provide written feedback to DH by completing the proforma provided with this document, and forwarding it to HDSS as indicated by **Wednesday 7 December 2011**.

Assessment of the impact of proposals

Each proposal is assessed against a set of principles designed to assess the impact that implementation of the proposal is likely to have on services, the Department, software vendors and data users. The principles reflect best practice and standard information management principles.

Each proposal will be assessed using the Measures listed in the table below. The assessment and the feedback from stakeholders will be used to determine whether the proposal is accepted for inclusion in the final specifications for changes for 2012-13.

Category	Measures
Scope	a) The change should be within the scope of the collection.
Collectability	a) The data should already be collected by the service. b) There should be value for the service in collecting the data. c) Collection of the data should be aligned with normal business processes in the service. d) It should be legal for the service to collect the data.
Intended Use	a) Sufficient business justification must be submitted in the proposal. b) The change must be consistent with Departmental policy. c) There should not be a limited time-period for the use of the data. If there is, other avenues of collection should be investigated to ensure this is the most appropriate.
Best Practice	a) The collection of the data should be compliant with relevant standards and policies? If not, specify where non-compliant.
Implementation	a) The proposal must be clearly specified to enable implementation. b) It should be technically possible for services and DH to implement without significant issues.
Data Quality	a) There should be a person, unit or organisation identified to monitor quality. b) There should be minimal transformation of data required by services to meet reporting requirements. c) Reporting of the data should be mandatory for a specified cohort.
Consequential impact	a) The impact on other data already collected, or proposed to collect must be articulated. b) There should not be a negative effect on the reputation or integrity of the collection. c) Identify any dependencies with other projects or plans. d) The impact on time-series data must be quantified. e) The impact on reports, extracts or automated processes must be quantified.
Cost and collection burden	a) The effort required to implement and collect should be commensurate with the frequency of the event triggering collection of reportable data. b) All options for the collection of this data should be assessed and the most appropriate method and

	collection selected.
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Orientation to this document

As this document provides 'proposals' for revisions, there are a few features that require explanation:

- New values and definitions relating to existing items are highlighted in orange.
- Changes to existing items are highlighted in green.
- Redundant values and definitions relating to existing items ~~are struck through~~.
- Comments relating only to the proposal document [*appear in square brackets and italics.*]
- Page numbers representing cross referencing to another section of the VEMD Manual are represented by a #.
- Edits that are proposed to change are marked when listed as part of a Data Item or after an Edit Table with a * after the edit number. New proposed edits will be shown with an edit number of ###.
- The text is divided into the categories of 'Specification' and 'Administration' as presented in the *Victorian Emergency Minimum Dataset Manual (VEMD 16th Edition, 1 July 2011)*.
 - Specification:* details the reporting requirements for the item.
 - Administration:* provides additional information including the purpose of the collection of the data item and the source of the code set and definitions.
- Further information such as the background to each proposal is provided.

Abbreviations

ABS	Australian Bureau of Statistics
ACHI	Australian Classification of Health Interventions
AEED	Admitted, Emergency and Elective Data Unit
AHCA	Australian Health Care Agreement
AIHW	Australian Institute of Health and Welfare
AIMS	Agency Information Management System
AR-DRG	Australian Refined Diagnosis Related Group
DH	Department of Health
ED	Emergency Department
ERC	Expenditure Review Committee
HDSS	Health Data Standards and Systems
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification
ICU	Intensive Care Unit
MIRI	Monash Injury Research Institute, Monash University
NHDD	National Health Data Dictionary
NIPM	Nurse Initiation of Patient Management
NMDS	National Minimum Data Set
PRS/2	Patient Reporting System, Version 2
VACCDI	Victorian Advisory Committee on Casemix Data Integrity
VAED	Victorian Admitted Episodes Dataset
VEMD	Victorian Emergency Minimum Dataset
VICC	Victorian ICD Coding Committee
VISU	Victorian Injury Surveillance Unit, Monash University

Symbols

<	Less than
>	Greater than
=	Equal to
≠	Not equal to
&	And

Proposed revisions/additions to data items

Proposal 1 – Addition of Alcohol Involvement in Injury

It is proposed to	Collect information about the involvement of alcohol in patients presenting for the treatment of injuries.
Proposed by	Monash Injury Research Institute Monash University
Supported by	The framework of the whole of Government Alcohol and Drug Strategy
Implementation Date	1 July 2012
Reason for proposal	Improved reporting of alcohol involvement in injury in hospital datasets for prevention, evaluation, health monitoring and research purposes. The proposal is to include a new data element to collect the assessment of alcohol involvement in a patient presenting to the Emergency Department for the treatment of an injury.
Details of change	This proposal incorporates the following changes: <ul style="list-style-type: none">1.1 Amend <i>Injury Surveillance</i> in Section 21.2 Addition of <i>Alcohol Involvement in Injury</i> in Section 31.3 Amend <i>Injury Surveillance</i> in Section 41.4 Changes to file structure1.5 Addition of edits

Proposal 2 – Modify Specification of Ambulance Case Number

It is proposed to	Modify the specification of Ambulance Case Number (awaiting advice from Ambulance Victoria on specifications).
Proposed by	Admitted, Emergency and Elective Data unit Funding & Information Policy Department of Health
Implementation Date	1 July 2012
Reason for proposal	VEMD Ambulance Case Numbers specifications do not align with the numbers as provided by Ambulance Victoria.
Details of change	This proposal incorporates the following changes: <ul style="list-style-type: none">2.1 Change to specification in Section 3.2.2 Changes to Edits

Section 2 Concept & Derived Items

Injury Surveillance

<i>Proposal</i>	<i>Description</i>
1.1	Add <i>Alcohol Involvement in Injury</i> to <i>Injury Surveillance</i>

Classification Concept

Definition A set of data items generally collected at triage when an injury has occurred. These are mandatory items for presentations related to injuries.

Guide for Use Injury Surveillance will ordinarily be accompanied by an injury diagnosis (a Diagnosis code starting with an 'S' or 'T'). However in circumstances where a patient leaves before assessment or treatment by a definitive care provider Injury Surveillance can be reported with no accompanying Diagnosis code.

The following Injury Surveillance data items must be completed:

- Activity When Injured
- Body Region
- Description of Injury Event
- Human Intent
- Injury Cause
- Nature of Main Injury
- Place Where Injury Occurred.
- **Alcohol Involvement in Injury**

Section 3 Data Definition amendments

New data elements

<i>Proposal</i>	<i>Description</i>
1.2	Addition of <i>Alcohol Involvement in Injury</i>

Alcohol Involvement in Injury

Specification

Definition An assessment of the level of intoxication of a patient admitted for treatment of an injury.

Data type Numeric **Form** Code

Field size 1 **Layout** N

Reported for All Emergency Department presentations where the Primary Diagnosis code is an injury, poisoning or other consequence of an external cause (VEMD diagnosis codes beginning with S or T) and the S or T code does *not* have a flag indicating Injury Surveillance is optional in the VEMD Editing Matrix (Editing Tables).

Code set	Code	Descriptor
	1	No suspicion or evidence of alcohol use by the <i>injured person</i>
	2	Suspicion or evidence of alcohol use by the <i>injured person</i> : mild
	3	Suspicion or evidence of alcohol use by the <i>injured person</i> : moderate
	4	Suspicion or evidence of alcohol use by the <i>injured person</i> : severe

Reporting guide Report the level of alcohol of the patient as assessed by a clinician where the Primary Diagnosis code is an injury, poisoning or other consequence of an external cause code (excluding those 'S' and 'T' codes where completion of Injury Surveillance fields is optional).

1 No suspicion or evidence of alcohol use by the *injured person*

Includes:

- no suspicion arising from the report of the injured person or a relevant informant
- no suspicion arising from observing the injured person (eg., no smell of alcohol, no slurred speech, no difficulty walking)
- biological evidence from injured person or others does not indicate alcohol use (eg., a negative blood/breath alcohol level)

2 Suspicion or evidence of alcohol intoxication by the injured person: mild

Smell of alcohol on breath, slight behavioural disturbance in functions and responses, or slight difficulty in coordination

3 Suspicion or evidence of alcohol intoxication by the injured person: moderate

Smell of alcohol on breath, moderate behavioural disturbance in functions and responses, or moderate difficulty in coordination

4 Suspicion or evidence of alcohol intoxication by the injured person: severe

Severe disturbance in functions and responses, severe difficulty in coordination or impaired ability to cooperate.

Edits ### Alcohol Involvement in Injuries Invalid

Related items Section 2: Injury Surveillance
Section 3: Diagnosis - Primary Diagnosis Code
Section 4: Injury Surveillance

Administration

Purpose For development of prevention programs, evaluation, monitoring and research purposes.

Principal data users Monash Injury Research Institute

Collection start 2012

Definition source DH **Value Domain Source** DH

Amended Data Elements

<i>Proposal</i>	<i>Description</i>
2.1	Modify the Specification of <i>Ambulance Case Number</i>

Ambulance Case Number

Specification

Definition	Unique identifier issued by Ambulance Victoria for each ambulance transport occasion.		
Datatype	Alpha/numeric	Form	Identification Number
Field Size	Five	Layout	NNNNN, A, AA, AAA or blank
Reported for	Arrival Transport Mode 1, 2, 3 or 10, indicating arrival by ambulance, other than hospital contracted private ambulance car.		
Reporting guide	All case number ranges recommence each day at midnight (based on dispatch time) and depend on geographic area of ambulance dispatch.		

MAS and RAV merged on 1 July 2008 to form AV. Case number field size and valid ranges changed on 8 June 2010 to accommodate the requirements of a single service. The field size has been modified to five characters to accommodate for a greater number of cases being attended to on a daily basis. These changes are staged and therefore old case numbers will persist to some extent during the implementation phase. This means a mixed model of case numbers will persist for a period of time.

Alternate Codes

Ambulance Case Number not available due to:

- B** Industrial action (for example: bans, strikes)
- U** Not provided by the Ambulance Officer

Valid combinations

Arrival Transport Mode	Ambulance Case Number
1, 2	NNNNN
	B, U
	ACT, NSW, NT, QLD, SA, TAS, or WA
3, 10	NNNNN (within ranges to be specified by Ambulance Victoria)
	B, U
	ACT, NSW, NT, QLD, SA, TAS, or WA
6, 8, 9, 11, 99	Blank

**Reporting guide
(cont'd)**

AV- Metro

Valid Ambulance Case Number ranges

If Arrival Transport Mode equals:

1 - Air Ambulance; **OR**

2 - Helicopter

Victorian Ambulance Case Number **to be specified**

3 - Road Ambulance Service

Victorian Ambulance Case Number **to be specified:**

10 - Ambulance Service – private ambulance car – AV
contracted.

Victorian Ambulance Case Number **to be specified by Ambulance
Victoria**

Ambulance Victoria - Rural

Valid Ambulance Case Number ranges

If Arrival Transport Mode equals:

**3– Road Ambulance Service or AV Contracted Private
Ambulance**

Ballarat	to be specified by Ambulance Victoria
Bendigo	to be specified by Ambulance Victoria
Wangaratta	to be specified by Ambulance Victoria
Morwell	to be specified by Ambulance Victoria
Geelong	to be specified by Ambulance Victoria

Interstate Ambulance Services

Valid Ambulance Case Number ranges

If the patient arrives via an interstate ambulance service and the Arrival Transport Mode equals

1 - Air Ambulance; **OR**

2 - Helicopter; **OR**

3 - Road Ambulance Service; **OR**

10 - Ambulance Service – private ambulance car – AV contracted

Ambulance Case Number should be either:

ACT, NSW, NT, QLD, SA, TAS or WA

E151 Ambulance Case Number and Arrival Transport Mode Combination Invalid

Related items This section Arrival Transport Mode.

Administration

Purpose Analysis of ambulance service delivery:

Principal data users Ambulance Victoria; Monash Injury Research Institute, Monash University; Department of Health.

Collection start	1 July 1995	Version	1	Effective 01.07.95)
			2	(Effective 01.07.02)
			3	(Effective 01.07.03)
			4	(Effective 01.07.04)
			5	(Effective 01.09.07)
			6	(Effective 01.07.11)

Definition source	Department of Health	Code set source	Ambulance Victoria
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<i>Proposal</i>	<i>Description</i>
1.3	Add <i>Alcohol Involvement in Injury</i> to <i>Injury Surveillance</i>

Injury Surveillance

If a patient presents with an injury and receives treatment all of the following data items must be reported for all presentations with an S or T diagnosis code where the S or T code does not have a flag indicating Injury Surveillance is optional in the VEMD Editing Matrix (Editing Tables):

- Activity when Injured (See Section 3)
- Body Region (See Section 3)
- Description of Main Injury Event (See Section 3)
- Human Intent (See Section 3)
- Injury Cause (See Section 3)
- Nature of Main Injury (See Section 3)
- Place where Injury occurred (See Section 3)
- Primary Diagnosis code beginning with an S or T (See Section 3)
- **Alcohol Involvement in Injury** (See Section 3)

If a patient presents with an injury, but leaves without treatment then report:

- As many Injury Surveillance fields as were collected prior to the patient's departure.
- Departure Status of 10, 11 or 30.
- No Diagnosis codes

Injury surveillance fields (including Description of Injury Event) are not permitted with any diagnosis that is not an injury code (starting with either 'S' or 'T').

An illustration of how the Injury Surveillance fields should be utilised is detailed below. Each of the three scenarios has been allocated an appropriate code or data item in the table below.

Examples:

- Poisoning as child ingested 8 paracetamol tablets (cardboard packet of brand X) found in bathroom cabinet while playing in the bathroom at home.
- Crush injury to foot, wooden pallet dropped onto foot whilst working at a construction site, wearing safety boots with steel capped toes at the time.
- Shop assistant received contusion to cheek, punched in face by angry customer at the local shopping centre.

	Example 1	Example 2	Example 3
Primary Diagnosis	[Use code T391] Poisoning, paracetamol	[Use code S978] Crush injury of foot	[Use code S0080] Contusion of cheek
Nature of Main Injury	[Use code 20] Poisoning, toxic effect	[Use code 9] Crushing injury	[Use code 1] Superficial
Body Region	[Use code 22] Body Region not applicable	[Use code 19] Foot	[Use code 2] Face
Description of Injury Event	Poisoning as child ingested 8 paracetamol tablets (cardboard packet of brand X) found in bathroom cabinet while playing at home	Crush injury to foot, wooden pallet dropped onto foot whilst working at a construction site, safety boots with steel capped toes	Shop assistant received contusion to cheek, punched in face by angry customer at the local shopping centre
Injury Cause	[Use code 17] Poisoning - other or unspecified substance	[Use code 24] Struck by or collision with object	[Use code 23] Struck by or collision with person
Human Intent	[Use code 1] Accident	[Use code 1] Accident	[Use code 7] Assault not otherwise specified
Place Where Injury Occurred	[Use code H] Own home, bathroom	[Use code C] Construction site	[Use code T] Shopping centre
Activity When Injured	[Use code L] Leisure	[Use code W] Working for income	[Use code W] Working for income
Alcohol Involvement in Injury	Code 1,2,3 or 4 as appropriate	Code 1,2,3 or 4 as appropriate	Code 1,2,3 or 4 as appropriate

In order to protect patient and employee privacy, collection staff should be instructed NOT to record identifying details in the Description of Injury field.

For example:

- 'Tripped on tree root in back yard. TBSB Dr Jacob' becomes
'Tripped on tree root in back yard.'
- 'James presented with third overdose this week' becomes
'Patient presented with third overdose this week.'

Hospitals and software vendors should contact HDSS if they have any further queries.

Section 5 Compilation and Submission amendments

Key	Field Name	Max Characters	Alpha / Numeric	Format/Value	Excel Position
1	Campus Code	4	A/N	XXXX	A
1	Unique Key	9	A/N	XXXXXXXXXX	B
1	Patient Identifier	10	A/N	XXXXXXXXXX	C
2	Medicare Number	11	N	NNNNNNNNN NN or blank	D
1	Medicare Suffix	3	A/N	XXX	E
14	DVA Number	9	A/N	See, Section 3	F
1	Sex	1	A/N	1, 2, 3, 4	G
1	Date of Birth	8	N	DDMMYYYY	H
1	Date of Birth Accuracy Code	4	A/N	XXX	I
1	Country of Birth	4	A/N	XXXX	J
1	Indigenous Status	1	A/N	2, 5, 6, 7, 8, 9	K
1	Interpreter Required	1	A/N	1, 2, 3	L
1	Preferred Language	4	A/N	XXXX	M

Key	Field Name	Max Characters	Alpha / Numeric	Format/Value	Excel Position
1	Locality	22	A/N	XXXXXXXXXX XXXXXXXXXX XX	N
1	Postcode	4	N	NNNN	O
1	Type of usual Accommodation	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 18, 19	P
1	Arrival Transport Mode	2	A/N	1, 2, 3, 6, 8, 9, 10, 11, 99	Q
1	Referred By	2	A/N	0, 1, 2, 4, 6, 8, 14,15,16,17,18 , 19,20	R
3	Transfer Source	4	A/N	XXXX	S
1	Type of Visit	2	A/N	1, 2, 8, 9, 10	T
1	Compensable Status	1	A/N	1, 2, 3, 4, 5, 6, 7	U
4	Ambulance Case Number	5	A/N	See, Section 3	V
1	Arrival Date	8	N	DDMMYYYY	W
1	Arrival Time	4	N	HHMM	X
1	Triage Date	8	N	DDMMYYYY	Y
1	Triage Time	4	N	HHMM	Z
1	Triage Category	1	A/N	1, 2, 3, 4, 5, 6	AA
8	Nurse Initiation of Patient Management Date	8	N	DDMMYYYY or Blank	AB
8	Nurse Initiation of Patient Management Time	4	N	HHMM or Blank	AC

Key	Field Name	Max Characters	Alpha / Numeric	Format/Value	Excel Position
9	First Seen by Doctor Date	8	N	DDMMYYYY or Blank	AD
9	First Seen by Doctor Time	4	N	HHMM or Blank	AE
8	First Seen by Mental Health Practitioner Date	8	N	DDMMYYYY or Blank	AF
8	First Seen by Mental Health Practitioner Time	4	N	HHMM or Blank	AG
13	Procedure	89	A/N	XX (x30)	AH
12	Inpatient Bed Request Date	8	N	DDMMYYYY or Blank	AI
12	Inpatient Bed Request Time	4	N	HHMM or Blank	AJ
1	Departure Date	8	N	DDMMYYYY or Blank	AK
1	Departure Time	4	N	HHMM or Blank	AL
1	Departure Status	2	A/N	1, 3, 5, 7, 8, 10, 11, 12, 14, 15, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 30	AM
5	Transfer Destination	4	A/N	XXXX	AN
1	Referred to on Departure	2		1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 16, 17, 18, 19	AO
5	Reason for Transfer	1	A/N	1, 2, 3, 4, 5, 6, 7, 9	AP
15	Escort Source	1	A/N	1, 2, 3, 4, 5, 6, 7, 9 or Blank	AQ
6	Departure Transport Mode	2	A/N	1, 2, 3, 4, 6, 7, 8, 10, 11, 19	AR

Key	Field Name	Max Characters	Alpha / Numeric	Format/Value	Excel Position
6	Primary Diagnosis	5	A/N	VEMD ICD-10-AM Code	AS
11	Additional Diagnosis 1	5	A/N	VEMD ICD-10-AM Code	AT
	Additional Diagnosis 2	5	A/N	VEMD ICD-10-AM Code	AU
7	Nature of Main Injury	2	A/N	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 26	AV
7	Body Region	2	A/N	F1, F2, F3, F4, F5, F6, F7 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22	AW
7	Description of Injury Event	250	A/N	Free text	AX
7	Injury Cause	2	2	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30	AY
7	Human Intent	2	2	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	AZ
7	Place Where Injury Occurred	1	1	H, I, S, A, R, T, C, Q, F, M, P, O, U	BA
7	Activity When Injured	1	1	S, L, W, E, C, N, V, O, U	BB
7	Alcohol involvement in Injury	1	N	1,2,3,4	BC

Mandatory Items Key (Table 2)

Key	Descriptor
1	Mandatory item
2	Mandatory if Medicare Suffix does not equal C-U, N-E or P-N
3	Mandatory if Referred By = 6
4	Should be reported if Arrival Transport Mode = 1, 2, 3, 10
5	Mandatory if patient is transferred to another hospital campus. Departure status is: 17 - Mental Health bed at another Hospital campus 19 - Another hospital campus (excludes for Mental Health and ICU or CCU transfer) 20 - Another Hospital Campus - Intensive Care Unit 21 - Another Hospital Campus - Coronary Care Unit
6	Mandatory where Departure Status code is not 10 – Left after clinical advice regarding treatment options, 11 – Left at own risk, without treatment, or 30 - Left after clinical advice regarding treatment options - GP Co-Located Clinic. Blank for Departure Status codes 10, 11 or 30
7	See Section 4 – Business Rules, Injury Surveillance.
8	Blank if Departure Status = 8, 10, 11, or 30
9	Blank where Departure Status = 10 –Left after clinical advice, regarding treatment options, 11- Left at own risk, without treatment, or 30- Left after clinical advice regarding treatment options - GP Co-Located Clinic.
11	Mandatory if Primary Diagnosis code = 'Z099 – Attendance for Follow-up (includes injections) / Review following earlier treatment'.
12	Mandatory if an inpatient bed request was made, regardless of whether the patient is actually moved to an inpatient bed.
13	Optional if Primary Diagnosis item is completed.
14	Mandatory if Compensable Status = 2
15	Optional if patient is transferred to another hospital campus (Departure Status is 17, 19, 20 or 21).
16	Mandatory where Departure Status code is not 8 – Dead on arrival, 10 – Left after clinical advice, regarding treatment options, 11 – Left at own risk, without treatment, or 30 - Left after clinical advice regarding treatment options- GP Co-Located Clinic. Blank for Departure Status codes 8, 10, 11 or 30.

Deleted Edits

~~E381 — Unexpected Number of Departures per Day~~

~~E379 — Significant Change in Preferred Language Profile~~

~~E380 — Significant Change in Country of Birth Profile~~