



Government of **Western Australia**
Department of **Health**

Synthetic Unlinked Emergency Department Data Collection Data Dictionary

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Abbreviations

DoH	Department of Health
EDDC	Emergency Department Data Collection
EDIS	Emergency Department Information System
GP	General Practitioner
HITH	Hospital In The Home
ICD-10-AM	International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification
PAS	Patient Administration System
SJOGM	St John of God Midland Public Hospital*
SSU	Short Stay Unit
WA	Western Australia
webPAS	Web-based Patient Administration System * SJOGM uses a private version of webPAS, referred to as Midland webPAS

1. Purpose

The purpose of the synthetic Emergency Department Data Collection Data Dictionary is to detail the data elements captured in the synthetic Emergency Department Data Collection (EDDC) unlinked representative synthetic data. Background

The generation of synthetic emergency department data by the Department of Health is dependent on good quality data entered into the collection at the source

The generation of EDDC synthetic data at the Department of Health is performed in accordance with the data definitions.

The scope of the synthetic EDDC data is record of presentations at Emergency Departments between 01/01/2022 and 31/12/2022. Synthetic instances that are close to the source data have been removed to protect the patients' privacy. Data definitions

The following section provides specific information about data elements captured in the synthetic EDDC, including definitions, permitted values, guide for use, rules and operational examples.

All information relating to data elements in this data dictionary is specific to the synthetic EDDC and caution should be taken if these data elements are compared with those of other data collections.

Where relevant, related national definitions have been referenced. The Department of Health Western Australia acknowledges the assistance of the Australian Institute of Health and Welfare (AIHW) for services provided in relation to METeOR, Australia's repository for national metadata standards for the health, community services, early childhood, homelessness and housing assistance sectors, which is owned by the AIHW.

Person Identifier

Field Name:	synth_person_ID
Definition:	The identifier generated for synthetic data.
Data Type:	String
Format:	X(10)
Permitted Values:	N/A

Guide for use

This data element is synthesized by the DoH and used for synthetic data only.

Age Range

Field Name:	age
Definition:	Patient age at the time of presentation.
Data Type:	Numeric
Format:	N(2)
Permitted Values:	N/A

Guide for use

Ages are grouped in 5-year brackets and displayed as the lowest number in the bracket

Ages between 0-4 Age in data set = 0

Ages between 5-9 Age in data set = 5

Ages between 10-14 Age in data set = 10

Ages between 15-19 Age in data set = 15

Ages between 20-24 Age in data set = 20

Ages between 25-30 Age in data set = 25

Continuing up to age 100.

Examples

	Recorded Age
A patient aged 87 at time of presentation	85
A patient aged 24 at time of presentation	20
A patient aged 9 months at time of presentation	0

Sex recorded at birth, code

Field Name:	Sex
Definition:	A person's sex recorded at birth based upon their sex characteristics.
Data Type:	String
Format:	N(1)
Permitted Values:	1 Male 2 Female

Guide for use

The collection of Sex is mandatory.

Sex is often used interchangeably with gender, however they are distinct concepts and it is important to differentiate between them.

When comparing the concepts of sex and gender:

- Sex is understood in relation to sex characteristics.
- Gender is about social and cultural differences in identity, expression and experience.

Sex recorded at birth is important clinical information and must be collected for all patients. To ensure accuracy and consistency of data collection, gender diverse patients must still report their sex recorded at birth and their current gender in the gender field.

Examples

	Sex
A patient presented to ED and discloses their sex recorded at birth is male.	1 – Male
A patient presented to ED discloses that their sex recorded at birth is male but they currently identify as a female.	1 – Male

Aboriginal Status

Field Name:	ethnicity
Definition:	A person's Aboriginal status.
Data Type:	String
Format:	N(1)
Permitted Values:	1 Aboriginal but not Torres Strait Islander origin 2 Torres Strait Islander but not Aboriginal origin 3 Both Aboriginal and Torres Strait Islander origin 4 Not Aboriginal or Torres Strait Islander origin 9 Unknown

Guide for use

There are three components to the Commonwealth definition of Aboriginal or Torres Strait Islander: descent, self-identification, and community acceptance. In practice, it is not feasible to collect information on community acceptance in general purpose data collections. Therefore, standard questions on Aboriginal status relate to descent and self-identification only.

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal peoples are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

Examples

	Aboriginal Status
A person who identifies as Aboriginal attends the Hospital ED.	1 Aboriginal but not Torres Strait Islander origin
A person who is a descendant of both Aboriginal and Torres Strait Islander origin and identify as both Aboriginal and Torres Strait Islander attends Hospital ED.	3 Both Aboriginal and Torres Strait Islander origin

Triage Category

Field Name:	triage_category
Definition:	The urgency of the patient's need for medical and nursing care, as represented by a code.
Data Type:	String
Format:	N(1)
Permitted Values:	<ul style="list-style-type: none"> 1 Resuscitation: immediate (within seconds) 2 Emergency: within 10 minutes 3 Urgent: within 30 minutes 4 Semi-urgent: within 60 minutes 5 Non-urgent: within 120 minutes

Guide for use

The collection of Triage category is Mandatory.

A patient must have a triage assessment completed as soon as possible on arrival, to enable them to be prioritised on the basis of illness or injury severity and their need for medical and nursing care.

The patient must be assigned a triage category based on the Australasian Triage Scale (ATS). The triage category cannot be retrospectively changed to another category except under exceptional circumstances, for example, if the patient's condition deteriorates during the course of their episode and a second triage assessment was conducted to reflect a different triage category.

Examples

	Aboriginal Status
A person arrived ED by ambulance and sent to resuscitation directly.	1 Resuscitation: immediate (within seconds)

Establishment Code

Field Name:	establishment_code
Definition:	A unique four-digit number that is assigned by Department of Health (WA) to hospitals and other health related locations or establishments.
Data Type:	Numeric
Format:	N(4)
Permitted Values:	N/A

Guide for use

An establishment refers to an authorised/accredited physical location where patients can receive health care and stay overnight. This includes acute hospitals, residential aged care and nursing homes, rehabilitation and residential mental health facilities. For the purposes of reporting and other business requirements, virtual hospitals, same-day clinics, surgeries, nursing posts, detention centres or prisons may also be assigned an establishment identifier.

Presentation Date Time

Field Name:	presentation_datetime
Definition:	The date and time the patient first arrives at the Emergency Department earlier of Arrival Date and Triage Date.
Data Type:	Date / Time
Format:	DD/MM/YYYY HH:MM:SS
Permitted Values:	N/A

Guide for use

Presentation Datetime is the earliest point of contact within an emergency department. It is derived from the earlier of Arrival Datetime and Triage Datetime. It is the reference period for all Emergency department local reporting. (National reporting uses the Discharge Datetime as the reference period).

Clinical Care Commencement Datetime

Field Name:	clinical_care_commencement_datetime
Definition:	Time clinical care commenced by medical or health practitioner.
Data Type:	Date / Time
Format:	DD/MM/YYYY HH:MM:SS
Permitted Values:	N/A

Guide for use

This is a calculated field in the EDDC based on the actual time the patient was seen by the doctor or health practitioner.

Examples

	Clinical Care Commencement Datetime
Patient was seen by a nurse in a rural health establishment on 14 October 2021 at 1:45pm.	14/10/2021 13:45:00
Patient was seen by a doctor in metro ED t on 14 October 2021 at 1:45pm.	14/10/2021 13:45:00

Bed Request Datetime

Field name:	bed_request_datetime
Definition:	Date and time that an inpatient bed is requested for a patient.
Data type:	Datetime
Format:	DD/MM/YYYY HH:MM:SS
Permitted values:	N/A

Guide for use

The time when bed request is sent. It is expected for all patients who are admitted. When no bed is available in the hospital the patient may be transferred to another hospital for admission.

Examples

	Bed Request Datetime
An ED clinician has requested a bed for a patient on 14 October 2021 at 1:45pm.	14/10/2021 13:45:00

Discharge Datetime

Field Name:	discharge_datetime
Definition:	The Date and time that the patient is discharged from the ED.
Data Type:	Datetime
Format:	DD/MM/YYYY HH:MM:SS
Permitted Values:	N/A

Guide for use

The date that the patient is physically discharged from ED.

If the patient is subsequently admitted to hospital (including those who are admitted and subsequently die before leaving the emergency department), then record the date the patient's emergency department non-admitted clinical care is completed.

If the service episode is completed without the patient being admitted, then record the date the patient's emergency department non-admitted clinical care is completed.

If the service episode is completed and the patient is referred to another hospital for admission, then record the date the patient's emergency department non-admitted clinical care is completed.

If the patient did not wait, then record the date the patient leaves the emergency department or was first noticed as having left.

If the patient left at their own risk, then record the date the patient leaves the emergency department or was first noticed as having left.

If the patient died in the emergency department as a non-admitted patient, then record the date the patient was certified dead.

If the patient was dead on arrival, then record the date the patient was certified dead.

If the patient was registered, advised of another health-care service, and left the emergency department without being attended by a health-care professional, then record the date the patient leaves the emergency department.

Examples

	Discharge Datetime
A patient who was discharged from Hospital on 15 March 2021 at 2:00 pm.	15/03/2021 14:00:00
A patient who presented to Hospital ED on 5 April 2021 at 10:00am and did not wait after 2 hours in the waiting room.	05/04/2021 12:00:00

Departure Status

Field Name:	departure_status																								
Definition:	The outcome of a patient's ED attendance. Also known as Episode End Status, Disposition or Emergency Discharge Status.																								
Data Type:	String																								
Format:	N(2)																								
Permitted Values:	<table><tr><td>1</td><td>Admitted to the hospital ward</td></tr><tr><td>2</td><td>ED service event completed; departed under own care</td></tr><tr><td>3</td><td>Transferred to another hospital for admission</td></tr><tr><td>4</td><td>Did not wait to be attended by medical officer</td></tr><tr><td>5</td><td>Left at own risk</td></tr><tr><td>6</td><td>Died in ED</td></tr><tr><td>8</td><td>Referred at Triage to other Health Care Service</td></tr><tr><td>9</td><td>Unknown</td></tr><tr><td>10</td><td>Admitted to ED Short Stay Unit</td></tr><tr><td>14</td><td>Returned to Hospital in the Home</td></tr><tr><td>19</td><td>Discharged after admission</td></tr><tr><td>20</td><td>Admitted Reversal</td></tr></table>	1	Admitted to the hospital ward	2	ED service event completed; departed under own care	3	Transferred to another hospital for admission	4	Did not wait to be attended by medical officer	5	Left at own risk	6	Died in ED	8	Referred at Triage to other Health Care Service	9	Unknown	10	Admitted to ED Short Stay Unit	14	Returned to Hospital in the Home	19	Discharged after admission	20	Admitted Reversal
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19	Discharged after admission																								
20	Admitted Reversal																								

Guide for use

Further details about the permitted values and use are detailed below:

1. If the patient was admitted to the hospital ward. This includes inpatients being returned to a physical ward.
2. If the patients service event is complete and then leaves ED under their own care.
3. If transferred to (an) other acute hospital – refers to patients separated to another acute care facility. This includes designated psychiatric units that are part of an acute hospital.
4. If the patient did not wait to be attended by a health care professional for clinical care to commence.
5. Left at own risk after being attended by a health care professional but before the non-admitted patient emergency department service episode was completed.
6. Refers to patients separated due to their death while at ED.
8. If the patient got referred at ED triage to other Health Care Service for treatment.
9. Unknown.
10. When the patient is admitted to ED Short Stay Unit as a result of triage.
14. Returned to Hospital in the Home.
19. Discharged after admission
20. When the patient is admitted reversal from the ED short stay unit back to ED.

Examples

	Departure Status
A patient who attended Hospital ED is sent home after being treated by an ED doctor.	2 – ED service event completed; departed under own care
A patient who attended Hospital ED is admitted as they require further medical care.	1 – Admitted to the hospital (SSU / HITH / ward)
A patient who attended Hospital ED decided that they did not want to wait to be seen by medical staff after having been triaged.	4 – Did not wait to be attended by medical officer
A patient who attended Hospital ED has care commenced by a health care professional but left the ED before the episode was completed.	5 – Left at own risk

Mode of Arrival

Field Name:	mode_of_arrival
Definition:	Patient's mode of arrival at the ED.
Data Type:	Numeric
Format:	N(2)
Permitted Values:	1 Private transport 2 Public transport 3 Ambulance 4 Hospital transport 5 Police/Correctional Services 6 Helicopter rescue 7 Royal Flying Doctor Service 8 Other 9 Not Stated/Unknown 10 Taxi

Guide for use

This field provides information regarding how they arrived at the ED.

If a patient is transported by the Royal Flying Doctor Service to an airport and then taken to hospital by ambulance, the Royal Flying Doctor Service must be coded as it takes priority over other forms of transport.

Examples

	Mode of Arrival
A patient arrived at Hospital by St John WA Ambulance.	3 – Ambulance
A patient evacuated to Hospital by emergency helicopter.	6 – Helicopter rescue
Royal Flying Doctor Service evacuates a patient from smaller hospital to a larger regional or metro hospital. The patient lands at an airport close to the transfer hospital and the patient is transferred from the airport to the next hospital by ambulance.	7 – Royal Flying Doctor Service

Primary Diagnosis ICD10AM Chapter

Field name - Dataset:	primary_diagnosis_ICD10AM_chapter – [Masterfile] – [vw_emergency_episode]
Definition:	Chapter level roll of the Principal Diagnosis.
Data type:	String
Format:	X(2)
Permitted values:	N/A

Guide for use

Derived from Primary Diagnosis. Groupings based on AIHW grouping as per Emergency department care 2016–17: Australian hospital statistics report.

A0 Infectious diseases
C0 Neoplasms
D5 Diseases of blood
E0 Endocrine disorders
F0 Mental disorders
G0 Diseases of nervous system
H0 Diseases of eye & adnexa
H6 Diseases of ear & mastoid process
I0 Diseases of circulatory system
J0 Diseases of respiratory system
K0 Diseases of digestive system
L0 Diseases of skin
M0 Diseases of musculoskeletal system
N0 Diseases of genitourinary system
O0 Complications of pregnancy
P0 Conditions of perinatal period
Q0 Congenital anomalies
R0 Symptoms/signs and ill-defined conditions
S0 Injury and poisoning
U0 Codes for special purposes
U5 External causes of morbidity and mortality
Z0 Supplementary classifications
is Missing
th Other

Affected by Drugs and or Alcohol

Field Name:	affected_by_drugs_and_or_alcohol
Definition:	Patient affected by drugs or alcohol.
Data Type:	Numeric
Format:	N(1)
Permitted Values:	0 No 1 Yes

Guide for use

This is a calculated field in the EDDC based on DoH standard definitions for drugs and alcohol or drug and alcohol use.

Self Harm Attendance

Field Name:	self_harm_attendance
Definition:	Flag if patient self harm injured
Data Type:	Number
Format:	N(1)
Permitted Values:	0 Not a self harm related attendance 1 A self harm related attendance

Guide for use

This flag is applied based on clinical assessment. If the patient demonstrates an injury that was intentionally caused to the patient by the patient, then the self-harm related attendance flag is applied.

Metropolitan Hospital Flag

Field Name:	metropolitan_hospital_flag
Definition:	Whether the Hospital the patient visited was a Metro hospital.
Data Type:	Number
Format:	N(1)
Permitted Values:	0 Rural hospital 1 Metropolitan hospital

Guide for use

This flag is applied based on the location of the hospital. If the hospital is located within the geographical area defined as metro, then the metropolitan hospital flag is applied. If the hospital is not located in the geographical area defined as metro then the rural hospital flag is applied.

Examples

	Metropolitan Hospital Flag
A hospital is located outside of the geographical area determined to be metro area is classed as rural	0
A hospital is located in the geographical area determined to be metro	1

Mental Health Attendance

Field Name:	mental_health_attendance
Definition:	Flag all Mental attendances based on certain Primary Diagnoses.
Data Type:	Number
Format:	N(1)
Permitted Values:	0 Not mental health related 1 Mental health related

Guide for use

This is a calculated field based on DoH standard definition related to mental health condition.

Mental Health Admission

Field Name:	mental_health_admission
Definition:	Flag all Mental admissions based on departure status of admitted and Principal Diagnoses.
Data Type:	Number
Format:	N(1)
Permitted Values:	0 Not admitted following a mental health related attendance 1 Admitted following a mental health related attendance

Guide for use

This is a calculated field based on DoH standard definition related to mental health condition.

Potentially Avoidable General Practitioner Type Attendance

Field Name:	potentially_avoidable_general_practitioner_type_attendance
Definition:	This flag is applied if the ED attendance meets a list of specific criteria. This calculation has already been applied to the data present in this data set.
Data Type:	Number
Format:	N(1)
Permitted Values:	0 Non avoidable Attendance 1 Avoidable Attendance

Guide for use

This field includes a number of data variables in its calculation and has therefore been pre-calculated in the synthetic data set.

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