ECDS

Emergency Care Data Set

Version 1.0 - **DRAFT** for consultation

July 2015

Contents

Introduction

'We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line. There is science in what we do, yes, but also habit, intuition, and sometimes plain old guessing. The gap between what we know and what we aim for persists. And this gap complicates everything we do.'"

Atul Gawande [1]

The current data set used for Emergency Department (ED) diagnostic coding, the 'Accident & Emergency Commissioning Data Set (CDS type 010)', was developed in the early 1980s. At that time the work of the Emergency Department was largely minor injuries and occasional major trauma.

Since that time there has been a sustained and rapid increase in volume, scope and complexity of Emergency Care. The main factors driving the change in Emergency Department use include the changing health needs of the population such as an ageing population and multiple comorbidities, changes to the provision of care and how the population chooses to access the care that they need.

The current Commissioning Data Set has not been developed to keep pace with these changes, resulting in an 'information gap' in the data collected from emergency departments. The 'information gap' has led to the following issues:

- Current metrics of healthcare do not consistently measure inputs or outputs, making comparisons of 'value added' or different modes of healthcare delivery impossible.
- Urgent and Emergency Care system capacity and demand management are impossible to determine accurately.
- Multiple current coding systems with inconsistent implementation means data are not valid or reliable. This renders the information insufficient for either clinical use or policy-making.
- Data quality - audits have shown that a valid, coded diagnosis exists for only half of all Emergency Department attendances.

It is recognised that in order to address these issues a new dataset that can properly capture and represent the full extent and granularity of Emergency Department activity is required.

Emergency Care Data Set (ECDS)

The proposed Emergency Care Data Set, of which this document is a draft, will replace CDS type 010 and will be implemented across Emergency Departments in England as an Information Standard Notice (ISN).

[1] Complications: a Surgeon's Notes on an Imperfect Science. London: Profile Books 2001

This process is managed by the Health and Social Care Information Centre (HSCIC) Standardisation Committee for Care Information (SCCI) : further information regarding this process can be accessed at the HSCIC website[2].

The Emergency Care Data Set will deliver the following benefits:

- Improved patient outcomes through better information and information exchange including a reduction in risk by improving communication and increased use of existing information-sharing mechanisms, e.g. the Summary Care Record.
- Improved quality of data collected in Emergency Departments relating to patient presentation, diagnosis, discharge and follow up, which will facilitate improved healthcare commissioning and the effective delivery of future healthcare policy and strategy.
- Improved communication between health professionals, which will enable accurate measurement, costing and remuneration of acute healthcare, specifically an improvement in the understanding of the cost and value of Emergency Care.

The draft Emergency Care Data Set is derived from the Minimum Dataset for Emergency Care (MDEC), developed over the last few years by the Royal College of Emergency Medicine (RCEM) in response to the growth in volume and complexity of urgent and emergency care[3]. The components and structure of MDEC were informed by collaboration with national and international emergency medicine colleagues with previous experience of the development of similar datasets.

This is a minimum dataset and is not intended to restrict the data that is used in emergency care. It is designed to bring together many disparate local initiatives and practices to benefit all through being able to describe the work done across a range of providers in a common language. Inevitably, it will supersede existing data collection arrangements and the Project Board is keen to ensure we draw on the expertise within the NHS to help ensure that the dataset we implement is the most effective possible.

This document presents the first draft of the ECDS and is the result of an extensive piece of work to translate the terms originally included in MDEC with appropriate SNOMED CT terminology and to ensure that its content aligns to national data set standards identified by the HSCIC Data Dictionary and Messaging Team.

[2] http://www.hscic.gov.uk/isce

[3] http://www.rcem.ac.uk/Shop-Floor/Informatics

Data Dictionary for the Emergency Care Data Set

ECDS Data Dictionary Structure

Data, Codes, Language and Terminology

An Emergency Department visit ('Episode of Care') consists of a series of steps from presentation through to discharge. These steps are captured as data items, which need to be recordable as a code.

The ideal code set is both:

- exhaustive – the codes available cover all reasonably predictable 'real-life' scenarios.
- exclusive – any 'real-life' event should only map to one code.

In addition the data types should be 'normalised' – there should be no duplication of data collected. The range of data collected needs to balance desire to collect data with the cost of data collection and maintain user engagement.

Data type and layout

The type of symbol, character or other designation used to represent a data item. For example:

ALPHA/ Alphanumeric - a field on which calculations are not performed

NUMBER - a field on which calculations may be performed

Time and date are specified using the NHS / ISO 8601 standard. The time zone is not used.

DATE – a date field in the format YYYY-MM-DD

DATETIME – YYYY-MM-DDThh:mm:ss (19 characters)

'YYYY' is year

'MM' is month range 01 to 12

'DD' is date range 01 to 31

'T' separates the date and time

'hh' is hours range 00 to 23

'mm' is minutes range 00 to 59

'ss' is seconds range 00 to 59

In Emergency Care, it is common for care episodes to cross midnight and errors can occur when date and time entities are handled separately, so wherever possible combined datetime fields are used.

Size

The **maximum** number of characters accommodated by this field.

Provenance

The provenance of the data items included in this dataset is described.

NHSDD This item is a current part of the NHS Data Dictionary. This means that this data item is already collected, although some of the proposed data items may be updated in range and/or format.

UK This item is not part of the current NHS data dictionary but is collected in some form in some UK Emergency Departments.

INT This item is collected internationally.

NEW This item is a new proposal.

Data Entry Role

Part of the dataset project mandate is to minimise the burden on all staff but particularly clinical staff. Therefore wherever possible we have specified which staff group should collect the data item. If neither clerical or clinical staff are specified then the data item should be entered automatically as a result of other interactions.

CLERICAL This item would normally be entered by clerical staff

CLINICAL This item would normally be entered by clinical staff

Local/ National data

LOCAL This data will not be transmitted nationally, Collection of local data in a standardised format ensures that if local patient details are needed e.g. contact tracing, audit/ research etc. then they are in a consistent format.

1.1 Person Demographics

Column	Datatype	Size	Comments
Person_Given_Name	ALPHA	35	
Person_Family_Name	ALPHA	35	
Person_Stated_Gender	ALPHA	1	Dropdown box
Person_Birth_Date	DATE	10	DATE
Person_Age_At_Attendance	NUMBER	3	
Person_NHS_Number	NUMBER	10	
Person_NHS_Number_Status_Indicator	ALPHA	2	
Person_Local_Number	ALPHA	20	
Person_Local_Number_Org_Code	ALPHA	5	
Person_Address1	ALPHA	35	Local only
Person_Address2	ALPHA	35	Local only
Person_Postcode	ALPHA	10	Postcode
Person_Residence_Type	ALPHA	18	SNOMED, Dropdown box
Person_LSOA	ALPHA	10	Office of National Statistics
Person_Phone_Home	ALPHA	15	Local only
Person_Phone_Mobile	ALPHA	15	Local only
Person_Email	ALPHA	50	Local only
Person_GP_Practice_Code	ALPHA	6	NHS ODS GP code
Person_GP_Name	ALPHA	50	Alphanumeric – dropdown box
Person_GP_Phone	ALPHA	15	Alphanumeric – derived from GP name
Person_GP_Email	ALPHA	50	Alphanumeric – derived from GP name
Person_Comm_Lang	ALPHA	18	SNOMED or NHSDD/ ISO
Person_Interpreter_Rqd	ALPHA	18	SNOMED or NHSDD/ ISO
Person_Ethnic_Category	ALPHA	2	NHS PDS list
Person_School	ALPHA	50	Local only, free text
Person_Next_of_Kin	ALPHA	50	Local only
Person_NoK_Contact	ALPHA	50	Local only, phone number or other contact
Person_Companion	ALPHA	100	Local only, carer or guardian with person
Person_Adverse_Reaction	ALPHA	255	Local only, SNOMED/ XML
Person_Special_Patient_Note	ALPHA	1000	Local only, free text
Person_Comorbidities	ALPHA	255	SNOMED/ XML from SCR
Person_Current_Meds	ALPHA	255	SNOMED/ XML from SCR

1.1.1 Person_Given_Name

NHSDD

CLERICAL

Definition

The legally recognised given name for the patient

Layout

Alphanumeric, 35 Characters

Source

NHS Data Dictionary

Reported for

All presentations

Notes

The patient's given/ first name. Further given names are not recorded.

1.1.2 Person_Family_Name

NHSDD

CLERICAL

Definition

The legally recognised family name of the patient.

Layout

Alphanumeric, 35 Characters

Source

NHS Data Dictionary

Reported for

All presentations

Notes

The patient's family name / surname

1.1.3 Person_Stated_Gender

NHSDD

CLERICAL

Definition

See notes below.

Layout

Alphanumeric , 1 Character

Source

NHS Data Dictionary

Reported for

All presentations

Code Set

Descriptor	Code
Male	1
Female	2
Indeterminate	9
Unknown (not recorded)	X

Notes

World Health Organisation definitions [4]:

- "Sex" refers to the biological and physiological characteristics that define men and women.
- "Gender" refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

Gender should be inferred or accepted as reported by the respondent. It is usually unnecessary and may be inappropriate or even offensive to ask a person their gender. Gender may be inferred from other cues such as observation, relationship to respondent, or first name.

A person's sex may change during their lifetime as a result of procedures known alternatively as sex change, gender reassignment or transgender reassignment. However, throughout the process, which may be over a considerable period of time, a person will usually identify with a specific gender allowing gender to clearly be recorded as either Male or Female.

The 'Indeterminate' category is available to cater for persons who do not identify with a particular gender.

[4] http://www.who.int/gender/whatisgender/en/ [accessed 29/4/2015]

1.1.4 Person_Birth_Date

NHSDD

CLERICAL

Definition

Patient's Date of Birth

Layout

DATE (YYYY-MM-DD) 10 characters

Source

NHS Data Dictionary

Reported for

All presentations

Notes

If a patient's birth date is unknown, the Person_Age_At_Attendance field can still be completed.

1.1.5 Person_Age_At_Attendance

NHSDD

CLERICAL

Definition

Patient's age

Layout

NNN

Source

NHS Data Dictionary

Reported for

All presentations

Notes

Normally calculated at the date of first contact in the ED

= complete years (Date(EmCare_Arrive_DateTime) minus (Person_Birth_Date)).

If the date of birth is **not** known e.g. for an unconscious patient, an approximate age may be entered instead.

[Age is needed for the dataset to be anonymised and therefore does not duplicate Person_Birthdate]

1.1.6 Person_NHS_Number

NHSDD

CLERICAL

Definition

The patient's NHS number

Layout

Number, 10 Characters

Source

NHS Data Dictionary

Reported for

All presentations

Notes

Standardised format as per NHS data dictionary (9 digit + checksum) .

The patient's NHS number if available.

If no NHS number then reported as null.

Linked with Person_NHS_Number_Status_Indicator.

NHSDD

CLERICAL

1.1.7 Person_NHS_Number_Status_Indicator

Definition

Status of the NHS number above.

Layout

Alphanumeric, 2 Characters

Source

NHS Data Dictionary

Reported for

All presentations

Code Set

Code	Descriptor
01	Number present and verified
02	Number present but not traced
03	Trace required
04	Trace attempted - No match or multiple match found
05	Trace needs to be resolved - (NHS Number or PATIENT detail conflict)
06	Trace in progress
07	Number not present and trace not required
08	Trace postponed (baby under six weeks old)

Notes

Should be reported in conjunction with Person_NHS_Number.

NHSDD

CLERICAL

1.1.8 Person_Local_Number

Definition

Patient's unique local identifier

Layout

Alphanumeric, 20 Characters

Source

NHS Data dictionary

Reported for

All presentations

Description

The patient's unique identifier given by the hospital in which the patient is first treated.

no spaces – all spaces should be removed

Combined with Person_Local_Number_Org_Code to identify the source of the Hospital Number.

NHSDD

CLERICAL

1.1.9 Person_Local_Number_Org_Code

Definition

Patient's unique local identifier

Layout

Alphanumeric, 5 Characters

Source

NHS Data dictionary

Reported for

All presentations

Description

The organisation code of the organisation that issued the patient's unique Local Patient Identifier (LocPatId)

no spaces – all spaces should be removed

Used in combination with Person_Local_Number.

1.1.10 Person_Usual_Address1

NHSDD

CLERICAL

LOCAL

Definition

First line of the address of the person's current place of residence

Layout

Alphanumeric, 35 Characters

Source

NHS Data Dictionary, but only used locally

Reported for

All presentations, Local only

Description

In most circumstances, the first line of the address should include the house number and road.

These details should be those recorded by the Land Registry.

Do not use the house name unless that is what is recorded on the Land Registry.

If the patient is from abroad, this should be all the address except for the country of origin.

[format of address details to be confirmed with NHS data dictionary team]

NHSDD

CLERICAL

LOCAL

1.1.11 Person_Usual_Address2

Definition

Second line of the address of the patient's current place of residence

Layout

Alphanumeric, 35 Characters

Source

NHS Data Dictionary, but only used locally

Reported for

All presentations, Local only

Description

In most circumstances, the second line of the address should include the village/ suburb and postal town.

These details should be those recorded by the Land Registry.

If the patient is from abroad, this should be the country of origin only.

[format of address details to be confirmed with NHS data dictionary team]

1.1.12 Person_Usual_Address_Postcode

NHSDD

CLERICAL

Definition

Postcode of Patient's current place of residence

Layout

Alphanumeric, 10 Characters

Source

NHS Data Dictionary, but

Local use only unless NHS number not known.

Reported for

All presentations

Description

The postcode of the place at which the patient normally resides.

For hotels, prison, sheltered housing or homeless in hostel, use postcode of building.

Not to be transmitted UNLESS NHS number not known, in which case only the first four characters should be transmitted.

[format of address details to be confirmed with NHS data dictionary team]

Code set

[Standard NHSDD list - to incorporate the full NHS DD list of the special/ country postcodes e.g.

Patient from abroad	ZZ99_1ZZ
Homeless patients not in hostel	ZZ99_2ZZ
Refuge centres, patient requesting anonymity	ZZ99_3ZZ]

NEW

CLERICAL

1.1.13 Person_Residence_Type

Definition

The type of residence where the patient normally resides.

Layout

SNOMED Number, 18 Characters

Source

NHS Data Dictionary

Reported for

All presentations

Notes

This is necessary to identify rates of ED treatment, admission and discharge of populations of patients who may have very high healthcare needs. This will aid planning and delivery of care for these population groups at both a local and central level.

Code set

Code	Descriptor	Includes	Excludes
SNOMED	Home	House, home premises, farm house, non-institutional place of residence, apartment, flat, boarding house, caravan park, refuge	Institutional place of residence Abandoned or derelict house
SNOMED	Residential institution without routine nursing care	Children's home, residential home, old people's home, military camp, prison, monastery	Hospital, nursing home, hospice
SNOMED	Residential institution **with** routine nursing care	Nursing home, hospice	Hospital, residential home
SNOMED	Medical service area	Hospital, clinic, GP surgery	Hospice, nursing home
SNOMED	Homeless in temporary accommodation	Night shelter, homeless shelter	
SNOMED	Homeless without accommodation	Homeless, abandoned or derelict housing	Night shelter, homeless shelter
SNOMED	Other specified place		Foreign national
SNOMED	Not Applicable	Foreign national	
SNOMED	Unspecified place	Not known, refuses to say	

Provenance

This item is from the Australian Victorian Emergency Minimum Dataset (VEMD) and has been collected for 20 years.

1.1.14 Person_Residence_LSOA

NHSDD

NEW

Definition

Lower Super Output Area of Patient's current place of residence

Layout

Alphanumeric, 10 Characters,

Source

Office of National Statistics.

This code generated *automatically* using Office of National Statistiscs LSOA lookup table from Person_Usual_Address_Postcode.

Reported for

All presentations

Description

The Lower Layer Super Output Area is the geographical coding system used by the Office of National Statistics to aggregate data for health and social care analysis.

Provenance

The LSOA is used for analysis e.g. in anonymised datasets to minimise the risk of patient identifiable data.

The LSOA is used in the NHS Sexual Health/ Genitourinary Medicine data set for this reason.

1.1.15 Person_Phone_Home

NHSDD

CLERICAL

LOCAL

Definition

Patient's home telephone number

Layout

Number, 15 Characters

Source

Local only

Reported for

Optional, but at least one of home phone, mobile phone and email should be completed to allow immediate contact for follow-up e.g. if missed fracture.

Description

The patient's home phone number.

No zeros, spaces or brackets should be in the data, as the number may be re-formatted for display using these conventions.

Non-UK phone numbers, should be prefixed with +, country code and then phone number, with leading zero removed, if necessary.

A clear statement should be made regarding the use of this information:- "Your contact details will only be used in relation to aspects of your care".

NHSDD

CLERICAL

LOCAL

1.1.16 Person_Phone_Mobile

Definition

Patient's mobile telephone number

Layout

Number, 15 Characters

Source

Local only

Reported for

Optional, but at least one of home phone, mobile phone and email should be completed to allow immediate contact for follow-up e.g. if missed fracture.

Description

No zeros, spaces or brackets should be in the data, as the number may be re-formatted for display using these conventions.

Non-UK phone numbers, should be prefixed with +, country code and then phone number, with leading zero removed, if necessary.

A clear statement should be made regarding the use of this information:- "Your contact details will only be used in relation to aspects of your care".

NEW

CLERICAL

LOCAL

1.1.17 Person_Email

Definition

Patient's email address

Layout

Alphanumeric, 50 Characters

Source

Local only

Reported for

Optional, but at least one of home phone, mobile phone and email should be completed to allow immediate contact for follow-up e.g. if missed fracture.

Description

The patient's email address.

Must be validated as a 'real' email address structure during data entry.

A clear statement should be made regarding the use of this information:- "Your contact details will only be used in relation to aspects of your care".

This data item (and possibly others in this group) may need to be amended to comply with the Accessible Information Standard currently under consideration by HSCIC.

NHSDD

CLERICAL

1.1.18 Person_GP_Practice_Code

Definition

The NHS code of the practice at which the patient is registered

Layout

Alphanumeric, 6 Characters

Source

NHS Data Dictionary Organisational Data Services (ODS) Code

Reported for

All presentations where GP known

Description

Validated against lookup from NHS ODS codes

(includes codes for unknown/ in custody/ foreign national)

Should be implemented in a way that allows common choices to be coded easily.

NHSDD

CLERICAL

LOCAL

1.1.19 Person_GP_Phone

Definition

The patient's usual GP practice telephone number

Layout

Number, 15 Characters

Source

Local only

Reported for

All presentations where GP known

Description

Should be automatically derived from a database of GP data based on Person_GP_Practice_Code.

No zeros, spaces or brackets should be in the data, as the number may be re-formatted for display using these conventions.

NHSDD

CLERICAL

LOCAL

1.1.20 Person_GP_Email

Definition

Email address of patient's GP practice

Layout

Number, 50 Characters

Source

Local only

Reported for

All presentations where GP known

Description

Should be automatically derived from a database of GP data based on Person_GP_Practice_Code.

This must be an NHS practice email address (i.e. nhs.net) rather than a personal one, ensuring secure confidential data transfer.

1.1.21 Person_Comm_Lang

NHSDD

CLERICAL

Definition

The patient's preferred communication language

Layout

Alphanumeric 18 character SNOMED

Source

NHS Data Dictionary – based on ISO Language list

Reported for

All presentations

Code set

SNOMED dataset if available, otherwise to use ISO/ NHSDD

Description

This information must:

- Be checked for every emergency presentation
- Not be set up to a default code on computer Emergency Department Information systems
- Be collected on, or as soon as possible after, admission.

The standard question to ask is:

"What is *[your] [the person's]* preferred language? "

Patient unable to consent (e.g. baby, child or confused):

Where a person is not able to consent for themselves (e.g. baby, child or confused) then the language of the person who is consenting will be recorded. For example a parent/guardian or someone with enduring power of attorney.

NHSDD

CLERICAL

1.1.22 Person_Interpreter_Rqd

Definition

Answers the question: "Does the patient require an interpreter to communicate?"

Layout

SNOMED, 18 Character

Source

NHS Data Dictionary & Summary Care Record

SNOMED dataset if available, otherwise to use ISO/ NHSDD

Reported for

All presentations

Code set

Descriptor	Code
Yes	SNOMED / NHSDD
No	SNOMED / NHSDD
Unknown	SNOMED / NHSDD

Description

Preferred Language to be asked before Interpreter Required.

If the Preferred language is English, Interpreter Required can be assumed to be 'N'.

This information must:

- Be checked for every admitted patient episode
- Not be set up to a default code on computer systems
- Be collected on, or as soon as possible after, registration.

The standard question is:

[Do you] [Does the person] [Does (name)] require an interpreter?

The question 'Do you require an interpreter?' is asked to determine patient need for an interpreter, not the capacity of the hospital to provide an interpreter.

Use 'Y' if the patient indicates they need an interpreter.

Use 'N' if the patient indicates they do not need an interpreter/ if preferred language is English.

Use 'U' if neither Yes nor No can be accurately ascertained.

Patient is unable to consent (e.g. baby, child or confused):

Where a person is not able to consent for themselves (e.g. baby, child or confused) then the need for an interpreter is recorded for the person who is consenting. For example a guardian or someone with enduring power of attorney.

NHSDD

CLERICAL

1.1.23 Person_Ethnic_Category

Definition

The patient's description of their ethnic origin.

Layout

Alphanumeric, 2 characters

Source

NHS Data Dictionary (Patient Demographics Service)

Reported for

All presentations

Code set

Code	Descriptor
A	British, Mixed British
B	Irish
C	Any other White background
C2	Northern Irish
C3	Other white, white unspecified
CA	English
CB	Scottish
CC	Welsh
CD	Cornish
CE	Cypriot (part not stated)
CF	Greek
CG	Greek Cypriot
CH	Turkish
CJ	Turkish Cypriot
CK	Italian
CL	Irish Traveller
CM	Traveller
CN	Gypsy/Romany
CP	Polish
CQ	All republics which made up the former USSR
CR	Kosovan
CS	Albanian

CT	Bosnian
CU	Croatian
CV	Serbian
CW	Other republics which made up the former Yugoslavia
CX	Mixed white
CY	Other white European, European unspecified, European mixed
D	White and Black Caribbean
E	White and Black African
F	White and Asian
G	Any other mixed background
GA	Black and Asian
GB	Black and Chinese
GC	Black and White
GD	Chinese and White
GE	Asian and Chinese
GF	Other Mixed, Mixed Unspecified
H	Indian or British Indian
J	Pakistani or British Pakistani
K	Bangladeshi or British Bangladeshi
L	Any other Asian background
LA	Mixed Asian
LB	Punjabi
LC	Kashmiri
LD	East African Asian
LE	Sri Lanka
LF	Tamil
LG	Sinhalese
LH	British Asian
LJ	Caribbean Asian
LK	Other Asian, Asian unspecified
M	Caribbean
N	African
P	Any other Black background
PA	Somali
PB	Mixed Black
PC	Nigerian
PD	Black British
PE	Other Black, Black unspecified
R	Chinese

S	Any other ethnic group
SA	Vietnamese
SB	Japanese
SC	Filipino
SD	Malaysian
SE	Any Other Group
Z	Not stated

Description

Systems should not be set up to enter a default code.

Patients should be presented with the above list and asked "Which one of these groups most closely matches your ethnic origin?"

NHSDD

CLERICAL

LOCAL

1.1.24 Person_School

Definition

The name of the patient's normal place of education or childcare.

Layout

Alphanumeric, 50 characters

Source

Local safeguarding requirement

Reported for

All presentations of patients between four and 16.

Description

If child from a country outside the UK, code as 'Abroad'.

Should be implemented in a way that allows common choices to be coded easily.

If child is between schools and new school known, use that school, otherwise code as old school.

NHSDD

CLERICAL

LOCAL

1.1.25 Person_Next_of_Kin

Definition

The patient's next of kin

Layout

Alphanumeric, 255 Characters

Source

Local only

Reported for

All presentations

Description

Patient's 'next of kin' is the person who the patient would most likely want to be notified about changes in the patient's condition. This would normally be the patient's spouse or civil partner, but in the event that they have none, it would be a person's closest living blood relative.

The relationship of the next of kin to the patient should be included in brackets e.g. John Smith [brother]

The 'next of kin' should be checked at every presentation and not assumed to be the same.

NHSDD

CLERICAL

LOCAL

1.1.26 Person_NoK_Contact

Definition

Contact details for person's Next of Kin

Layout

Alphanumeric, 255 Characters

Source

Local only

Reported for

All presentations

Description

Will normally be a phone number – landline or mobile, but possibly email address.

NHSDD

CLERICAL

LOCAL

1.1.27 Person_Companion

Definition

The person attending with the patient, when that person is not a first-degree relative e.g. parent or child.

Layout

Alphanumeric, 255 Characters

Source

Local only

Reported for

All presentations where person attending may have reduced capacity for autonomous decision-making e.g. child, elderly and confused, and who is accompanied by a person who is not their first-degree relative.

Description

The person attending with patient.

The role of the companion should also be described wherever possible, preferably in brackets.

Examples include a grandparent, carer, guardian, school teacher or nurse, police, custodial staff e.g.

Mr John Brown [carer] , Mrs J Smith [schoolteacher]

1.1.28 Person_Adverse_Reaction

NHSDD

CLERICAL

LOCAL

Definition

Record of any allergy or sensitivity that the patient reports.

Layout

Alphanumeric, SNOMED/ XML 255 Characters

Source

Local only

Reported for

All presentations

Description

Free text, unless

If No Known Drug Allergies, 'NKDA' should be reported.

Should be completed as early as possible in the person's stay in ED.

This field should include any allergy or sensitivity that the patient reports, together with the reported reaction to exposure, *and how this has been validated*. e.g.

- Penicillin results in anaphylaxis requiring adrenaline
- Co-trimoxazole results in widespread itchy blotchy rash
- NSAIDs have resulted in gastric irritation confirmed on endoscopy

This information should be recorded early in the patient attendance, and should be reproduced next to any drug prescription chart produced by an EDIS.

A fully implemented electronic patient record system will include this functionality.

[An internationally agreed allergy classification is to be implemented within SNOMED/ XML in 2015, which includes both propensity to anaphylaxis, together with events. If this has been validated prior to this data set being implemented, it will replace this data item.]

NHSDD
CLERICAL
LOCAL
CLINICAL

1.1.29 Person_Special_Patient_Note

Definition

Confidential information about a patient relevant to their ED management such as warnings and alerts about medical conditions or behavioural issues.

Layout

Alphanumeric, 1000 Characters, free text

Source

Local only (but is an agreed SNOMED term)

Reported for

Optional

Description

Confidential details that may be relevant about patients who attend the ED e.g. risk of violence to staff or others, management plans for specific conditions e.g. Munchausen's, self-harm.

This information would be discoverable under the Freedom of Information Act/ Data Protection Act and therefore must be factual, avoid opinions and be up to date. This section should not include details (e.g. ex-partner's contact details) to which the patient should not have access.

These should ***not*** include general medical details but may be appropriate to include specific medical details that are relevant to treatment in the ED e.g. ECG or neurological abnormalities, urgent treatment

Possible items that might be included in this area are:

- Haemophiliac, normal treatment is…
- Hereditory angioedema, treatment is …
- Munchausen
- History of violence
- Transplant patient
- Visually impaired
- Hearing impaired
- Communication difficulties
- Chronic pain
- Special needs
- Particular sensitivies
- Care plan available

- Advance directives details
- Contact details of relevant other health professionals

Entries into this record must only be performed by a senior clinician and must be timed and dated, so that they can be reviewed and changed when no longer current.

NHSDD

NEW

CLINICAL

1.1.30 Person_Comorbidities

Definition

If the person has one or more of the NHS list of medical co-morbidities, these should be recorded.

Layout

Alphanumeric, SNOMED / XML 255 Characters

Source

NHS Data dictionary

Reported for

Optional

Description

A fully implemented electronic patient record system will include this functionality.

The EDIS should draw this information down from the SCR automatically ***without any clinician input***.

This item should not allow ED clinicians to enter data – this is just a holder for information drawn from either the SCR or a local equivalent.

[A nationally agreed co-morbidity classification list is to be implemented within SNOMED/ XML in 2015. If this has been validated prior to this data set being implemented, it will supersede this data item.]

1.1.31 Person_Current_Meds

NHSDD

NEW

CLINICAL

Definition

The list of current medications from the Summary Care Record

Layout

Alphanumeric, SNOMED / XML 255 Characters

Source

NHS Data dictionary/ Summary Care Record

Reported for

Optional

Description

This is part of the Summary Care Record and the EDIS should draw this information down from the SCR automatically ***without any clinician input***.

This item should not allow ED clinicians to enter data – this is just a holder for information drawn from either the SCR or a local equivalent.

A fully implemented electronic patient record system will include this functionality.

1.2 Episode Demographics

Column	Datatype	Size	Comments
EmCare_Site_Code	ALPHA	9	NHSDD (Organisation Data Service)
EmCare_Site_Type	ALPHA	1	
EmCare_Unique_ID	NUMBER	12	Unique, zero-filled
EmCare_Arrive_Transport_Mode	ALPHA	2	dropdown box
EmCare_Amb_Incident_Number	ALPHA	20	
EmCare_Arrive_DateTime	DATETIME	19	
EmCare_Visit_Type	ALPHA	2	dropdown box
EmCare_Referred	ALPHA	2	dropdown box
EmCare_Arrive_Transfer_Source	ALPHA	9	NHSDD (Organisation Data Service)
EmCare_Assess_DateTime	DATETIME	19	
EmCare_CPR_Chk	ALPHA	1	Tickbox / autofill
EmCare_GP_SCR_Chk	ALPHA	1	Tickbox / autofill
EmCare_Clinician_DateTime	DATETIME	19	
EmCare_RefOpinion_DateTime	DATETIME	19	
EmCare_RefAdmission_DateTime	DATETIME	19	
EmCare_Referred_Service	ALPHA	18	Dropdown box, SNOMED
EmCare_Complete_DateTime	DATETIME	19	
EmCare_Depart_DateTime	DATETIME	19	
EmCare_Depart_Specialty	ALPHA	18	?SNOMED/ ?DD Treatment Function Codes

NHSDD

1.2.1 EmCare_Site_Code

Definition

Organisation site code using the standard NHS Data Dictionary ODS terms

Layout

Alphanumeric, up to 9 Characters

Source

NHS Data Dictionary (Organisational Data Services)

Reported for

All patients

Description

This uses a standard maintained list of organisational codes, and is the same for all patients in a particular site, although co-located primary care facilities would generally have their own code.

This data will be auto-entered by the system.

NHSDD

1.2.2 EmCare_Site_Type

Definition

Emergency care site type using the standard NHS Data Dictionary terms

Layout

Alphanumeric 1 Characters

Source

NHS Data Dictionary

Reported for

All patients

Description

This data will be auto-entered by the system.

Code set

Descriptor	Code
Type 1 – General Emergency Department	1
Type 2 – Specialist Emergency Department (e.g. paediatric, ophthalmology)	2
Type 3 – Minor Injury Unit	3
Type 4 – Walk in Centre	4

NHSDD

1.2.3 EmCare_Unique_ID

Definition

Local unique identifier of patient episode.

Layout

Number, 12 Characters zero-filled

Notes

A12 digit zero-filled incremental attendance counter e.g. 000000042355

A unique identifier is implemented in ED information systems but not in a consistent format.

Having a consistent unique record identifier will enable a consistent interface for data tracking e.g. contact tracing, research, audit.

Some ED information systems reset the counter every year. These systems should be coded as year + 8 digit zero-filled number e.g. 201500042355.

Implementation

- The EmCare_Unique_ID must be generated at the time of first contact within the ED, whether clinical assessment or reception desk.
- An EmCare_Unique_ID ***must not be changed***: if there is a problem with an EmCare_Unique_ID, the visit should be deleted and re-started with a new EmCare_Unique_ID.
- An EmCare_Unique_ID ***must never be re-used:*** it must not be re-assigned to another presentation for the same patient or to another patient.
- In the case of duplicate EmCare_Unique_IDs being recorded, one or (preferably) both must be deleted.

[current name = A and E Attendance Number]

NHSDD

1.2.4 EmCare_Arrive_Transport_Mode

Definition

Transport mode by which the patient arrived at the ED

Layout

Numeric, 2 Characters

Source

NHS Data Dictionary

Reported for

All presentations

Code set

Descriptor	Code
Patient's own transport	11
Public transport	12
NHS Road Ambulance	21
Other Road Ambulance	22
Air Ambulance - helicopter	26
Fixed Wing/ Medical repatriation by air	28
Police/ Prison	51
Other specified	97
Unspecified	99

Description

For journeys involving more than one transport mode, select the mode of transport in which the greater distance of the journey was undertaken.

e.g. patients transported by air require road transportation to and/or from the transferring hospital. Assuming the air transport involves the greater distance, select code 23.

NHSDD

1.2.5 EmCare_Amb_Incident_Number

Definition

Unique ambulance incident identifier

Layout

Alphanumeric, 20 Characters

Source

NHS Data Dictionary

Reported for

All patients whose EmCare_Transport_Mode code is 21 - 30 (i.e. Ambulance/Helicopter/Aircraft)

Description

If the patient did not arrive by ambulance, this field should be null.

NHSDD

1.2.6 EmCare_Arrive_DateTime

Definition

The time the patient was first clinically assessed or registered in the ED, whichever comes first.

Layout

Datetime 19 characters (YYYY-MM-DDThh:mm:ss)

Source

NHS Data Dictionary

Reported for

All presentations

Description

If EmCare_Presentation_Time is earlier than EmCare_Arrive_Time, then EmCare_Arrive_Time should be set as the EmCare_Presentation_Time.

NHSDD

1.2.7 EmCare_Arrive_Visit_Type

Definition

Reason for patient's visit

Layout

Number, 2 Characters

Source

NHS Data Dictionary

Reported for

All presentations

Code set

Descriptor	Code
Emergency presentation: Presentation due to a **new** clinical condition OR **deterioration** of a chronic condition	11
Return visit – ***unplanned or unanticipated*** return visit **within 7 days** following attendance at **this ED**	21
Return visit – ***planned or anticipated*** return visit **within 7 days** following attendance at **this ED**	22
Unplanned attendance with **same/ related problem** as has attended **another health provider** in **within 28 days**. Includes failed discharge.	31
Arranged admission	41
Patient in transit to another institution	51
Transfer from another medical institution for increased care	61
Dead on arrival – declared dead before ED, no intent to resuscitate	81
Other specified	97
Unspecified	99

Description

Should be completed as soon as possible after arrival in the ED.

As part of the registration process, clerical staff should ask the patient "have you already seen your GP or anyone else about this problem?"

UK

CLERICAL

NEW

1.2.8 EmCare_Arrive_Referred

Definition

Source from which patient was referred to the Emergency Department. **Not** mode of transport.

Layout

Number, 2 Characters

Source

NHS Data Dictionary

Reported for

All presentations

Code set

Descriptor	Code
Self, family, friends,	11
Carer (external, not family or friend)	14
GP/ practice nurse	21
Out of hours GP service	22
Emergency care practitioner	23
Walk-in centre/ Urgent care centre/ Minor injuries unit	24
NHS Telephone/ internet advice e.g. NHS 111	31
Non-NHS telephone / internet advice	32
Another hospital	41
ED planned review	42
Nurse (not practice nurse) e.g. school nurse, community midwife, health visitor	51
Pharmacist/ Dentist/ Optician	52
Police/ Forensic medical officer	61
Fire service	62
Search and rescue / Coastguard/ Mountain rescue	63
Mental health assessment team/ Social services	71
Private specialist	81
Other specified	97
Unspecified	99

Description

Nurse includes:

- District Nurse, Community Midwife, Health Visitor, nurses employed within Aged Care Residential Home, Hostel, Respite Care Facility, Nursing Home and Custodial Care Facility.

Excludes:

- Healthcare Assistants (HCA), Community Psychiatric Nurse (code as mental health assessment team)
- Nurses within this hospital or other acute care facility.

Code referral from radiology as GP as this is the source of the request for radiology.

Provenance

This item from Victorian Emergency Minimum Dataset (Australia). Collected > 20 years

UK

CLERICAL

NEW

1.2.9 EmCare_Arrive_Transfer_Source

Definition

ODS code of the healthcare facility from which the patient has been transferred to this Emergency Department.

Layout

Alphanumeric, 9 Characters

Source

NHS Data Dictionary (Organisation Data Services)

Reported for

All presentations where EmCare_Arrive_Referred = 41 (Another Hospital)

Description

If transfer from overseas hospital code as 999999999

Provenance

This data is already collected for some interhospital transfers e.g. neonates and this allows patient tracking between organisations.

This has become more important as patients are transferred to tertiary care for acute care delivered in regional centres e.g. Stroke, Cardiac, Trauma.

NHSDD

1.2.10 EmCare_Assess_DateTime

Definition

The date and time the patient was first ***clinically*** assessed in the ED.

Layout

Datetime YYYY-MM-DDThh:mm:ss 19 Characters

Source

NHS Data Dictionary

[replaces Accident and Emergency Initial Assessment Date, Accident and Emergency Initial Assessment Time]

Reported for

All presentations

Description

This is the first time a qualified healthcare professional has assessed the patient.

This may include:

- The taking of a brief patient history
- Pain assessment and treatment
- Vital signs / early warning score

Depending on the model of care used, this may be either the same as the EmCare_Arrive_DateTime or EmCare_Clinician_DateTime, or it may be different from either of these.

1.2.11 EmCare_CPR_Chk

NEW

CLERICAL

Definition

Answers the question: "Has the child protection register been checked in respect of this attendance ***before*** the patient is seen by the treating clinician?"

Layout

Alphanumeric, 1 Character

Source

NHS Data Dictionary

Reported for

All presentations for patient below 16 years.

Should be automatically entered by the computer based on user's actions.

Code set

Descriptor	Code
Yes	Y
No	N
No CPR available	9

Description

Implementation:

- Should be performed as early in the patient's ED visit as possible, ideally at the time of clinical assessment or registration.
- Automatic completion (preferable): if the data from the CPR record is automatically presented to the clinician this may ticked automatically.
- Manual completion: should be presented as a tickbox that must not be pre-filled with a tick.
- If the CPR information is not available for reasons outside the control of the hospital/ provider, then '9' should be entered.

Provenance

This is a new data item, designed to measure whether safeguarding information is available to the clinician at the point of care.

1.2.12 EmCare_SCR_Chk

NEW

CLERICAL

Definition

Answers the question: "Has the GP record or NHS Summary Care Record been seen by the treating clinician ***before*** assessing and treating this patient?"

Layout

Alphanumeric, 1 Character

Source

NHS Data Dictionary

Reported for

All Patients.

Should be automatically entered by the computer based on user's actions.

Code set

Descriptor	Code
Yes	Y
No	N
Patient does not have GP	8
No SCR/ GP data link	9

Description

Implementation:

- Should be performed as early in the patient's ED visit as possible, ideally on registration but ***must be before*** the treating clinician sees the patient (may be after initial clinical assessment).
- Manual completion: should be presented as a tickbox that must not be pre-filled with a tick.
- Automatic completion (preferable): if the data from the GP record is automatically presented to the clinician ***from within the ED information system***, in such a way that they must see this information, this may ticked automatically.
- If there is no physical data link between the ED Information System and either the Summary Care Record or a GP system, then '9' should be entered for all records.

Notes

The GP information/ Summary Care Record viewer should be integrated into the ED information system. If a separate system is used to view the GP patient record, then automatic completion must not be used and 'Yes' should only be ticked if a written summary is available to the treating clinician ***before*** seeing the patient.

Provenance

This is a new data item, designed to measure whether key background clinical information is available to the clinician at the point of care.

NHSDD

1.2.13 EmCare_Clinician_DateTime

Definition

The date and time the patient was first seen in the ED by a treating clinician (see below).

Layout

DateTime, 19 Characters

Source

NHS Data Dictionary

[Replaces 'Accident and Emergency Date Seen for Treatment', and 'Accident and Emergency Time Seen for Treatment']

Reported for

All presentations , unless Discharge_Status = '61 - Left after clinical advice regarding treatment options' or '63 - Left at own risk, without treatment'.

Description

This data is automatically collected by the Emergency Department Information System when the clinician assumes responsibility for that patient.

Clinician in this case is the first clinician who sees the patient **AND** who has the professional authority to perform **ALL** of these functions:

- examine the patient,
- make a diagnosis,
- prescribe treatment and
- discharge the patient

Clinician is therefore either a doctor, Emergency Nurse Practitioner (which may also include other higher grades in the Nursing hierarchy e.g. Sister/ Matron/ Nurse Manager/ Advanced Nurse Practitioner/ Nurse Consultant), Emergency Care Practitioner, or Extended Scope Physiotherapist.

Clinician in this context does not include Medical Student, Nursing Student, or nursing staff not in the specified groups above.

1.2.14 EmCare_RefOpinion_DateTime

UK

NEW

CLINICAL

Definition

The time the patient was first **referred** to an inpatient service for **an opinion**.

Referral for an opinion occurs when the Emergency Department clinician expects that the patient will not require admission but does require specialist advice regarding management. Responsibility for the patient's management remains with the Emergency Department.

Layout

Datetime, 19 Characters

Source

NHS Data Dictionary

Reported for

All patients referred to an inpatient specialty for an opinion.

Description

The time at which referral for an opinion is ***first undertaken*** by the treating clinician.

This data item is captured automatically on an EPR system when a referral is made and therefore although nominally a clinician entered value, *in many systems this data is already automatically captured*. This is certainly the case with electronic referral systems.

The time of first referral is taken irrespective of acceptance or otherwise by the relevant inpatient specialty.

1.2.15 EmCare_RefAdmission_DateTime

NHSDD

Definition

The time the patient was first **referred** to an inpatient specialty **for admission**.

Referral for admission implies that responsibility for the management of that patient transfers from the Emergency Department to the inpatient specialty.

Layout

Datetime, 19 Characters

Source

NHS Data Dictionary

[replaces 'Decision to Admit']

Reported for

All patients referred to an inpatient specialty for admission.

If patient is to stay under the care of the ED in an observation unit, then it will be the time at which the decision is made to admit the patient to the observation unit.

Description

The time at which referral for an admission is ***first undertaken*** by the treating clinician.

This data item is captured automatically on an EPR system when a referral is made.

The time is taken irrespective of acceptance or otherwise by the relevant inpatient specialty.

This replaces 'Decision To Admit' as 'Referred For Admission' is a better description for the process, and is the internationally recommended[5] term.

[5] http://www.ncbi.nlm.nih.gov/pubmed/25899754

UK

NEW

CLINICAL

1.2.16 EmCare_Referred_Service

Definition

The service to which the patient was ***first*** referred for **admission or opinion** by the treating clinician .

Layout

Alphanumeric, 18 characters (SNOMED)

Source

NHS Data Dictionary / SNOMED (TBC)

Reported for

All patients referred to an inpatient specialty for an *opinion* or for *admission*.

Description

[NB This may be different from the final specialty that accepts the patient.]

The time at which referral for an opinion/ admission is ***first undertaken/ attempted*** by the treating clinician.

The time of referral is the start of the referral process, and is irrespective of acceptance or otherwise by the relevant specialty. This includes specialties that are supra-regional e.g. burns, neurosurgery, trauma, vascular etc.

If there is no dedicated service [e.g. trauma] available for referral, or local practice is that patients with these conditions are managed by another specialty, that code option should not be offered.

If the patient is referred to a sub-specialty not detailed on this list e.g. hepatology, the parent specialty e.g. gastroenterology should be used.

Code set

Descriptor	Code
Emergency Medicine Observation Unit	[SNOMED CODE]
Acute Medicine	[SNOMED CODE]
General (Internal) Medicine	[SNOMED CODE]
Intensive Care / High Dependency	[SNOMED CODE]
Cardiology	[SNOMED CODE]
Dermatology	[SNOMED CODE]
Endocrinology / Diabetes	[SNOMED CODE]
Gastroenterology	[SNOMED CODE]

Genito-urinary Medicine	[SNOMED CODE]
Geriatric Medicine	[SNOMED CODE]
Haematology	[SNOMED CODE]
Immunology/ Allergy	[SNOMED CODE]
Infectious Diseases/ Tropical Medicine	[SNOMED CODE]
Oncology Medical / Clinical	[SNOMED CODE]
Neurology	[SNOMED CODE]
Palliative Medicine	[SNOMED CODE]
Rehabilitation Medicine	[SNOMED CODE]
Renal Medicine	[SNOMED CODE]
Respiratory Medicine	[SNOMED CODE]
Rheumatology	[SNOMED CODE]
General Surgery	[SNOMED CODE]
Cardio-thoracic Surgery	[SNOMED CODE]
Otolaryngology (ENT)	[SNOMED CODE]
Neurosurgery	[SNOMED CODE]
Oral and Maxillo-facial Surgery	[SNOMED CODE]
Plastic Surgery	[SNOMED CODE]
Burns	[SNOMED CODE]
Trauma Surgery	[SNOMED CODE]
Orthopaedic Surgery	[SNOMED CODE]
Urology	[SNOMED CODE]
Ophthalmology/ Medical Ophthalmology	[SNOMED CODE]
Vascular Surgery	[SNOMED CODE]
Paediatrics	[SNOMED CODE]
Paediatric Surgery	[SNOMED CODE]
Paediatric Intensive Care/ High Dependency	[SNOMED CODE]
Paediatric Medical sub-specialties	[SNOMED CODE]
Paediatric Surgical sub-specialties	[SNOMED CODE]
Obstetrics	[SNOMED CODE]
Gynaecology	[SNOMED CODE]
General Psychiatry	[SNOMED CODE]
Child and Adolescent Psychiatry	[SNOMED CODE]
Old Age Psychiatry	[SNOMED CODE]
General Practice	[SNOMED CODE]
Sport and Exercise Medicine	[SNOMED CODE]
Occupational Health	[SNOMED CODE]

1.2.17 EmCare_Complete_DateTime

NHSDD

CLERICAL

Definition

The time the patient's Emergency Care treatment was complete.

Layout

Datetime , 19 Characters

Source

NHS Data Dictionary

[replaces Accident and Emergency Attendance Conclusion Time, Accident and Emergency Attendance Conclusion Date]

Reported for

All presentations unless patient left before treatment.

Null if patient left before assessment/ treatment.

Description

This defines when the patient is ready to move and therefore will identify when 'exit block' is occurring, and is an internationally recognised standard[6] for this reason.

If the patient is to be admitted, then
EmCare_Complete_DateTime = EmCare_RefAdmission_DateTime.

'Exit block' from emergency departments is associated with adverse patient outcomes, it is an important factor to record.

Some existing EDIS/ EPR systems routinely record this data, but may be phrased as 'ready for transfer'.

[6] http://www.ncbi.nlm.nih.gov/pubmed/25899754

NHSDD

1.2.18 EmCare_Depart_DateTime

Definition

The date and time when the patient physically left the Emergency Department.

Layout

Datetime 19 characters

Source

NHS Data Dictionary

Reported for

All presentations

Description

The patient must have been transferred out of the Emergency Department. This includes internal transfers e.g. to an ED observation unit.

1.2.19 EmCare_Depart_Specialty

UK

CLERICAL

Definition

The specialty to which the patient was admitted.

Layout

SNOMED alphanumeric, 18 characters

Source

NHS Data Dictionary [TBC]

[?? to use common SNOMED codes with EmCare_Referred_Service or ?? to use Data Dictionary Treatment Function Codes which would allow linkage to admitted care records. ? SNOMED + crossmap]

Reported for

All patients admitted to an inpatient unit –EmCare_Discharge_Status codes 21-59

Description

If there is no dedicated service [e.g. trauma] available for referral, or local practice is that patients with these conditions are managed by another specialty, that code option should not be offered.

If the patient is admitted to a sub-specialty not detailed on this list e.g. hepatology, the parent specialty e.g. gastroenterology should be used.

Code set

Descriptor	Code
Emergency Medicine Observation Unit	[SNOMED CODE]
Acute Medicine	[SNOMED CODE]
General (Internal) Medicine	[SNOMED CODE]
Intensive Care / High Dependency	[SNOMED CODE]
Cardiology	[SNOMED CODE]
Dermatology	[SNOMED CODE]
Endocrinology / Diabetes	[SNOMED CODE]
Gastroenterology	[SNOMED CODE]
Genito-urinary Medicine	[SNOMED CODE]
Geriatric Medicine	[SNOMED CODE]
Haematology	[SNOMED CODE]
Immunology/ Allergy	[SNOMED CODE]

Infectious Diseases/ Tropical Medicine	[SNOMED CODE]
Oncology Medical / Clinical	[SNOMED CODE]
Neurology	[SNOMED CODE]
Palliative Medicine	[SNOMED CODE]
Rehabilitation Medicine	[SNOMED CODE]
Renal Medicine	[SNOMED CODE]
Respiratory Medicine	[SNOMED CODE]
Rheumatology	[SNOMED CODE]
General Surgery	[SNOMED CODE]
Cardio-thoracic Surgery	[SNOMED CODE]
Otolaryngology (ENT)	[SNOMED CODE]
Neurosurgery	[SNOMED CODE]
Oral and Maxillo-facial Surgery	[SNOMED CODE]
Plastic Surgery	[SNOMED CODE]
Burns	[SNOMED CODE]
Trauma Surgery	[SNOMED CODE]
Orthopaedic Surgery	[SNOMED CODE]
Urology	[SNOMED CODE]
Ophthalmology/ Medical Ophthalmology	[SNOMED CODE]
Vascular Surgery	[SNOMED CODE]
Paediatrics	[SNOMED CODE]
Paediatric Surgery	[SNOMED CODE]
Paediatric Intensive Care/ High Dependency	[SNOMED CODE]
Paediatric Medical sub-specialties	[SNOMED CODE]
Paediatric Surgical sub-specialties	[SNOMED CODE]
Obstetrics	[SNOMED CODE]
Gynaecology	[SNOMED CODE]
General Psychiatry	[SNOMED CODE]
Child and Adolescent Psychiatry	[SNOMED CODE]
Old Age Psychiatry	[SNOMED CODE]
General Practice	[SNOMED CODE]
Sport and Exercise Medicine	[SNOMED CODE]
Occupational Health	[SNOMED CODE]

1.3 Clinical information

Column	Datatype	Size	Comments
EmCare_Presentation_Acuity	ALPHA	1	
EmCare_Presentation_ChiefComplaint	ALPHA	18	SNOMED
EmCare_Clinical_Narrative	ALPHA	1500	Free text
EmCare_Diagnosis	ALPHA	255	SNOMED / XML
EmCare_Diagnosis_Modifier	ALPHA	1	
EmCare_Invest_Treat	ALPHA	255	SNOMED / XML

UK

INT

CLINICAL

1.3.1 EmCare_Presentation_Acuity

Definition

The acuity of the patient on first assessment in the ED

Alphanumeric Layout

Number (Range 1-6) - 1 Character

Source

Used in some centres in the UK and internationally

Reported for

All patients

Code set

Descriptor	Code
Resuscitation	1
Emergency	2
Urgent	3
Semi-urgent	4
Non-urgent	5
Dead on arrival	6

Description

A single number that represents the acuity of the patient's illness, in accordance with internationally used definitions of acuity measurement.

Presentation Acuity and Presentation Symptom should be recorded by the first clinician who sees the patient.

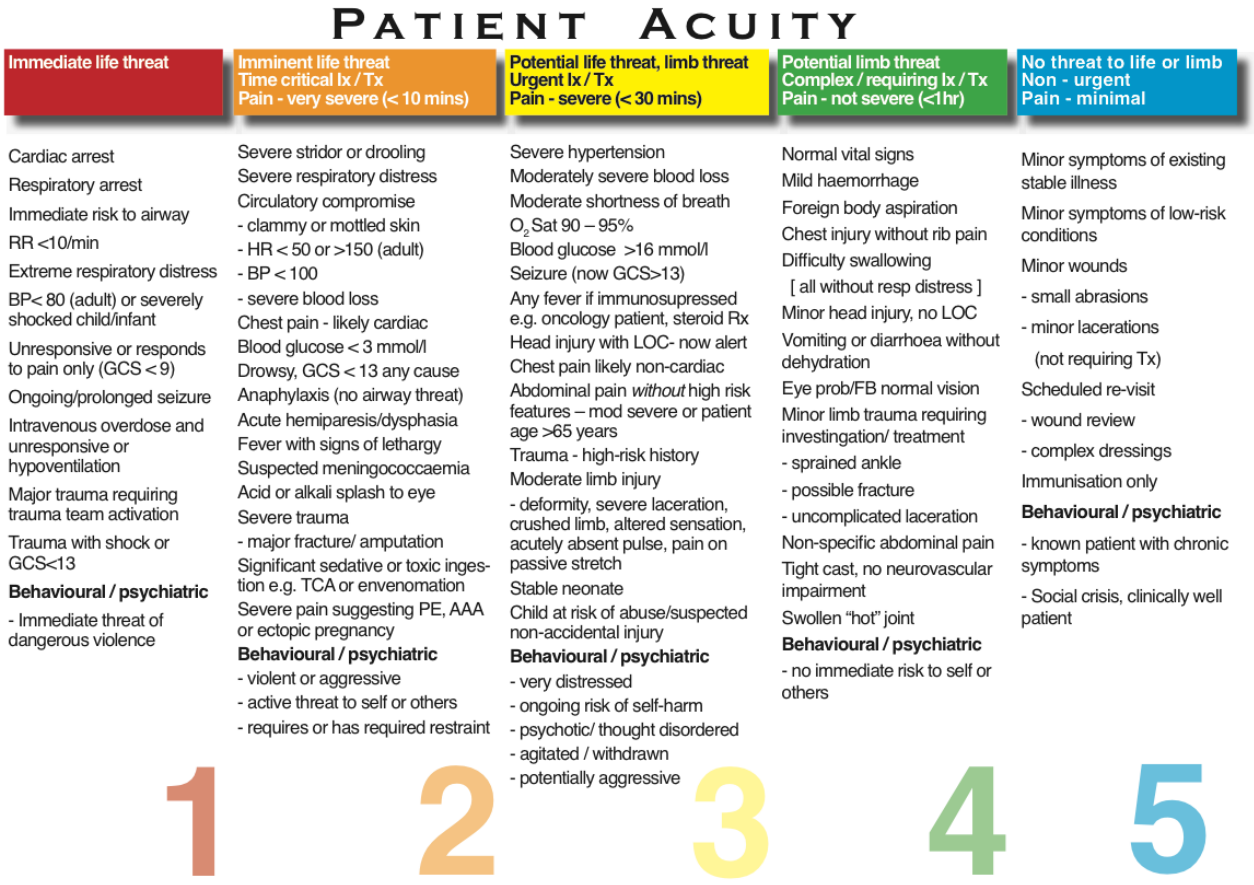
To understand the value added by any system (including healthcare), it is important to be able to measure inputs and outputs.

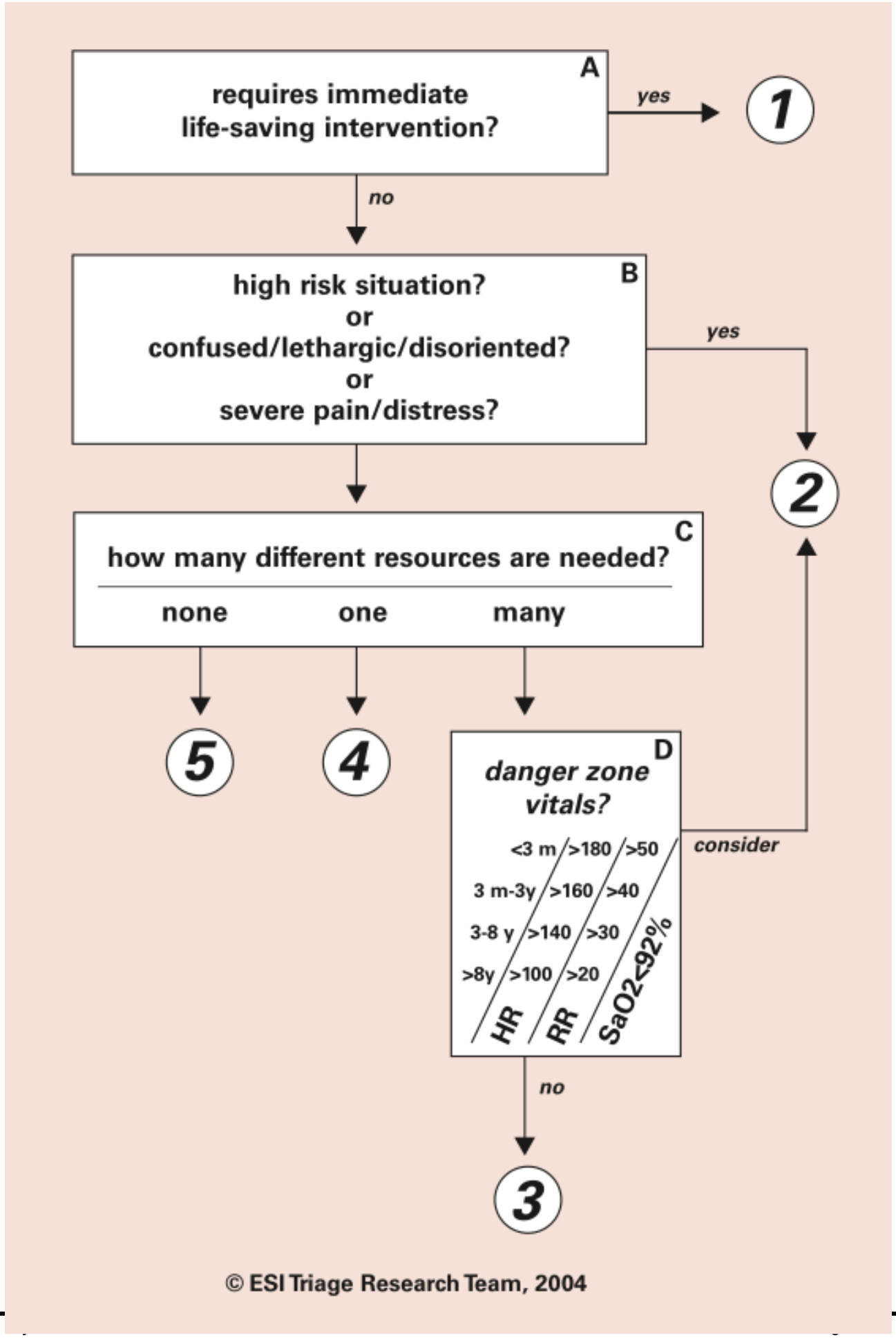
In the case of urgent and emergency care, there are two elements to the patient presentation: Presentation Acuity and Presentation Symptom.

In the UK many EDs have historically used their own ways of labelling acuity. There is a need for Emergency Care to standardise their input measurement to record accurately the acuity of patients attending across a range of Emergency Care services, which will help inform optimum use of resources in the provision of Emergency Care.

Presentation Acuity and Presentation Symptom is not a triage process and does not imply or require a triage process, although these data may be collected as part of a triage process.

The following are international examples of Presentation Acuity allocation – from Australia and the USA:




A
requires immediate life-saving intervention?
yes
1
no
B
high risk situation?
or
confused/lethargic/disoriented?
or
severe pain/distress?
yes
2
C
how many different resources are needed?
none
one
many
5
4
D
danger zone vitals?
<3 m
3 m-3y
3-8 y
>8y
HR
>180
>160
>140
>100
RR
>50
>40
>30
>20
SaO2<92%
consider
no
3
© ESI Triage Research Team, 2004

1.3.2 EmCare_Presentation_ChiefComplaint

UK

CLINICAL

Definition

The nature of the patient's chief complaint as assessed by the clinician first assessing the patient.

Alphanumeric Layout

Alphanumeric, 18 Characters

Source

NHS Data Dictionary

Reported for

All presentations

Description

Chief Complaint should generally be recorded by the first clinician who sees the patient, but could be completed by the patient themselves e.g. using a kiosk system.

To understand the value added by any system (including healthcare), it is important to be able to measure inputs and outputs. In the UK there has been no single measure of presenting symptoms, and many EDs have historically used their own set of measures or modified existing systems.

There is a need for Emergency Care to standardise their input measurement to record accurately the acuity of patients attending across a range of Emergency Care services, which will help inform optimum use of resources in the provision of Emergency Care.

Presentation Acuity and Presentation Symptom is not a triage process and does not require a triage process, although these data may be collected as part of a triage process.

This data should be entered using a two linked drop-down boxes

> The first box enters the category e.g. 'respiratory'/'skin'/'cardiac', which then populates the second box with the specific data items.

Provenance

This list is derived from the Canadian Triage Acuity Scale, with minor adaptations. This list has had more than 10 years use in Canada, the Carribean and SouthEast Asia and is in use in the UK.

Descriptor	Code
Cardiovascular Group	
Cardiac arrest non-traumatic	[SNOMED CODE]
Cardiac arrest traumatic	[SNOMED CODE]
Chest pain	[SNOMED CODE]
Palpitations/ irregular heart beat	[SNOMED CODE]
General weakness	[SNOMED CODE]
Faint with loss of consciousness	[SNOMED CODE]
Oedema/ swelling – generalised	[SNOMED CODE]
Unilateral leg swelling/ oedema	[SNOMED CODE]
Painful cold leg or arm	[SNOMED CODE]
Head and Neck	
Earache	[SNOMED CODE]
Foreign body ear	[SNOMED CODE]
Loss of hearing	[SNOMED CODE]
Tinnitus (ringing in ears)	[SNOMED CODE]
Ear discharge	[SNOMED CODE]
Ear injury	[SNOMED CODE]
Dental problem	[SNOMED CODE]
Facial trauma	[SNOMED CODE]
Sore throat	[SNOMED CODE]
Neck swelling/ pain	[SNOMED CODE]
Neck trauma	[SNOMED CODE]
Difficulty swallowing	[SNOMED CODE]
Facial pain	[SNOMED CODE]
Nosebleed	[SNOMED CODE]
Nasal congestion/ hayfever	[SNOMED CODE]
Foreign body nose	[SNOMED CODE]
Nasal trauma	[SNOMED CODE]
Environmental	
Frostbite	[SNOMED CODE]
Noxious inhalation	[SNOMED CODE]
Electrical injury	[SNOMED CODE]
Chemical exposure	[SNOMED CODE]
Hypothermia	[SNOMED CODE]
Near drowning	[SNOMED CODE]
Gastrointestinal	

Abdominal pain	[SNOMED CODE]
Loss of appetite	[SNOMED CODE]
Constipation	[SNOMED CODE]
Diarrhoea	[SNOMED CODE]
Foreign body in rectum	[SNOMED CODE]
Groin pain/ mass	[SNOMED CODE]
Vomiting and or nausea	[SNOMED CODE]
Rectal/ perineal pain	[SNOMED CODE]
Vomiting blood	[SNOMED CODE]
Blood in stool/ melaena	[SNOMED CODE]
Jaundice	[SNOMED CODE]
Hiccoughs	[SNOMED CODE]
Abdominal mass/ distension	[SNOMED CODE]
Anal/ rectal trauma	[SNOMED CODE]
Oral/ oesophageal foreign body	[SNOMED CODE]
Genitourinary	
Flank pain	[SNOMED CODE]
Blood in urine (haematuria)	[SNOMED CODE]
Genital discharge/ lesion	[SNOMED CODE]
Penile swelling	[SNOMED CODE]
Scrotal pain and/or swelling	[SNOMED CODE]
Urinary retention	[SNOMED CODE]
UTI complaints	[SNOMED CODE]
Oliguria	[SNOMED CODE]
Polyuria	[SNOMED CODE]
Genital trauma	[SNOMED CODE]
Mental health	
Depression/ suicidal/ deliberate self harm	[SNOMED CODE]
Anxiety/ situational crisis	[SNOMED CODE]
Hallucinations/ delusions	[SNOMED CODE]
Insomnia	[SNOMED CODE]
Violent behaviour	[SNOMED CODE]
Paediatric disruptive behaviour	[SNOMED CODE]
Social problem	[SNOMED CODE]
Bizarre behaviour	[SNOMED CODE]
Concern for patient's welfare	[SNOMED CODE]
Neurologic	
Altered level of consciousness/ drowsy	[SNOMED CODE]
Confusion	[SNOMED CODE]

Dizziness (vertigo)	[SNOMED CODE]
Headache	[SNOMED CODE]
Seizure	[SNOMED CODE]
Unsteady walking (ataxia)	[SNOMED CODE]
Head injury	[SNOMED CODE]
Tremor	[SNOMED CODE]
Weakness on one side of the body/ symptoms of stroke	[SNOMED CODE]
Floppy child	[SNOMED CODE]
Numbness / tingling (paraesthesia)	[SNOMED CODE]
Obstetrics and Gynaecology	
Menstrual / period problems	[SNOMED CODE]
Foreign body in vagina	[SNOMED CODE]
Vaginal discharge	[SNOMED CODE]
Sexual assault	[SNOMED CODE]
Vaginal bleed	[SNOMED CODE]
Labial swelling	[SNOMED CODE]
Vaginal pain/ itch	[SNOMED CODE]
Pregnancy problems >20 weeks	[SNOMED CODE]
Pregnancy problems <20 weeks	[SNOMED CODE]
Eye	
Chemical exposure – eye	[SNOMED CODE]
Foreign body in/on eye	[SNOMED CODE]
Visual disturbance	[SNOMED CODE]
Eye pain	[SNOMED CODE]
Red eye, discharge	[SNOMED CODE]
Photophobia	[SNOMED CODE]
Diplopia (double vision)	[SNOMED CODE]
Periorbital swelling	[SNOMED CODE]
Eye trauma	[SNOMED CODE]
Eye review	[SNOMED CODE]
Orthopaedics	
Back pain	[SNOMED CODE]
Traumatic back/ spine injury	[SNOMED CODE]
Amputation	[SNOMED CODE]
Upper limb injury	[SNOMED CODE]
Lower limb injury	[SNOMED CODE]
Upper limb pain	[SNOMED CODE]
Lower limb pain	[SNOMED CODE]
Joint swelling	[SNOMED CODE]

Respiratory	
Shortness of breath	[SNOMED CODE]
Difficulty breathing	[SNOMED CODE]
Noisy breathing	[SNOMED CODE]
Cough, congestion	[SNOMED CODE]
Infant having episodes not breathing (apnoea)	[SNOMED CODE]
Respiratory arrest	[SNOMED CODE]
Haemoptysis – coughing up blood	[SNOMED CODE]
Respiratory foreign body	[SNOMED CODE]
Allergic reaction	[SNOMED CODE]
Skin	
Bite	[SNOMED CODE]
Sting	[SNOMED CODE]
Abrasion	[SNOMED CODE]
Laceration/ puncture	[SNOMED CODE]
Burn/ scald	[SNOMED CODE]
Blood/ body fluid exposure	[SNOMED CODE]
Pruritis (itchy skin)	[SNOMED CODE]
Rash	[SNOMED CODE]
Localised swelling/ redness	[SNOMED CODE]
Wound check	[SNOMED CODE]
Other skin condition	[SNOMED CODE]
Lumps, bumps calluses	[SNOMED CODE]
Spontaneous bruising	[SNOMED CODE]
Foreign body in/on skin	[SNOMED CODE]
Substance misuse/ overdose	
Substance intoxication (recreational use)	[SNOMED CODE]
Substance overdose/ ingestion	[SNOMED CODE]
Substance withdrawal	[SNOMED CODE]
Trauma	
Major trauma – penetrating injury	[SNOMED CODE]
Major trauma – blunt injury	[SNOMED CODE]
General and Minor	
Exposure to communicable disease	[SNOMED CODE]
Fever, unspecified	[SNOMED CODE]
Hyperglycaemia	[SNOMED CODE]
Hypoglycaemia	[SNOMED CODE]
Direct referral for admission	[SNOMED CODE]
Dressing change	[SNOMED CODE]

Removal of staples/ sutures	[SNOMED CODE]
Cast check	[SNOMED CODE]
Imaging tests	[SNOMED CODE]
Medical device problem	[SNOMED CODE]
Medication/ prescription request	[SNOMED CODE]
Ring removal	[SNOMED CODE]
Abnormal results follow-up	[SNOMED CODE]
Post-op complications	[SNOMED CODE]
Congenital Problem in child	[SNOMED CODE]
Inconsolable crying in infant	[SNOMED CODE]
Pallor/ anaemia	[SNOMED CODE]
Minor complaints, unspecified	[SNOMED CODE]

1.3.3 EmCare_Clinical_Narrative

UK

CLINICAL

Definition

Free text description of patient's reason for attendance, diagnostic and treatment process and recommendations for further management and follow-up.

Alphanumeric Layout

Free text

Source

Local

Reported for

All presentations

Description

This field may be started on initial clinical assessment with a short history e.g.

'Tripped over paving slab and fell, hit head – 3 cm laceration R forehead. no LOC'

This field may be further elaborated by clinicians treating the patient during their journey within the Emergency Department.

'Tripped over paving slab and fell, hit head – 3 cm laceration R forehead. no LOC – cleaned and sutured 5x5/0 nylon sutures'

Specific discharge instructions should be entered into the Discharge_Instructions field.

It is possible to use this field to collect more detailed injury information over and above that collected in the injury surveillance fields that may be available regarding:

> ***Product:*** Specific product involved in the injury e.g. Brand X shampoo, Brand Y trampoline, Brand Z scooter.
>
> ***Safety Equipment:*** Safety devices in use or absent when injury occurred e.g. wearing steel toe capped boots, not wearing seatbelt, mouthguard used, airbag, child resistant packaging.

Similarly, there may be more information entered here in the case of infectious disease e.g.

> ***Duration of symptoms***
>
> ***Overseas travel***
>
> ***Contact with infection***

UK

CLINICAL

1.3.4 EmCare_Diagnosis

Diagnoses of the patient, in order of their relevance to the emergency presentation.

Layout

Alphanumeric 255 characters SNOMED + XML

Source

NHS Data Dictionary

Reported for

All presentations

Description

Up to 5 diagnosis codes will be accepted.

The order of diagnosis should reflect the relevance each diagnosis to the current presentation – if a patient with heart failure secondary to ischaemic heart disease has a syncopal episode and falls fracturing their neck of femur, this is coded:

#NoF/Syncope/ CCF/IHD

Code set

A SNOMED subset list of approximately 500 terms will be used.

This SNOMED subset list will be published separately.

Each SNOMED subset diagnosis will be combined with a modifier.

The modifier allows the clinician to express the (un) certainty of the diagnosis.

The diagnostic codes should be presented as linked dropdown boxes or menu items to allow rapid hierarchical coding.

Diagnosis Moderator Code set

Descriptor	Code
Possible	3
Probable	6
Proven/ Certain	9 (default)

Provenance

The SNOMED subset list has been used in several hospitals in the last five years, and produces a high rate of coding with good quality data.

A full review of the options for a diagnosis coding system will be conducted as part of ECDS project.

NHSDD

CLINICAL

1.3.5 EmCare_Invest_Treat

Definition

Investigations and Treatments performed in the Emergency.

Layout

Alphanumeric – 255 characters. SNOMED + XML

Source

NHS Data Dictionary

Reported for

All presentations

Description

The code set combines investigations and treatments to make it easier to group these into similar categories to make it easier to code.

This information is currently used to capture the investigations and treatments that are thought to best predict the resource use, and this is used to determine remuneration on a patient by patient basis.

Code Set

Group	Investigation / Treatment	Code
Airway / Breathing	Oxygen/ entonox	[SNOMED CODE]
Airway / Breathing	Nebuliser/ spacer	[SNOMED CODE]
Airway / Breathing	NIV - CPAP / BiPAP	[SNOMED CODE]
Airway / Breathing	Oral / nasal airway	[SNOMED CODE]
Airway / Breathing	Sedation for agitation/ withdrawal	[SNOMED CODE]
Airway / Breathing	Procedural Sedation	[SNOMED CODE]
Airway / Breathing	ET intubation	[SNOMED CODE]
Airway / Breathing	General Anaesthesia	[SNOMED CODE]
Airway / Breathing	Chest drain/ aspiration	[SNOMED CODE]
Circulation	intravenous cannula	[SNOMED CODE]
Circulation	Intraosseous line	[SNOMED CODE]
Circulation	Infusion of fluids	[SNOMED CODE]
Circulation	ECG	[SNOMED CODE]
Circulation	Blood transfusion	[SNOMED CODE]
Circulation	Arterial line	[SNOMED CODE]
Circulation	Central line	[SNOMED CODE]
Circulation	Cardiopulmonary Resuscitation	[SNOMED CODE]

Circulation	External pacing	[SNOMED CODE]
Circulation	Defibrillation	[SNOMED CODE]
Circulation	Active rewarming/ cooling	[SNOMED CODE]
Circulation	Thrombolysis	[SNOMED CODE]
Pathology	Urinalysis	[SNOMED CODE]
Pathology	Urine C&S	[SNOMED CODE]
Pathology	Urine pregnancy test	[SNOMED CODE]
Pathology	Urinary catheter inserted	[SNOMED CODE]
Pathology	Biochemistry	[SNOMED CODE]
Pathology	Cardiac Troponin	[SNOMED CODE]
Pathology	Haematology	[SNOMED CODE]
Pathology	Blood G&S / XM	[SNOMED CODE]
Pathology	Blood culture	[SNOMED CODE]
Pathology	VBG / ABG	[SNOMED CODE]
Pathology	Lumbar puncture	[SNOMED CODE]
Radiology	General X-rays	[SNOMED CODE]
Radiology	ultrasound	[SNOMED CODE]
Radiology	CT scan	[SNOMED CODE]
Radiology	MR scan	[SNOMED CODE]
Radiology	Interventional radiology	[SNOMED CODE]
Woundcare	Clean & dress	[SNOMED CODE]
Woundcare	Clean & glue	[SNOMED CODE]
Woundcare	Clean & staple	[SNOMED CODE]
Woundcare	Local anaesthetic	[SNOMED CODE]
Woundcare	Clean & suture < 10cm	[SNOMED CODE]
Woundcare	Clean & suture > 10cm	[SNOMED CODE]
Woundcare	Removal of FB	[SNOMED CODE]
Woundcare	Removal of sutures/ staples	[SNOMED CODE]
Woundcare	Tetanus booster	[SNOMED CODE]
Woundcare	Tetanus immunoglobulin	[SNOMED CODE]
Trauma / orthopaedic	Splint / bandage	[SNOMED CODE]
Trauma / orthopaedic	Crutches/ frame/ stick	[SNOMED CODE]
Trauma / orthopaedic	Sling / collar and cuff	[SNOMED CODE]
Trauma / orthopaedic	Plaster of paris	[SNOMED CODE]
Trauma / orthopaedic	Removal of plaster	[SNOMED CODE]
Trauma / orthopaedic	Manipulation # upper limb	[SNOMED CODE]
Trauma / orthopaedic	Manipulation # lower limb	[SNOMED CODE]
Trauma / orthopaedic	Manipulation of dislocation	[SNOMED CODE]
Trauma / orthopaedic	Regional block / intravenous regional	[SNOMED CODE]

	anaesthesia	
Trauma / orthopaedic	Joint aspiration	[SNOMED CODE]
Consultations	Mental capacity assessment	[SNOMED CODE]
Consultations	Overdose/ DSH psychiatric assessment	[SNOMED CODE]
Consultations	Social work assessment	[SNOMED CODE]
Consultations	Occupational / physiotherapy assessment	[SNOMED CODE]
Consultations	Hospital security/ Police	[SNOMED CODE]
No investigations / treatments	No investigations / treatments	[SNOMED CODE]
Medications	oral / sublingual	[SNOMED CODE]
Medications	nasal / ear / eye	[SNOMED CODE]
Medications	per rectum	[SNOMED CODE]
Medications	intramuscular/ subcutaneous	[SNOMED CODE]
Medications	intravenous	[SNOMED CODE]
Medications	intravenous infusion	[SNOMED CODE]
Medications	TTO	[SNOMED CODE]

1.4 Patient Injury

Column	Datatype	Size	Comments
EmCare_Inj_DateTime	DATETIME	19	
EmCare_Inj_Place_LatLong	ALPHA	50	XML, Local only
EmCare_Inj_Place_Exact	ALPHA	255	Free text
EmCare_Inj_Place_Type	ALPHA	2	
EmCare_Inj_Activity	ALPHA	18	SNOMED
EmCare_Inj_Mechanism	ALPHA	2	
EmCare_Inj_Drug_Alcohol	ALPHA	255	SNOMED/ DMD/ XML [TBC]
EmCare_Inj_Intent	ALPHA	2	

Injury data has been collected in a piecemeal way in the UK, driven by particular focuses on particular injuries e.g. road trauma, major trauma, assault, firework injuries, injuries due to alcohol/ violence, domestic violence, sporting injuries, safeguarding-related injuries. Because these injury data collection mechanisms have been single focus, they have often relied on clerical staff remembering to tick a box, rather than being integrated into the workflow.

The ECDS represents an opportunity to step back and re-think the way that this injury-related data is collected. It is an opportunity to replace these disparate data sets with a single more efficient and consistent proven way of recording data. This would satisfy the needs of these stakeholders and provide information that would allow Public Health England to judge how to best avoid injury, which is a leading cause of loss of productive life years.

This injury data set described here is derived from combining the injury dataset from the Victorian (Australia) Emergency Minimum Dataset (VEMD)[7] with the European 'Joint Action for Minimisation of Injuries in Europe' (JAMIE)[8] project which states that all countries should collect Emergency Department injury data by 2015.

In the UK and in Victoria, *clinical* staff are tasked with collecting this data, however there is no clinical expertise required to ask these questions and interpret the answers. Over the past five years a multidisciplinary group from the Royal College of Emergency Medicine, Public Health England, the Royal Society for the Prevention of Accidents have worked together to find alternative ways of collecting the data that would also minimise the burden on clinical staff.

Two methods were trialled – using clerical staff to enter the data, and using a kiosk to allow patients to enter the data. As a result of these trials we believe that asking clerical staff to collect this data is the most effective and efficient method of collecting this data.

[7] http://www.health.vic.gov.au/hdss/vemd/

[8] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3733502/

UK

CLERICAL

1.4.1 EmCare_Inj_DateTime

Definition

The date and time that the injury occurred, estimated if necessary.

Layout

Datetime, 19 Characters

Source

NHS Data Dictionary

Reported for

Presentations where the first diagnosis code is an injury code.

Description

This data item is currently collected as part of the 'Information Sharing to Tackle Violence'.

This item could be collected from ambulance EPR where available.

NEW

CLERICAL

LOCAL

1.4.2 EmCare_Inj_Place_LatLong

Definition

The latitude and longitude of the exact place at which the injury occurred.

Layout

50 Characters, with XML around latitude and longitude.

Source

NHS Data Dictionary, Local only

Reported for

Optional for presentations where the first diagnosis code is an injury code.

Description

Should be collected by clerical rather than clinical staff.

Could be implemented using mapping software e.g. Google Maps geocoding API[9] to allow rapid accurate estimation of locality of injury.

Alternatively this data may be directly collected from the ambulance service EPR / satellite navigation data.

[9] http://code.google.com/apis/maps/documentation/geocoding/

NHSDD

CLERICAL

1.4.3 EmCare_Inj_Place_Exact

Definition

Description of the exact locality at which the injury occurred.

Layout

255 Characters, alphanumeric.

Source

NHS Data Dictionary

Reported for

Optional for presentations where the first diagnosis code is an injury code.

Description

Not a description of the exact location on the body affected by the injury.

Example: "10 metres outside the Kings Head pub in Lower Loxley".

Should be collected by clerical rather than clinical staff.

Is part of the current 'Information Sharing To Tackle Violence' dataset.

UK

CLERICAL

1.4.4 EmCare_Inj_Place_Type

Definition

The type of location at which the person was present when the injury occurred.

Layout

Alphanumeric, 2 Characters

Source

NHS Data Dictionary

Reported for

Presentations where the first diagnosis code is an injury code.

Code set

Code	Descriptor	Includes	Excludes
11	Home	House, home premises, farm house, non-institutional place of residence, apartment, flat, boarding house, caravan park (resident), private: driveway to home, garage, garden/yard or home, path to home, swimming pool in private house, garden.	Institutional place of residence Abandoned or derelict house Home under construction and not yet occupied
12	Residential institution	Children's home, orphanage, home for the sick, residential home, nursing home, old people's home, hospice, military camp, prison	Hospital
21	Medical service area	Hospital, clinic, GP surgery	Hospice, Nursing Home
31	School, educational area	School (state or private), college, university, institution for higher education, kindergarten/ pre-school. Includes sports activities within school grounds undertaken as part of education	Hospital Recreation area Sports area, Trade or service area Building under construction Residential institution
41	Athletics and sports area	Cricket ground, football, hockey field, riding school, basketball court, golf course, stadium, skating rink, tennis, squash court, swimming pool	Education
51	Road, street or motorway	Motorway, A road, B road, minor road, footpath,	Private driveway (Home)
61	Industrial or construction area	Any building under construction, industrial yard, workshop, dry dock, dock yard, factory building/ premises, gasworks, oil rig & other offshore installation, power station (coal/nuclear/oil), shipyard, mine, quarry	
64	Farm	Farm buildings and land	Farmhouse (H)
71	Licensed premises	Bar, pub, restaurant, hotel bar area, casino, café (licensed)	Hotel accommodation area (Trade or service area)

72	Trade or service area	Bank, petrol station, supermarket, airport, café (unlicensed), garage (commercial), petrol station, hotel, market, office building, radio or television station, service station, shop (commercial), shopping mall, station (bus/rail), warehouse.	Garage in private home (Home) Area serving alcohol (Licensed Premises)
81	Public/ recreational area	Buildings and adjacent grounds used by the general public or by a particular group of the public such as: assembly hall, public hall, church, clubhouse, court house, post office, day care centre, youth centre, gallery, library, museum, cinema, theatre, opera house, concert hall, dance hall, campsite, caravan site, public park, public playground, holiday park, theme park and zoo	Sports, Educational Large national park
82	Countryside/ Beach/ Sea	Forest, hill, mountain, large national park, water reservoir, lake, pond, canal, marsh, river, stream, beach, sea, seashore	
97	Other specified place	Abandoned or derelict house, military training ground, car park, railway line,	
98	Not Applicable	[non-injury main diagnosis]	
99	Unspecified place	Unspecified place of occurrence	

Description

Report the code which best characterises the location where the patient was situated at the time the injury occurred, on the basis of the information available at the time it is recorded.

Wherever possible, the coding should reflect the organisational area of responsibility e.g.

Sports area in a school grounds – code as 'school'

Lake on an historic National Trust estate– code as 'recreational area'

If two or more categories are equally appropriate, select the code sequenced first in above code list.

NHSDD

CLERICAL

1.4.5 EmCare_Inj_Activity

Defintion

The type of activity being undertaken by the person at the moment the injury occurred.

Layout

Alphanumeric SNOMED, 18 Characters

Source

SNOMED

Reported for

Presentations where the first diagnosis code is an injury code.

The codes should be presented as linked dropdown boxes to allow rapid hierarchical searching.

Code set

Group	Descriptor	Code
Road Traffic Collision	RTC Pedestrian	[SNOMED CODE]
Road Traffic Collision	RTC Cyclist	[SNOMED CODE]
Road Traffic Collision	RTC Motorcycle rider	[SNOMED CODE]
Road Traffic Collision	RTC Motorcycle passenger	[SNOMED CODE]
Road Traffic Collision	RTC Motor Vehicle Driver	[SNOMED CODE]
Road Traffic Collision	RTC Motor Vehicle Passenger (not public transport)	[SNOMED CODE]
Road Traffic Collision	RTC Motor Vehicle passenger (public transport)	[SNOMED CODE]
Road Traffic Collision	RTC Other specified (not motorsport)	[SNOMED CODE]
Working/ Education	Working for Income	[SNOMED CODE]
Working/ Education	Voluntary work	[SNOMED CODE]
Working/ Education	Other work	[SNOMED CODE]
Working/ Education	Education (student)	[SNOMED CODE]
Working/ Education	Education (teacher)	[SNOMED CODE]
Working/ Education	Professional sports	[SNOMED CODE]
Institutional care	Prison / custodial / detention centre / police custody	[SNOMED CODE]
Institutional care	Being nursed/ cared for in residential facility	[SNOMED CODE]
Institutional care	Looked after child	[SNOMED CODE]

Leisure	walking outside house	[SNOMED CODE]
Leisure	shopping	[SNOMED CODE]
Leisure	food consumption	[SNOMED CODE]
Leisure	entertainment	[SNOMED CODE]
Leisure / at home	food preparation	[SNOMED CODE]
Leisure / at home	food consumption	[SNOMED CODE]
Leisure / at home	In lounge/ sitting room	[SNOMED CODE]
Leisure / at home	using electronic device	[SNOMED CODE]
Leisure / at home	in bedroom/ sleeping	[SNOMED CODE]
Leisure / at home	Gardening	[SNOMED CODE]
Leisure / at home	bathing/ showering	[SNOMED CODE]
Leisure / at home	ascending / descending stairs	[SNOMED CODE]
Leisure / at home	DIY/ garage / workshop	[SNOMED CODE]
Leisure / at home	Play	[SNOMED CODE]
Leisure / at home	Crafts and hobbies	[SNOMED CODE]
Leisure / at home	Walking indoors	[SNOMED CODE]
Leisure / at home	Walking outdoors	[SNOMED CODE]
Sports - Ball	Football	[SNOMED CODE]
Sports - Ball	Rugby Union	[SNOMED CODE]
Sports - Ball	Rugby League	[SNOMED CODE]
Sports - Ball	Netball	[SNOMED CODE]
Sports - Ball	Basketball	[SNOMED CODE]
Sports - Ball	Cricket	[SNOMED CODE]
Sports - Ball	Hockey	[SNOMED CODE]
Sports - Ball	Baseball/ Softball	[SNOMED CODE]
Sports - Ball	Badminton	[SNOMED CODE]
Sports - Ball	Tennis	[SNOMED CODE]
Sports - Ball	Squash	[SNOMED CODE]
Sports - Ball	Lacrosse	[SNOMED CODE]
Sports - Ball	Other ball sport	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Running/ jogging	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Aerobics	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Trampoline	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Gymnastics (not trampoline)	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Weightlifting/ Strength building	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Indoor gym equipment	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Combat sports	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Cycling	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Skateboarding	[SNOMED CODE]

Sports - Running/ Gym/ Wheeled	Rollerblades/ skates	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Motorsports - off-road 3 or 4 wheeled	[SNOMED CODE]
Sports - Running/ Gym/ Wheeled	Motorsports - off-road 2 wheeled	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Ice-skating (inc. ice hockey)	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Skiing	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Snowboarding	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Swimming	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	SCUBA diving (recreational)	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Watersports – non-motorised	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Watersports – motorised	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Horse-riding	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Golf	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Climbing/ mountaineering/ caving	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Hiking / hill-walking	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Air sports - motorised	[SNOMED CODE]
Sports - Winter/ Water/ Outdoor	Air sports - non-motorised	[SNOMED CODE]
Not applicable	Not applicable	[SNOMED CODE]

Description

If two or more categories are equally appropriate, select the code sequenced first in above code list.

This is particularly relevant in the case of Road Traffic Collisions, when the person may have been working for income. In these cases, code as the relevant RTC.

NHSDD

CLERICAL

1.4.6 EmCare_Inj_Mechanism

Definition

How the injury was caused.

Layout

Alphanumeric, 2 Characters

Source

NHS Data Dictionary

Reported for

Presentations where the first diagnosis code is an injury code.

Code set

Code	Descriptor
11	Fall/ slip/ trip – LOW (< 1 metre, or no information)
12	Fall/ slip/ trip – HIGH (> 1 metre)
21	Blunt force/ pushed
22	Blow from object
23	Punched and/or kicked
29	Crushing injury
30	Stabbed/ cut with knife
31	Stabbed/ cut with glass object
32	Cutting, piercing by other sharp object
33	Shot by firearm/ air driven weapon
36	Shot by other weapon
38	Explosion
41	Burn - thermal
42	Burn – electrical
43	Burn – chemical/ radiation
51	Poisoning/ overdose
61	Drowning/ near drowning
62	Threat to breathing – inhaled object/ substance
63	Threat to breathing – hanging or strangling
64	Threat to breathing – object covering mouth
71	Physical over-exertion
72	Hypothermia/ Hyperthermia

97	Other specified
98	Not applicable – non injury
99	Unspecified external cause

Notes

These data items incorporate the data items already collected as part of the 'Information Sharing to Tackle Violence' data set.

NHSDD

CLERICAL

1.4.7 EmCare_Inj_Drug_Alcohol

Definition

Use of drugs or alcohol by the patient, which are thought likely to have contributed to the need to attend the ED.

Layout

Alphanumeric 255 characters – SNOMED/ DMD + XML

Source

SNOMED / Dictionary of Medicine and Devices

[To Be Confirmed]

Reported for

Presentations where the first diagnosis code is an injury code.

Description

'Prescription' drug includes all officially packaged medication, which may or may not have been legitimately dispensed to the person who has taken it.

Code Set

Code	Descriptor
[SNOMED CODE]	Alcohol
[SNOMED CODE]	Heroin (street drug)
[SNOMED CODE]	Cocaine/ Crack (street drug)
[SNOMED CODE]	Marijuana
[SNOMED CODE]	Amphetamine/ Meth/ Ice (sreet drug)
[SNOMED CODE]	Ecstasy (street drug)
[SNOMED CODE]	GHB/ GBL (steet drug)
[SNOMED CODE]	Legal High
[SNOMED CODE]	Other street drug
[SNOMED CODE]	Paracetamol
[SNOMED CODE]	Aspirin
[SNOMED CODE]	Benzodiazepine (prescription)
[SNOMED CODE]	Opiate (prescription)
[SNOMED CODE]	Non-TCA antidepressant (prescription)
[SNOMED CODE]	Tricyclic antidepressant (prescription)
[SNOMED CODE]	Other prescription drug
[SNOMED CODE]	Not Applicable – not injury code
[SNOMED CODE]	Unknown drug

1.4.8 EmCare_Inj_Intent

UK

CLERICAL

Definition

Most likely **human** intent in the occurrence of the injury or poisoning as assessed by clinician.

Layout

Number, 2 Characters

Source

NHS Data Dictionary

Reported for

Presentations where the first diagnosis code is an injury code.

Description

The issue is the intent to produce the injury, **not** the intent to undertake an activity that may have happened to result in injury.

If more than one category is judged to be equally appropriate, select the one listed first in the code set.

A dog used intentionally as a weapon would be coded according to the human intent.

Code Set

Code	Descriptor
11	Non-intentional harm
21	Intentional self-harm
31	Complication of medical care
41	Apparent Assault
61	Animal related e.g. dog bite
91	Intent deliberately withheld
97	Other specified intent e.g. euthanasia
98	Not Applicable – not injury code
99	Intent not specified

Provenance

Victorian Emergency Minimum Dataset (VEMD) and Joint Action to Minimise Injury in Europe (JAMIE) datasets.

1.5 Patient Discharge

Column	Datatype	Size	Comments
EmCare_Discharge_Status	ALPHA	2	
EmCare_Discharge_Referred	ALPHA	2	
EmCare_Discharge_Medication	ALPHA	255	?SNOMED / DM+D / XML (TBC)
EmCare_Discharge_Instructions	ALPHA	255	
EmCare_Discharge_GP_Letter	ALPHA	1	Autofill
EmCare_Discharge_Safeguarding	ALPHA	2	
EmCare_Discharge_Transfer_Destination	ALPHA	9	Organisation Data Services (ODS) code

NHSDD

CLINICAL

1.5.1 EmCare_Discharge_Status

Definition

Patient status or destination on discharge from the Emergency Department.

Layout

Number, 2 Characters, linked dropdown boxes

Source

NHS Data Dictionary

Reported for

All presentations.

Code set

Category	Descriptor	Code
Discharged	Home	11
Discharged	Residential care facility inc. Residential Home, Nursing Home	12
Discharged	Police/ Prison/ Custody Facility	15
Admitted	Ward – physical ward bed outside ED	21
Admitted	Virtual ward e.g. 'hospital in the home'	22
Admitted	High Dependency Unit/ Coronary Care Unit (Level 2)	31
Admitted	Intensive Care Unit (Level 3)	35
Admitted	Observation/ Short stay/ CDU managed by ED	41
Admitted	Transfer to another hospital	55
Left before treatment complete	Left at own risk after treatment started	61
Left before treatment complete	Left after advice about treatment options	65
Left before treatment complete	Left at own risk, without treatment	67
Died / Other	Died in the Emergency Department	81
Died / Other	Dead on arrival	82
Died / Other	Unspecified	99

Description

Used to identify the **immediate** destination or departure status of the patient upon departure from the ED. This may not necessarily be to the patient's usual place of residence.

Should be presented as two linked drop down boxes to allow rapid coding.

Home

Includes:

- house, flat, boarding/rooming house, hotel, caravan, youth hostel accommodation
- homeless person's shelters, refuges
- no fixed abode.

Excludes all accommodation described in remainder of this code set.

Residential care facility

Includes: nursing home, hostel, psychogeriatric nursing home, residential care respite bed and nursing home beds which are located within an acute or sub-acute hospital campus

Correctional / Custodial Facility

Includes detention centres, prison hospitals and forensic Mental Hospitals.

Ward

Includes patients who are admitted to a physical ward after attending the ED at the same hospital, and those patients who attend the ED from an inpatient ward at the same hospital and then return to the ward. *Includes* Medical/ Surgical Assessment Unit. *Excludes* Virtual Ward beds, ICU, HDU, CCU.

Virtual Ward

'Hospital in the Home' - an arrangement whereby a patient is kept as a nominal inpatient, managed as an outpatient with arranged reviews and may be readmitted if deterioration e.g. cellulitits, DVT.

Emergency Department Short Stay/ Observation Unit/ Clinical Decision Unit

Excludes Medical Assessment Unit and equivalent)

Another hospital campus (also record Transfer Destination)

Excludes correctional facility hospital (use 'Correctional/Custodial facility').

Left at own risk, after treatment started

Patient leaves the Emergency Department after being assessed by a doctor or Emergency Nurse Practitioner but before treatment has been completed, despite being advised by clinical staff NOT to leave. The appropriate hospital forms must be completed and signed by the patient.

Left after clinical advice regarding treatment options

At or subsequent to clinical assessment, the patient has received advice about the Emergency Department and alternative treatment options. On consideration of this advice, the patient chooses to leave the ED without a doctor or Emergency Nurse Practitioner completing assessment and treatment of their condition in the ED.

Left at own risk, without treatment

Patient leaves the Emergency Department before def assessed or treated doctor or Emergency Nurse Practitioner completing assessment and treatment of their condition in the ED. This may occur either:

- Without notifying staff; OR
- Despite being advised by clinical staff NOT to leave; OR
- Without receiving advice about alternatives to treatment in the Emergency Department

Common descriptions include: Did Not Wait, DNW, Failed To Answer, FTA.

71: Died Within ED

Patient died after commencement of ED presentation. Includes where there is an intention to resuscitate but the patient is later pronounced dead.

***72:* Dead on Arrival**

Patient is pronounced dead/life extinct by a medical practitioner or ambulance staff before (or without) being brought into the ED or where the patient is bought into the ED but there is no intention to resuscitate.

To enable consistent cross-validation with other codes in the future, reserve

- block 11-20 for discharged patients
- block 21-59 for all admitted patients
- block 60-99 for all other codes

NHSDD

CLINICAL

1.5.2 EmCare_Discharge_Referred

Definition

The agency to which the patient was referred for continuing care following their ED attendance.

Layout

Number, 2 Characters

Source

NHS Data Dictionary

Reported for

All presentations where patient discharged from ED

Code set

Descriptor	Code
GP	11
Review in ED – Scheduled	21
Ambulatory Care Service	25
Outpatients	31
Medical Specialist (private)	41
Dentist	42
Physiotherapy	45
Community psychiatric support services	47
Other community service	97
No referral	98
Not known	99

Description

In most cases the patient will be referred back to their GP for further management and co-ordination of care.

[N.B. codes kept clear between 50 - 80 to allow codes to be used from Discharge_Status for EDSSS recording]

UK

LOCAL

CLINICAL

1.5.3 EmCare_Discharge_Medication

Definition

Medications started in the ED with which the patient is discharged.

Layout

Alphanumeric, 255 characters

?SNOMED/ DMD/ XML (TBC)

Source

Local

Reported for

Optional.

Description

Free text description of medications on discharge - including the drug approved (generic) name, dose, frequency and duration

UK

LOCAL

CLINICAL

1.5.4 EmCare_Discharge_Instructions

Definition

Specific instructions relating to the patients discharge and follow up arrangements.

Layout

Alphanumeric, 255 Characters

Source

LOCAL

Reported for

All presentations

Description

Short free text description of the arrangements for follow-up following discharge from ED.

To be incorporated in the GP letter.

This is a normal component of the clinical letter. Specifying this as a separate field minimises the risk that follow up instructions are overlooked e.g. a fairly common discharge instruction is 'please refer this patient with a shadow on the X-ray to the respiratory team'.

1.5.5 EmCare_Discharge_GP_Letter

UK

NEW

Definition

Answers the question: "Has the GP a letter been printed and given to the patient?"

Layout

Alphanumeric, 1 Character

Source

Automatically recorded by EDIS when the letter is physically printed.

Reported for

All Patients.

Code set

Descriptor	Code
No	0
Yes , patient letter printed	1
N/A Patient does not have GP	9

Description

Implementation:

This field must be automatically completed by the IT system depending on the actions of the clinician.

This is designed to ensure that the patient is provided with a copy of the letter to the GP. This minimises the risk of miscommunication, and ensures that the patient always has a written follow up plan.

1.5.6 EmCare_Discharge_Safeguarding

NHSDD

CLINICAL

Definition

Identification of concerns regarding safeguarding during Emergency Department attendance.

Layout

Number, 2 Characters, linked dropdown boxes

Source

NHS Data Dictionary

Reported for

All attendances

Code set

Category	Descriptor: Concern regarding	Code
No safeguarding concern	No safeguarding concern	11
Child	Repeated Emergency Department attendances	21
Child	Delay in presentation to Emergency Department	23
Child	Concerning parent/ child interaction	31
Child	Worrying parental behaviour/ mental health	32
Child	Worrying child behaviour	33
Child	Bullying	41
Child	Self harm	42
Child	Significant injury	47
Child	Disclosure of abuse	50
Child	Possible drug use (inc legal highs)	61
Child	Possible alcohol use	62
Child	Possible grooming target	63
Child	Radicalisation	70
Child	Genital injury (not FGM)	71
Child	Female Genital Mutilation	72
Adult	Domestic Violence	80
Adult	Drug use	85
Adult	Alcohol use	86
Adult	Elder abuse	89

Description

Adapted from existing NHSDD codes 'Safeguarding Vulnerability Factors Type'.

Should be presented as two linked drop down boxes to allow rapid coding.

The question should be phrased as :

'Follow-up is requested regarding concerns of Emergency Department staff regarding :' .

NHSDD

CLERICAL

NEW

1.5.7 EmCare_Transfer_Destination

Definition

ODS code of the destination organisation.

Layout

Alphanumeric, 9 Characters

Source

NHS Data Dictionary Organisation Data Services

Reported for

All presentations where Discharge_Status is code 41 – Transfer to another hospital, irrespective of whether or not the patient is admitted at the sending hospital e.g. to Short Stay/ CDU/ Observation ward.

Description

If transferred to an overseas hospital, enter the first 10 letters of that country.

This data is routinely collected in specialties that routinely transfer patients from one hospital to another e.g. neonatology.

1.6 Clinician Demographics

Column	Datatype	Size	Comments
EMCare_Clinician	ALPHA	12	GMC/ NMC/ HCPC number, clinician responsible for discharging patient
EMCare_Clinician_Type	ALPHA	2	Code of grade/ type
EMCare_Doc_Review	ALPHA	12	GMC number of doctor responsible for reviewing/ signing off discharge of patient
EMCare_Doc_Review_Type	ALPHA	1	Code of grade/ type
EMCare_Consultant	ALPHA	12	GMC number, consultant responsible for patient episode

NHSDD

1.6.1 EmCare_Clinician

Definition

General Medical Council/ Nursing and Midwifery Council / Health & Care Professions Council number of the clinician responsible for discharging the patient.

Layout

Alphanumeric, up to 12 Characters

Source

NHS Data Dictionary

(current term = 'A and E Staff Member Code')

Reported for

All presentations, unless Discharge_Status = '61 - Left after clinical advice regarding treatment options' or '63 - Left at own risk, without treatment'.

Description

This would not be entered directly by the clinician but would be entered automatically by the EDIS based on the clinician who discharged the patient.

Clinician in this case is the last clinician who sees the patient who has the professional authority to perform **all** of the following functions:

- examine the patient,
- make a diagnosis,
- prescribe treatment and
- discharge the patient

Clinician is therefore either a doctor, Emergency Nurse Practitioner (which may also include other higher grades in the Nursing hierarchy e.g. Sister/ Matron/ Nurse Manager/ Nurse Consultant), Emergency Care Practitioner or Extended Scope Physiotherapist.

The discharging clinician is responsible for making sure that all treatment is complete, even if they did not initiate and conduct all treatment, and for completing coding and discharge documentation.

1.6.2 EmCare_Clinician_Type

UK

NEW

Definition

The Type/Grade of the treating clinician

Layout

Number, 2 Characters

Source

New

Reported for

All presentations, unless Discharge_Status = '61 - Left after clinical advice regarding treatment options' or '63 - Left at own risk, without treatment'.

Description

This would not be entered directly by the clinician but would be entered automatically by the EDIS based on the clinician who discharged the patient.

Clinician in this case is the last clinician who sees the patient who has the professional authority to perform **all** of the following functions:

- examine the patient,
- make a diagnosis,
- prescribe treatment and
- discharge the patient

Clinician is therefore either a doctor, Emergency Nurse Practitioner (which may also include other higher grades in the Nursing hierarchy e.g. Sister/ Matron/ Nurse Manager/ Nurse Consultant), Emergency Care Practitioner or Extended Scope Physiotherapist.

Code set

Descriptor	Tier	Code
Doctor – Consultant	6	11
Doctor – SAS/ Trust Grade/ Non training grade	5	21
Doctor – Registrar / Specialist Trainee ST4-6	5	31
Doctor – SAS/ Trust Grade/ Non training grade	4	21
Doctor – Specialist Trainee ST1-3	4	35
Doctor – FY2	3	41
Doctor – FY1	1	45
Nurse with extended skills e.g. Emergency Nurse Practitioner / Advanced Nurse Practitioner	2	51
Senior ENP/ ANP/ extended scope physiotherapist	3	55
Nurse Consultant	4	56
Physiotherapist	2	61
Emergency Care Practitioner	2	71

Job type description from Royal College of Emergency Medicine

Tier	What it means	Example
1	Require complete supervision	F1 doctors, trainee Emergency and Advanced Nurse Practitioners (ENP/ANP)
2	Able to practice independently within defined parameters, or within specific patient groups. Require access to direct supervision	ENPs / extended scope physiotherapists seeing only minor injuries, Physicians Assistants (PAs) and ANPs seeing only “majors,” some GPs practicing in EDs
3	Able to practice independently within defined parameters, but can see most patient groups. Require access to direct supervision	F2 doctors, CT1-2, some ENPs, some PAs and ANPs, some GPs
4	More senior / experienced clinicians, requiring less direct supervision	CT3 in EM, junior Speciality Doctors, some ANPs, some GPs
5	Senior clinicians able to supervise a department alone with remote support, possess some extended skills.	CT4 and above, senior Speciality Doctors
6	Senior clinicians with accredited advanced qualifications in EM/ full set of extended skills	Consultants in EM

UK

NEW

CLINICAL

1.6.3 EmCare_Doc_Review

Definition

GMC number of up to three middle grade/senior doctors who have treated the patient or reviewed the patient's treatment plan.

Layout

Alphanumeric, 50 Characters

XML container of up to three groups of up to 12 characters

[currently collected for specific conditions with sub-optimal compliance]

Source

NHS Data Dictionary

Reported for

Optional, unless Discharge_Status = '61 - Left after clinical advice regarding treatment options' or '63 - Left at own risk, without treatment', when should be blank.

Description

This may be the senior doctor with whom the primary treating clinician has discussed the patient's presentation, results and treatments. Alternatively this may be multiple consultants involved in a complex resuscitation or treatment.

This data is already collected in some circumstances (chest pain, fever in infants) as part of the quality metrics for emergency care, however because it is not part of routine data collection, it is collected inconsistently and is therefore of little value. Many ED systems already have the facility to collect this data as it is routinely collected in other countries.

There is good evidence that patients who have senior medical review have lower mortality. This metric will allow hospitals to understand and plan how to best use their senior staff.

UK

NEW

CLINICAL

1.6.4 EmCare_Doc_Review_Type

Definition

The Type/Grade of the most senior doctor who has reviewed the patient's treatment plan.

Layout

Alphanumeric, 1 Characters

Source

New

Reported for

Optional, unless Discharge_Status = '61 - Left after clinical advice regarding treatment options' or '63 - Left at own risk, without treatment', when should be blank.

Description

This records the level of medical seniority at which the patient treatment and discharge plan was made.

This would not be entered directly by the clinician but would be entered automatically by the EDIS based on the clinician who discharged the patient.

See above for the companion metric EmCare_Doc_Review.

Code set

Descriptor	Code
Consultant	1
SAS/ Trust Grade	4
Registrar / Specialist Trainee ST3-6	6
Specialist Trainee ST1-2	8
None	9

NHSDD

1.6.5 EmCare_Consultant

Definition

GMC number of the consultant responsible for the treatment episode.

Layout

Alphanumeric, up to 12 Characters

Source

NHS Data Dictionary

Reported for

All presentations.

Description

All treatment episodes are the responsibility of a named consultant. This data is already collected and there is NHS Data Dictionary terminology for this.

2 Appendices

Appendix 1: Abbreviations

ASCII	American Standard Code for Information Interchange
CCU	Coronary/Cardiac Care Unit
CDU	Clinical Decision Unit/ Observation Unit
DH	Department of Health
ED	Emergency Department
EDIS	Emergency Department Information System
EM	Emergency Medicine
GP	General Practitioner
ICD-10	International statistical Classification of Diseases and Related Health Problems, 10th Revision
ICU	Intensive Care Unit
LOS	Length of Stay
MAU	Medical Assessment Unit
OOH	Out of Hours
PHE	Public Health England
SNOMED-CT	Systematised Nomenclature Of MEDicine - Clinical Terms
SSU	Short Stay Unit/ Observation unit
XML	Extensible Markup Language – a computer-friendly way of tagging and organising information.

Appendix 2: Complete Dataset

Person details	Datatype	Size	Comments
Person_Given_Name	ALPHA	35	
Person_Family_Name	ALPHA	35	
Person_Stated_Gender	ALPHA	1	Dropdown box
Person_Birth_Date	DATE	10	DATE
Person_Age_At_Attendance	NUMBER	3	
Person_NHS_Number	NUMBER	10	
Person_NHS_Number_Status_Indicator	ALPHA	2	
Person_Local_Number	ALPHA	20	
Person_Local_Number_Org_Code	ALPHA	5	
Person_Address1	ALPHA	35	Local only
Person_Address2	ALPHA	35	Local only
Person_Postcode	ALPHA	10	Postcode
Person_Residence_Type	ALPHA	18	SNOMED, Dropdown box
Person_LSOA	ALPHA	10	Office of National Statistics
Person_Phone_Home	ALPHA	15	Local only
Person_Phone_Mobile	ALPHA	15	Local only
Person_Email	ALPHA	50	Local only
Person_GP_Practice_Code	ALPHA	6	NHS ODS GP code
Person_GP_Name	ALPHA	50	Alphanumeric – dropdown box
Person_GP_Phone	ALPHA	15	Alphanumeric – derived from GP name
Person_GP_Email	ALPHA	50	Alphanumeric – derived from GP name
Person_Comm_Lang	ALPHA	18	SNOMED or NHSDD/ ISO
Person_Interpreter_Rqd	ALPHA	18	SNOMED or NHSDD/ ISO
Person_Ethnic_Category	ALPHA	2	NHS PDS list
Person_School	ALPHA	50	Local only, free text
Person_Next_of_Kin	ALPHA	50	Local only
Person_NoK_Contact	ALPHA	50	Local only, phone number or other contact
Person_Companion	ALPHA	100	Local only, carer or guardian with person
Person_Adverse_Reaction	ALPHA	255	Local only, SNOMED/ XML
Person_Special_Patient_Note	ALPHA	1000	Local only, free text
Person_Comorbidities	ALPHA	255	SNOMED/ XML from SCR
Person_Current_Meds	ALPHA	255	SNOMED/ XML from SCR

Episode details	Datatype	Size	Comments
EmCare_Site_Code	ALPHA	9	NHSDD (Organisation Data Service)
EmCare_Site_Type	ALPHA	1	
EmCare_Unique_ID	NUMBER	12	Unique, zero-filled
EmCare_Arrive_Transport_Mode	ALPHA	2	dropdown box
EmCare_Amb_Incident_Number	ALPHA	20	
EmCare_Arrive_DateTime	DATETIME	19	
EmCare_Visit_Type	ALPHA	2	dropdown box
EmCare_Referred	ALPHA	2	dropdown box
EmCare_Arrive_Transfer_Source	ALPHA	9	NHSDD (Organisation Data Service)
EmCare_Assess_DateTime	DATETIME	19	
EmCare_CPR_Chk	ALPHA	1	Tickbox / autofill
EmCare_GP_SCR_Chk	ALPHA	1	Tickbox / autofill
EmCare_Clinician_DateTime	DATETIME	19	
EmCare_RefOpinion_DateTime	DATETIME	19	
EmCare_RefAdmission_DateTime	DATETIME	19	
EmCare_Referred_Service	ALPHA	18	Dropdown box, SNOMED
EmCare_Complete_DateTime	DATETIME	19	
EmCare_Depart_DateTime	DATETIME	19	
EmCare_Depart_Specialty	ALPHA	18	?SNOMED/ ?DD Treatment Function Codes
Clinical details	**Datatype**	**Size**	**Comments**
EmCare_Presentation_Acuity	ALPHA	1	
EmCare_Presentation_ChiefComplaint	ALPHA	18	SNOMED
EmCare_Clinical_Narrative	ALPHA	1500	Free text
EmCare_Diagnosis	ALPHA	255	SNOMED / XML
EmCare_Diagnosis_Modifier	ALPHA	1	
EmCare_Invest_Treat	ALPHA	255	SNOMED / XML
Injury details	**Datatype**	**Size**	**Comments**
EmCare_Inj_DateTime	DATETIME	19	
EmCare_Inj_Place_LatLong	ALPHA	50	XML, Local only
EmCare_Inj_Place_Exact	ALPHA	255	Free text
EmCare_Inj_Place_Type	ALPHA	2	
EmCare_Inj_Activity	ALPHA	18	SNOMED
EmCare_Inj_Mechanism	ALPHA	2	
EmCare_Inj_Drug_Alcohol	ALPHA	255	SNOMED/ DMD/ XML [TBC]
EmCare_Inj_Intent	ALPHA	2	
Discharge details	**Datatype**	**Size**	**Comments**

EmCare_Discharge_Status	ALPHA	2	
EmCare_Discharge_Referred	ALPHA	2	
EmCare_Discharge_Medication	ALPHA	255	?SNOMED / DM+D / XML (TBC)
EmCare_Discharge_Instructions	ALPHA	255	
EmCare_Discharge_GP_Letter	ALPHA	1	Autofill
EmCare_Discharge_Safeguarding	ALPHA	2	
EmCare_Discharge_Transfer_Destination	ALPHA	9	Organisation Data Services (ODS) code
EMCare_Clinician	ALPHA	12	GMC/ NMC/ HCPC number, clinician responsible for discharging patient
EMCare_Clinician_Type	ALPHA	2	Code of grade/ type
EMCare_Doc_Review	ALPHA	12	GMC number of doctor responsible for reviewing/ signing off discharge of patient
EMCare_Doc_Review_Type	ALPHA	1	Code of grade/ type
EMCare_Consultant	ALPHA	12	GMC number, consultant responsible for patient episode