Using SNAPshot V3.82e to collect the PCOC V2 Dataset

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Hinton D (2005) ***Using SNAPshot V3.6 to collect Palliative Care Data.*** Centre for Health Service Development, University of Wollongong.

PCOC also acknowledges the AROC team in their publication:
AROC (2007) ***Using SNAPshot V3.80 to collect the AROC version 3 dataset.*** Centre for Health Service Development, University of Wollongong.

Table of Contents

1 PURPOSE OF THIS GUIDE 3
1.1 More information -------- 3
1.1.1 What is Snapshot? 3
1.1.2 Logging on to SNAPshot 3
1.1.3 The Main Screen 4
1.1.4 Making changes or additions 5
1.2 General Operations -------- 6
1.2.1 Transactions 6
1.3 General Editing Controls -------- 6
1.3.1 Entering information into data fields 6
2 ENTERING CLIENT INFORMATION 7
2.1 The ‘Palliative Care’ data sets -------- 7
2.2 Default settings, mapped fields and ‘Auto’ responses -------- 8
2.3 Initial setup: the ‘facility’ screen -------- 8
2.4 Initial setup: the ‘provider unit’ screen -------- 8
2.5 Entering information into the ‘patient’ screen -------- 9
2.6 Entering information into the ‘episode’ screen -------- 10
2.7 Entering information into the ‘PallCare’ screen -------- 14
2.8 Entering information into the ‘PCOC’ screen -------- 17
2.9 Entering ‘number of days seen’ for ‘not-overnight admitted’ patients -------- 20
2.10 Entering information into the ‘Staff’ data set. -------- 21
3 GENERATING THE PCOC EXTRACT 22
4 DATA CONSISTENCY 23
4.1 Warning reports -------- 23
4.2 Fatal Reports -------- 24
Appendix 1 Control Keys -------- 25
Appendix 2 Searching for a client by name or by mrn -------- 26
Appendix 3 PCOC Data entry – ‘cheat sheet’ for entering INPATIENTS -------- 27
Appendix 4 PCOC Data entry – ‘cheat sheet’ for entering COMMUNITY PATIENTS -------- 29
Appendix 5 PCOC Data entry – ‘cheat sheet’ for entering CONSULTATIVE PATIENTS -------- 31
Appendix 6 PCOC Data Definitions Version 2 -------- 33

List of Tables

Table 1 Definitions for fields relevant to PCOC in the 'Facility' Data Set 8
Table 2 Definitions for fields relevant to PCOC in the 'Provider Unit' Data Set........ 8
Table 3 Definitions for fields relevant to PCOC in the 'Patient' Data Set 9
Table 4 Definitions for fields relevant to Palliative Care in the 'Episode' Data Set........ 11
Table 5 Definitions for fields in the 'PallCare' Data Set 14
Table 6 Definitions for fields in the 'PCOC' Data Set........ 18
Table 7 Definitions for fields in the 'Staff' data set........ 21

List of Figures

Figure 1-1 SNAPshot main screen. 4
Figure 1-2 Transaction buttons at the top of the 'Edit View' screen. 5
Figure 2-1 The 'Palliative Care' data sets in the set list........ 7
Figure 2-2 The EpiOOS data set 20
Figure 2-3 EpiOOS MultiList 21
Figure 3-1 PCOC Extract Dialogue........ 22
Figure 4-1 PCOC Warning Report........ 23
Figure 4-2 PCOC Fatal Report 24
Figure 4-3 Searching for a client record 26

1 Purpose of this guide

This is a guide for clinicians and data entry workers using SNAPshot software to enter the PCOC V2 dataset.

1.1 More information

For information about how to use SNAPshot please refer to the user's guide, available on the SNAPshot 3.82(e) CD or download from the CHSD SNAPshot webpage:
http://chsd.uow.edu.au/snapshot.html

It is strongly recommended that SNAPshot users obtain some training prior to using SNAPshot to collect the PCOC Version 2 dataset. For information about SNAPshot training please contact PCOC on (02) 4221 4411.

1.1.1 What is Snapshot?

SNAPshot is software designed primarily to collect ‘SNAP’ (Sub-Acute and Non-Acute Patient) information. It has been used since 1996. SNAPshot has been modified for a range of other applications including collecting the ACAT (ACAP), DVA, AROC and HACC Minimum Data Sets.

SNAPshot has not been specifically designed to collect Palliative Care Data. Information required for Palliative Care is therefore entered into a number of different screens. Some data fields can also be set to ‘default’ to the most common code or response for your facility to save time in data entry (see Section 2.3).

1.1.2 Logging on to SNAPshot

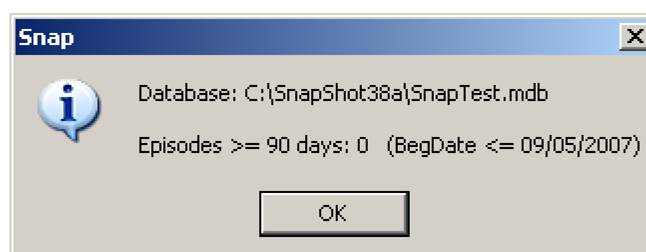
- Opening SNAPshot

  Double click on the SNAPshot shortcut on your desk top

  Shortcut to SNAPshot

  Or click Start, Programs, SNAPshot

- When SNAPshot opens, a pop-up will also open telling you how many Episodes require a 90 day review. The location of your database file is also displayed. Click OK.



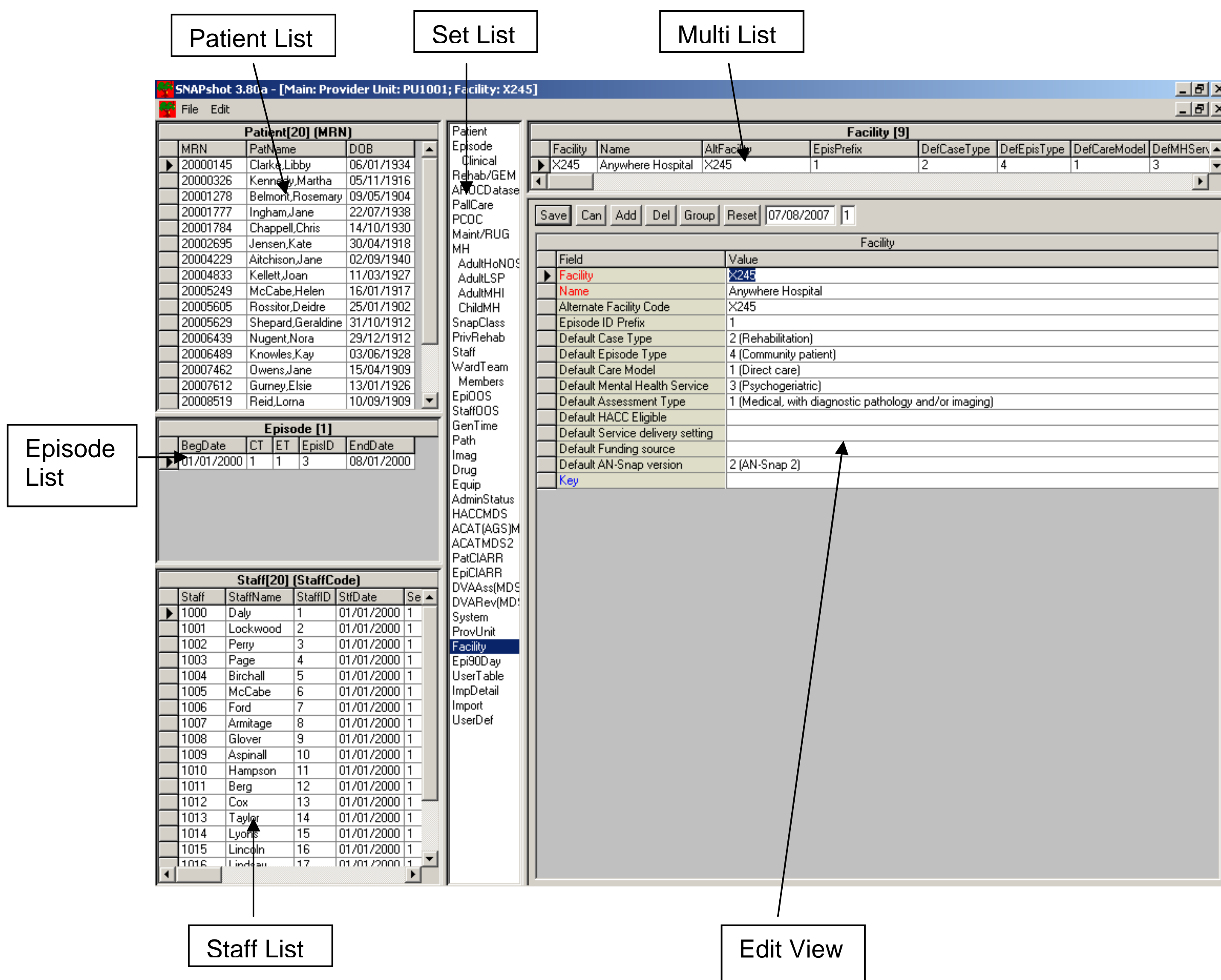
- Press Shift+F7 together. A pop-up will open asking you to enter the facility password to open the database.

1.1.3 The Main Screen

The Main Screen is where information is recorded about a facility, its staff, its client's personal information and health status, and occasions of service provided.

The Main Screen has 6 parts: a Patient List, an Episode List, a Staff List, a Set List, a Multi List, and an Edit View.

Figure 1-1 SNAPshot main screen.



1.1.3.1 Moving Around the Main Screen

Point and click with the mouse to move to another field or another part of the screen.
Or use the following 'short-cut' keys:

- Use the F6 key to move from one part of the Main Screen to another.
- Use the Enter or Tab keys to move to the right or down to the next field. Use the Shift + Tab key to move to the left or up to the previous field.

See Appendix 1 for a complete list of 'short-cut' keys.

1.1.3.2 Different parts of the screen

Patient List
The ‘Patient List’ displays the Name, Date of Birth and Medical Record Number (MRN) of the clients that have been registered by your facility.

Episode List
The ‘Episode List’ shows each of the Episodes that have been opened for the client selected in the ‘Patient List’. The Episode List displays the date the episode commence (BegDate), the Case Type (CT), the Episode Type (ET), the Episode Identifier (EpisID), and the date the episode ended (EndDate), if applicable.

Staff List
The ‘Staff List’ shows the staff registered in your facility by Staff Number (Staff), Staff Name (StaffName), Staff Id (used internally by SNAPshot), Commencement Date (StfDate), and Session Type (Ses) which is used to identify either individual or group staff records.

Set List
The ‘Set List’ shows all the different data sets contained within SNAPshot. The data set selected in the Set List is displayed in the Edit View window. Once selected, it is possible to make changes or additions to that data set.

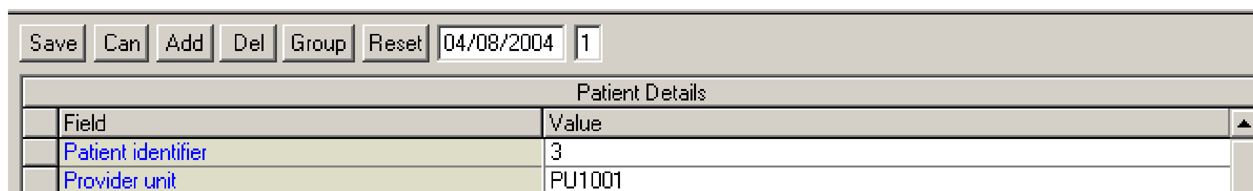
Multi List
The ‘Multi List’ contains various lists depending on the data set currently selected. For example, in the ‘PallCare’ screen the multi list will show all previous phases entered for the client selected in the patient list.

Edit View
The ‘Edit View’ is where information is added, deleted, edited or updated for the various data sets. If the patient data set is selected from the set list, then all of the fields for the patient data set are displayed in the edit view. This allows changes to be made to this data set.

1.1.4 Making changes or additions

The Edit View
The ‘Edit View’ (refer to 1.1.3.2 above) is where information is added, deleted (with due care), edited or updated for the various data sets.

Figure 1-2 Transaction buttons at the top of the ‘Edit View’ screen.



Choose the data set that you want to make changes or additions to from the set list.
Click **Add** to create a new record in the data set.
Click **Save** to save a record that you have added or changed.
Before you can save a record you must move the cursor out of the field that you have changed by hitting the ‘Enter’ or ‘Tab’ key or by using the mouse to click in another field.
Click **Cancel** to cancel any changes that you have just made.
Click **Delete** if you want to delete a record from the data set.
A warning message will ask you if you are sure that you want to delete the record.
The **Reset** button is used to select a different Facility and Provider Unit, it may also be necessary to re-select the facility and provider unit after the database has been moved or restored.
The **Group** button is used to group the data into an appropriate SNAP class (See Section 4).

1.2 General Operations

The SetList segment lists all of the data sets that you can edit. When you click on a data set name – such as 'Patient' or 'PallCare' – the fields for the data set are displayed in the EditView segment.

For some data sets – such as 'Facility' – when you make the selection a list will appear in the MultiList segment and the currently selected facility record will appear in the EditView.

1.2.1 Transactions

As described above, all database transactions are performed in the EditView segment and include:

- **Add** – which is used to insert a new record of the type currently displayed in EditView.
- **Del** – which is used to delete the record currently displayed in EditView.
- **Save** – which is used to save the record currently displayed in EditView.
- **Cancel** – which is used to discard changes you have made to the record currently displayed in EditView.
- **Reset** – which is used to re-select all lists when you change provider unit or facility but which can also be used to refresh the data currently being displayed to reflect any changes made by other users.

When you are editing a data set the SetList will disappear and the message ***Edit*** will appear.

1.3 General Editing Controls

To edit an existing record in EditView, simply click on the relevant field and enter data. If you are moving from field to field, F2 can be used to put you into field edit mode. If there are multiple columns you can use Tab or Shift-Tab to move right and left or you can use the left and right arrow keys. To move up and down use the up/down arrow keys. Before you can press the Save button to save changes you must move off the field you have just edited (pressing the Enter key is fine) otherwise you will receive an error prompt.

Date formats are flexible – for example 01 Jul 2007 can be entered as 1/7/07 but it will be displayed as 01/07/2007. Note that separator character such as slashes or spaces must be entered. The current year will be assumed – eg '1 7' will convert to 01/07/2007.

1.3.1 Entering information into data fields

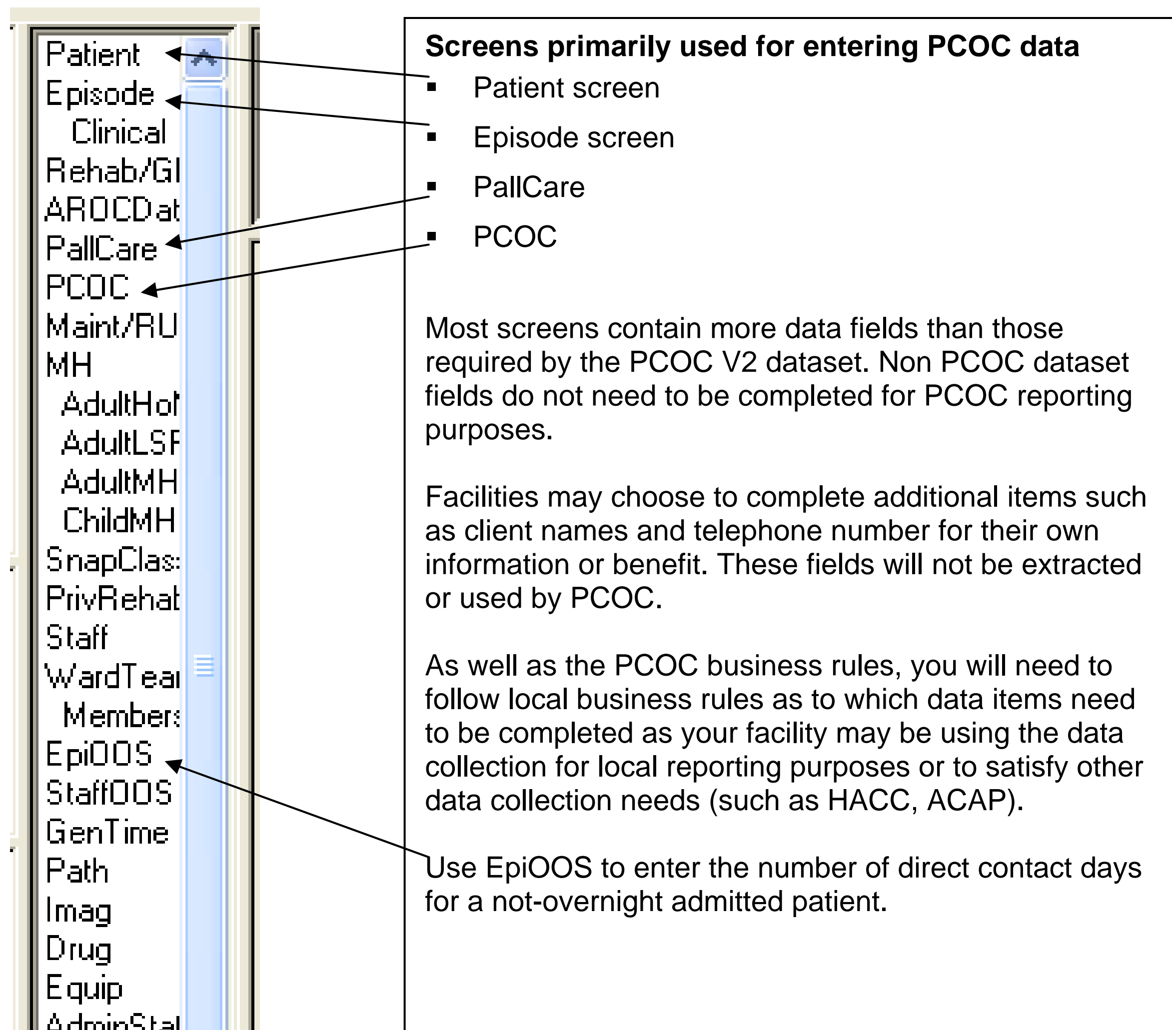
Many fields such as PC Phase have a drop down list with a code for each item. In these fields, you can either type the code directly into the field or make a selection from the drop down list. You can press **Alt + Down Arrow** together to open the drop down menu for the data field that you are in.

2 Entering client information

2.1 The 'Palliative Care' data sets

Client information for the PCOC dataset is mainly entered into SNAPshot in 4 screens as highlighted in Figure 2-1.

Figure 2-1 The 'Palliative Care' data sets in the set list



2.2 Default settings, mapped fields and 'Auto' responses

Some fields can have a default value set to the most common response within your facility. For example, Case Type can be set to default to Palliative Care (1). This saves time when entering data and can be over-written if required.

Many data items such as Mode of Episode Start are 'mapped' or copied from one Data Set to another. This minimises double data entry. Other data items such as the Episode Identifier are automatically generated. Mapped or automatically generated fields are coloured blue. They are 'read-only' and cannot be changed.

2.3 Initial setup: the 'facility' screen

The Facility Screen contains information to identify the facility, it is set up once, usually by the SNAPshot administrator at your site.

Table 1 Definitions for fields relevant to PCOC in the 'Facility' Data Set

Snapshot field	Description
Facility code	Enter a 4 character alphanumeric code for your facility.
Facility name	Enter the name of your establishment.

The following defaults can also be set in the Facility Screen:

- Default Case Type – Default to '1', Palliative Care
- Default Episode Type – Default to 0, 1, 2, 3, 4 or 5

It is also a good idea to default:

- Default Care Model
- Default AN-Snap Version [default to 2(AN-Snap 2)]
- Default Assessment only (Default to no)

2.4 Initial setup: the 'provider unit' screen

The Provider Unit Screen contains information to identify the provider unit, it is set up once, usually by the SNAPshot administrator at your site. Typically there is a unique provider unit associated with each medical record system, in practice, this means that for each facility there will be one provider unit.

Table 2 Definitions for fields relevant to PCOC in the 'Provider Unit' Data Set

Snapshot field	Description
Provider unit	Enter a 6 character alphanumeric code for your provider unit, e.g. PU0001
Name	Enter the name of your provider unit, e.g. PallCare

2.5 Entering information into the 'patient' screen

The Patient (Client) Screen contains identifying and demographic information.

Before adding a new patient/client, it is a good idea to check first to see if they are already in SNAPshot as this will avoid duplicate records. (Refer to Appendix 2 for how to search by MRN or Surname).

Adding a New Client (Patient) Record

1. Select the **'Patient'** data set from the **'Set List'**. The 'Patient Details' Screen will now be displayed in the 'Edit View'.
2. Click on **'Add'** — a new Client Record will be opened in the 'Edit View'.
3. Complete the fields as explained in Table 3 .

Table 3 Definitions for fields relevant to PCOC in the 'Patient' Data Set

No.	PCOC Item	SNAPshot Item	Item Description	Item Codes	Item Code-Set Description
2.1.1	Person/Client Identifier	Medical record number	Unique person identifier within the palliative care service		Any number that is unique for each patient. This number must be used at all times when recording patient, episode or phase details for this patient for PCOC. This number could be the patient record number
2.1.2	Date of Birth	Date of Birth	Birth date of patient	dd/mm/yyyy	
2.1.3	Sex	Sex	Patient's gender	1	Male
				2	Female
				3	Indeterminate
				9	Not stated/inadequately described
2.1.4	State Identifier	State	State of usual place of residence	1	NSW
				2	VIC
				3	QLD
				4	SA
				5	WA
				6	TAS
				7	NT
				8	ACT
				9	Other Australian Territory (Australian Antarctic Territory, Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)
				10	Other country
2.1.5	Postcode	Postcode	Postcode of usual place of residence Leave blank if State identifier is 9 or 10		Four digit postcode

No.	PCOC Item	SNAPshot Item	Item Description	Item Codes	Item Code-Set Description
2.1.6	Indigenous status	Indigenous status	Patient's indigenous status	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	Neither Aboriginal nor Torres Strait Islander origin
				9	Not stated / inadequately described
2.1.8	Country of birth	Country of birth	The country in which the person was born	xxxx	Standard Australian Classification of Countries (SACC) 4-digit (individual country) level. ABS catalogue no.1269.0 (1998)

Once all information on the screen has been entered click **'Save'**

NB you may find it helpful to refer to Appendices 3, 4 and 5 to assist you in data entry.

2.6 Entering information into the 'episode' screen

An episode of care is a period of contact between a patient/client and a palliative care service that is provided by one palliative care service and occurs in one setting. An episode of palliative care begins on the day the patient/client is clinically assessed (face to face) by the palliative care clinician and accepted to receive palliative care. An episode of care refers to the care received between admission and separation within one setting.

An episode of care begins when either:

- Overnight admitted – a patient/client undergoes a formal hospital admission process with the intent of discharge on a different day
- All others – patient/client undergoes an admission process to the palliative care service as a same day admitted, community, outpatient or consultative patient.

An episode of care ends when either:

- the principal clinical intent of the care changes and the patient is no longer receiving palliative care or
- when the patient is formally separated from the hospital/hospice/community.

Adding a new Episode Record

1. Select the **'Episode'** data set from the **'Set List'**. The 'Episode Admin Details' Screen will now be displayed in the 'Edit View'.
2. Click on **'Add'** — a new Episode Record will be opened in the 'Edit View'.
3. Complete the fields as explained in Table 4 below.

Table 4 Definitions for fields relevant to Palliative Care in the 'Episode' Data Set

No.	PCOC Item	SNAPshot Item	Item Description	Item Codes	Item Code Set Description
2.2.11	Mode of episode start	Mode of episode start NB: Some of the wording in the drop down list will be different but the coding remains the same. e.g. 5: Change from acute care to sub-/non-acute care – same ward = 5: Change from acute care to palliative care while remaining on same ward	How this episode began	Overnight admitted patients	
				1	Admitted from usual accommodation
				2	Admitted from other than usual accommodation
				3	Admitted (transferred) from another hospital
				4	Admitted (transferred) from acute care in another ward
				5	Change from acute care to palliative care while remaining on same ward
				6	Change of sub-acute/non-acute care type
				7	Statistical admission from leave
				9	Other
				Ambulatory patients	
				A	First visit following new referral
				B	First visit after discharge from being an overnight admitted palliative care patient
2.2.13	Episode start date	Episode begin date	The date a patient/client commences an episode of care	dd/mm/yyyy	For inpatients: date of admission
					For ambulatory patients: date of first face to face contact
2.2.14	Proposed model of care at episode start	Model of care	The type of care planned at the start of this episode of care	1	Direct care
				2	Shared care with another service provider/s (cancer care, respiratory, GP, MND, community health care providers)
				3	Consultation/liaison with another service provider
2.2.15	Episode type	Episode type NB: Some of the wording in the drop down list will be different but the coding remains the same. e.g. 0: O'night admitted patient: non-designated sub-/non-acute unit = 0: Overnight admitted patient in a non-designated inpatient palliative care bed/unit	The location of the patient for this episode	0	Overnight admitted patient in a non-designated inpatient palliative care bed/unit Go to 2.2.19 (Patient is admitted and discharged on different dates)
				1	Overnight admitted patient in a designated inpatient palliative care bed/unit Go to 2.2.19 (Patient is admitted and discharged on different dates)
				3	Ambulatory Go to 2.2.19 (Patient receives care on a same day admitted or outpatient basis)
				4	Community Go to 2.2.19 (Patient receives care in the home or other non-hospital site)
				5	Consultation service (Patient is seen by a consultative service) If 5 is ticked answer 2.2.16, 2.2.17 and 2.2.18

No.	PCOC Item	SNAPshot Item	Item Description	Item Codes	Item Code Set Description
2.2.20	Accommodation at episode start	Type of usual accommodation prior to	Type of usual accommodation at the commencement of the episode	1	Private residence (including unit in retirement village)
				2	Residential aged care, low level care (hostel)
				3	Residential aged care, high level care (nursing home)
				4	Community group home
				5	Boarding house
				6	Transitional living unit
				7	Other
2.2.21	Level of Support at episode start	Support provided prior to admission	Level of support received at the commencement of the episode. Complete only if Accommodation at episode start is 1 (Private residence). Otherwise leave blank	1	Lives alone (no support/care provided)
				2	Lives with others (no support/care provided)
				3	Lives alone with external support(s)
				4	Lives with others (who provide support/care)
				5	Lives with others, external support(s)
				6	Other arrangements
				99	Not stated/inadequately described
2.2.22	Episode end date	Episode end date	The date of episode end	dd/mm/yyyy	The date of discharge, death or transfer
2.2.23	Mode of episode end	Mode of episode end NB: Some of the wording in the drop down list will be different but the coding remains the same. e.g. 5: Change from sub-/non-acute to acute care – different ward = 5: Change from palliative care to acute care – different ward	How this episode ended	Overnight admitted patients	
				1	Discharged to usual accommodation
				2	Discharged to interim accommodation
				3	Death
				4	Discharged to another hospital
				5	Change from palliative care to acute care – different ward
				6	Change from palliative care to acute care – same ward
				8	Discharged at own risk
				99	Other
				Ambulatory patients	
				A	Discharge/case closure
				B	Death (Complete 2.2.26)
				C	Admitted for inpatient palliative care
				D	Admitted for inpatient acute care
				E	Transfer to another palliative care service or to primary care
				G	Not known
2.2.24	Accommodation at episode end	Accommodation post-discharge	Type of accommodation at episode end	1	Private residence (including unit in retirement village)
				2	Residential aged care, low level care (hostel)

No.	PCOC Item	SNAPshot Item	Item Description	Item Codes	Item Code Set Description
				3	Residential aged care, high level care (nursing home)
				4	Community group home
				5	Boarding house
				6	Transitional living unit
				7	Other
2.2.25	Level of Support at episode end	Support provided at episode end	Level of support received at episode end. Complete only if Accommodation at episode end is 1 (Private residence). Otherwise leave blank	1	Lives alone (no support/care provided)
				2	Lives with others (no support/care provided)
				3	Lives alone with external support(s)
				4	Lives with others (who provide support/care)
				5	Lives with others, external support(s)
				6	Other arrangements
				9	Not stated/inadequately described

Compulsory SNAPshot items for the Episode screen
Please note that SNAPshot also requires the following to be completed for **OVERNIGHT** patients:

- Assessment only: If the client was seen on one occasion only for assessment and/or treatment and no further intervention by this facility/team is planned within the next 90 days, he/she is classified as 'assessment only'. Enter the code indicating whether the patient was seen for assessment only as follows:
  1. Yes.
  2. No.

If the patient was admitted for assessment only (Yes), enter the code for the type of assessment as follows:
1. Medical, with diagnostic pathology and/or imaging.
2. Medical, without diagnostic pathology or imaging.
3. Non-medical.
4. Both medical and non-medical with diagnostic pathology and/or imaging.
5. Both medical and non-medical without diagnostic pathology or imaging.

These items are mandatory SNAPshot fields, they must be completed to enable the record to be saved. NB Both Model of Care and Assessment only can be defaulted in the Facility screen (see Section 2.3).

Please note that SNAPshot requires the following to be completed for **NOT-OVERNIGHT ADMITTED** patients:

- Model of Care: Please select from the drop down list the most appropriate model of care
- Assessment only: Please see the rules for OVERNIGHT patients above.
- Provider type - Please select from the drop down list the most appropriate Provider type
- Sole practitioner - Please select from the drop down list the most appropriate code for Sole practitioner

These items are mandatory SNAPshot fields, they must be completed to enable the record to be saved. NB Model of Care, Assessment only and Provider Type can all be defaulted in the Facility screen (see Section 2.3).

Once all information on the screen has been entered click **'Save'**

NB you may find it helpful to refer to Appendices 3, 4 and 5 to assist you in data entry.

2.7 Entering information into the 'PallCare' screen

Clinical information relating to the client's Palliative Care are recorded in the PallCare screen.
After adding a new Episode Record

1. Select the **'PallCare'** data set from the **'Set List'**. The 'Pall Care Phase Details' Screen will now be displayed in the 'Edit View'.
2. Click on **'Add'** — a new Pall Care Record will be opened in the 'Edit View'.
3. Complete the fields as explained in Table 5 below.

Table 5 Definitions for fields in the 'PallCare' Data Set

No.	PCOC Item	SNAPshot item	Item Description	Item Code Set	Item Code Set description
2.3.27	Date of phase start	Phase begin date	The date this phase began	dd/mm/yyyy	
2.3.28	Phase	PC Phase	Palliative Care Phase. Note: The first phase begin date = episode begin date	1	Stable
				2	Unstable
				3	Deteriorating
				4	Terminal
				5	Bereaved
2.3.29	RUG-ADL functional scores at phase start	RUG Bed mobility RUG Toileting RUG Transfer RUG Eating	RUG-ADL scores as recorded within 24 hours of the start of the phase. Note: a score of 2 is not valid on the bed mobility, toileting or transfer items	For bed mobility, toileting & transfers:	
				1	Independent or supervision only
				3	Limited physical assistance
				4	Other than two persons physical assist
				5	Two-person physical assist
				For eating:	
				1	Independent or supervision only
				2	Limited assistance
				3	Extensive assistance/total dependence/ tube fed
2.3.30	Symptom Assessment Score (SAS) at phase start	SAS (7 items + up to 3 other symptoms)	SAS as recorded within 24 hours of the start of the phase.		Insomnia, appetite problems, nausea, bowels, breathing, fatigue and pain (7 items + up to 3 other symptoms)
				0-10	Not at all - Worst Possible
2.3.31	Palliative Care Problem Severity scores at phase start	Pain score	Pain score as recorded within 24 hours of the start of the phase Leave blank if SAS is completed	0	Absent
				1	Mild
				2	Moderate
				3	Severe
2.3.32	Palliative Care Problem Severity scores at phase start	Symptom score	Other symptom score as recorded within 24 hours of the start of the phase Leave blank if SAS is completed	0	Absent
				1	Mild
				2	Moderate
				3	Severe

No.	PCOC Item	SNAPshot item	Item Description	Item Code Set	Item Code Set description
2.3.33	Palliative Care Problem Severity scores at phase start	Psych/spiritual score	Psychological/Spiritual score as recorded within 24 hours of the start of the phase	0	Absent
				1	Mild
				2	Moderate
				3	Severe
2.3.34	Palliative Care Problem Severity scores at phase start	Family/carer	Family/Carer score as recorded within 24 hours of the start of the phase	0	Absent
				1	Mild
				2	Moderate
				3	Severe
2.3.35	Karnofsky functional score at phase start	Karnofsky Rating Scale	Score on the Australian Modified Karnofsky Scale as recorded within 24 hours of the start of the phase	100	Normal; no complaints; no evidence of disease.
				90	Able to carry on normal activity; minor signs or symptoms.
				80	Normal activity with effort; some signs or symptoms of disease
				70	Cares for self; unable to carry on normal activity or to do active work
				60	Requires occasional assistance but is able to care for most of his needs
				50	Requires considerable assistance and frequent medical care
				40	In bed more than 50% of the time.
				30	Almost completely bedfast.
				20	Totally bedfast and requiring extensive nursing care by professionals and/or family.
				10	Comatose or barely arousable
				0	Dead
2.3.36	Model of care at phase end	Model of care - phase end	The type of care provided at the end of this phase of care	1	Direct care
				2	Shared care with another service provider/s (cancer care, respiratory, GP, MND, community health care providers)
				3	Consultation/liaison with another service provider
2.3.37	Date of phase end	Phase end date	The date on which a patient completes a phase of care	dd/mm/yyyy	Default to new episode
2.3.38	Reason for phase end	Reason for phase end	The reason this phase ended	1	Phase change
				2	Discharge/Case closure
				3	Died
				4	Bereavement phase end

No.	PCOC Item	SNAPshot item	Item Description	Item Code Set	Item Code Set description
2.3.40	RUG-ADL functional scores at phase end	RUG Bed mobility RUG Toileting RUG Transfer RUG Eating	RUG-ADL scores as recorded within 24 hours of the end of the phase. Note: a score of 2 is not valid on the bed mobility, toileting or transfer items Complete only if reason for phase end is (2) Discharge/Case closure	For bed mobility, toileting & transfers:	
				1	Independent or supervision only
				3	Limited physical assistance
				4	Other than two persons physical assist
				5	Two-person physical assist
				For eating:	
				1	Independent or supervision only
				2	Limited assistance
				3	Extensive assistance/total dependence/ tube fed
2.3.41	Symptom Assessment Score (SAS) at phase end	SAS (7 items + up to 3 other symptoms)	SAS as recorded within 24 hours of the end of the phase Complete only if reason for phase end is (2) Discharge/Case closure		Insomnia, appetite problems, nausea, bowels, breathing, fatigue and pain (7 items + up to 3 other symptoms)
				0-10	Not at all - Worst Possible
2.3.42	Palliative Care Problem Severity scores at phase end	Pain score	Pain score as recorded within 24 hours of the end of the phase Complete only if reason for phase end is (2) Discharge/Case closure Leave blank if SAS is completed	0	Absent
				1	Mild
				2	Moderate
				3	Severe
2.3.43	Palliative Care Problem Severity scores at phase end	Symptom score	Other symptom score as recorded within 24 hours of the end of the phase Complete only if reason for phase end is (2) Discharge/Case closure Leave blank if SAS is completed	0	Absent
				1	Mild
				2	Moderate
				3	Severe
2.3.44	Palliative Care Problem Severity scores at phase end	Psych/spiritual score	Psychological/Spiritual score as recorded within 24 hours of the end of the phase Complete only if reason for phase end is (2) Discharge/Case closure	0	Absent
				1	Mild
				2	Moderate
				3	Severe
2.3.45	Palliative Care Problem Severity scores at phase end	Family/carer	Family/Carer score as recorded within 24 hours of the start of the phase Complete only if reason for phase end is (2) Discharge/Case closure	0	Absent
				1	Mild
				2	Moderate
				3	Severe

No.	PCOC Item	SNAPshot item	Item Description	Item Code Set	Item Code Set description
2.3.46	Karnofsky functional score at phase end	Karnofsky Rating Scale	Score on the Australian Modified Karnofsky Scale as recorded within 24 hours of the end of the phase Complete only if reason for phase end is (2) Discharge/Case closure	100	Normal; no complaints; no evidence of disease.
				90	Able to carry on normal activity; minor signs or symptoms.
				80	Normal activity with effort; some signs or symptoms of disease
				70	Cares for self; unable to carry on normal activity or to do active work
				60	Requires occasional assistance but is able to care for most of his needs
				50	Requires considerable assistance and frequent medical care
				40	In bed more than 50% of the time.
				30	Almost completely bedfast.
				20	Totally bedfast and requiring extensive nursing care by professionals and/or family.
				10	Comatose or barely arousable
				0	Dead

Once all information on the screen has been entered click **'Save'**

NB In most cases a palliative care patient will have multiple phases of care. Please ensure that ALL phases of care are entered into SNAPshot.

NB you may find it helpful to refer to Appendices 3, 4 and 5 to assist you in data entry.

2.8 Entering information into the 'PCOC' screen

The remaining data items in the Version 2 PCOC dataset are entered into the 'PCOC' Screen. After adding a new Episode Record together with subsequent PallCare data.

1. Select the **'PCOC'** data set from the **'Set List'**. The 'PCOC' Screen will now be displayed in the 'Edit View'.
2. Click on **'Add'** — a new PCOC record will be opened in the 'Edit View'.
3. Complete the fields as explained in Table 6 below.

Please Note: It is compulsory to create a PCOC dataset record before ending palliative care (case type 1) episodes. SNAPshot will NOT allow you to end and episode of care in the Episode screen if the PCOC screen has not been completed.

Table 6 Definitions for fields in the 'PCOC' Data Set

No.	PCOC Item	SNAPshot item	Item Description	Item Code Set	Item Code Set description
2.2.9	Referral date	Referral date	Date agency received a referral for this patient/client from another party for palliative care services	dd/mm/yyyy	
2.2.10	Referral source	PCOC Source of referral	Location of source of referral for this episode	1	Public hospital – other than inpatient palliative care unit
				2	Private hospital – other than inpatient palliative care unit
				3	Public palliative care inpatient unit/hospice
				4	Private palliative care inpatient unit/hospice
				5	General Medical Practitioner rooms
				6	Specialist Medical Practitioner rooms
				7	Community-based palliative care agency
				8	Community-based service
				9	Residential aged care facility
				10	Self, carer(s), family or friends
				11	Other
2.2.12	Date of first contact with patient/client	First contact (telephone or face to face) by palliative care service following receipt of referral	First assessment (telephone or face to face) by palliative care service following receipt of referral	dd/mm/yyyy	
2.2.14	Proposed model of care at episode start	Proposed model of care - episode start	The type of care planned at the start of this episode of care	1	Direct care
				2	Shared care with another service provider/s (cancer care, respiratory, GP, MND, community health care providers)
				3	Consultation/liaison with another service provider

No.	PCOC Item	SNAPshot item	Item Description	Item Code Set	Item Code Set description
2.2.16	Reason for consultative service visit	Reason for consultative service	Type of consultative service provided Complete only if Episode Type is 5 (Consultative). Otherwise leave blank	1	Advice only
				2	One-off consultation
				3	Recurring consultation
				99	Not stated/inadequately described
2.2.17	Location of consultative service	Location of consultative service	Location where the consultative service was provided Complete only if Episode Type is 5 (Consultative). Otherwise leave blank	1	Inpatient – designated palliative care bed
				2	Inpatient – non-designated palliative care bed
				3	Hospital-based clinic or centre
				4	Community-based day centre
				5	Residential aged care facility
				6	Home
				99	Not stated/inadequately described
2.2.18	Mode of consultative service	Mode of consultative service	How was this service was provided Complete only if Episode Type is 5 (Consultative). Otherwise leave blank	1	Face to face
				2	Telephone/electronic communication
2.2.19	Diagnosis	PCOC Diagnosis	The broad diagnostic group established after study to be chiefly responsible for occasioning the patient's episode of palliative care.	1	Malignant (neoplasm)
					1.1 Bone and Soft Tissue
					1.2 Breast
					1.3 CNS
					1.4 Colorectal
					1.5 Gynaecological
					1.6 Haematological
					1.7 Head and Neck
					1.8 Lung
					1.9 Pancreas
					1.10 Prostate
					1.11 Skin
					1.12 Other GIT
					1.13 Other Urological
					1.14 Other Malignancy
					1.15 Unknown Primary

No.	PCOC Item	SNAPshot item	Item Description	Item Code Set	Item Code Set description
				2	Non-malignant (other diagnosis)
					2.1 Cardiovascular
					2.2 HIV/AIDS
					2.3 Kidney Failure
					2.4 Neurological Disease
					2.5 Respiratory Failure
					2.6 Other non-malignancy
2.2.26	Place of death	Place of death	Complete only if Mode of Episode End (item 2.2.23) is B (death). Otherwise leave blank	1	Private residence
				2	Residential aged care setting
				3	Other location
2.1.7	Main language spoken at home	Main language spoken at home	The main language reported by a patient as the main language spoken in his/her home.	xx	Standard 2 digit code.

Once all information on the screen has been entered click **'Save'**

NB you may find it helpful to refer to Appendices 3, 4 and 5 to assist you in data entry.

2.9 Entering 'number of days seen' for 'not-overnight admitted' patients

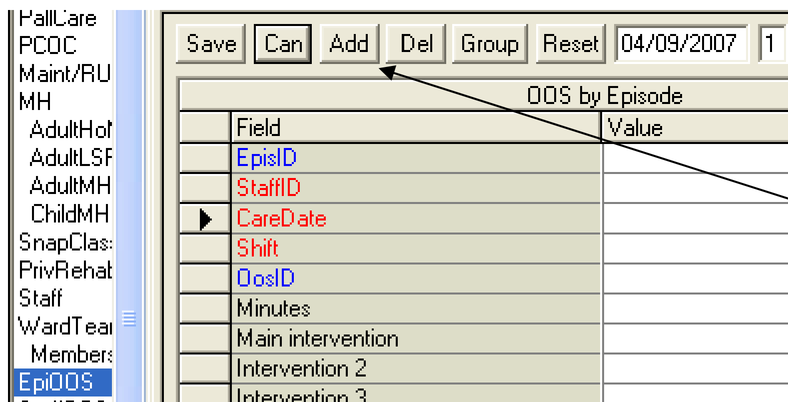
A facility may decide to collect 'not-overnight admitted' client palliative care data. This is relevant for patients (clients) whose episode can be described as 'same day admitted'; 'outpatient', consultative' or 'community'.

Use the 'EpiOOS' screen to record the total number of direct contact days during this episode. Note that at least one staff member must be defined (in the 'Staff' screen) before information can be entered in the 'EpiOOS' screen.

Entering number of days seen data

1. Open a new episode with the appropriate Episode Type (for example, 4 'Community patient').
2. Ensure that there is an appropriate staff member defined (Refer to 2.10 below)
3. Click on 'EpiOOS' in the set list.
4. Complete the fields as explained in Figure 2-2.

Figure 2-2 The EpiOOS data set



Click on 'Add' to populate: StaffID, CareDate and Shift.

Note that by default, the current date and shift '1' appear. These fields are simply used as default values when you add new OOS records and you can simply type over the default date to enter retrospective dates.

Shift is not part of the PCOC V2 dataset. Please ignore this field and do not delete.

Please note that as you add occasions of service they are recorded in the MultiList as shown in Figure 2-3.

Figure 2-3 EpiOOS MultiList

EpiOOS [8]							
	Staff	StaffName	CareDate	Shift	OosID	Mins	De
▶	1007	Armitage	01/01/2000	1			RN
	1009	Aspinall	01/01/2000	1			RN
	1011	Berg	01/01/2000	1			RN
	1004	Birchall	01/01/2000	1			RN
	1006	Ford	01/01/2000	1			RN
	1008	Glover	01/01/2000	1			RN
	1010	Hampson	01/01/2000	1			RN
	1005	McCabe	01/01/2000	1			RN

To edit an existing time record, select the record in MultiList, modify relevant field values and press Save.

2.10 Entering information into the 'Staff' data set.

At least one staff record must exist to allow occasions of service (EpiOOS) to be entered.

Adding a new Staff Dataset Record

1. Select the **'Staff'** data set from the **'Set List'**. The 'Staff Details' Screen will now be displayed in the 'Edit View'.
2. Click on **'Add'** — a new Staff Details Record will be opened in the 'Edit View'.
3. Complete the fields as explained in Table 7. The last three staff fields are not mandatory but if entered should comply with the Facility's business rules, especially if SNAPshot is used to collect and report multiple data collections.

Note: if a staff record is deleted ALL occasions of service that have been entered under that staff id will be deleted, so if you want to clean-up the staff records it is best to 'retire' a record by editing the staff name field rather to delete the record (and in doing so destroy the associated occasions of service data).

Table 7 Definitions for fields in the 'Staff' data set.

Snapshot field	Description
Staff	Enter a unique code for the staff member.
Staff Date	Enter the date on which the staff member started working at the facility, or a nominal start date for the entire date collection, for example 01/01/2007
Session type	Indicate whether this staff member provides group or individual occasions of service: 1=individual 2=group
Staff name	Enter a unique staff name, which can either be generic (e.g.Pallcare) or an individual's name.

3 Generating the PCOC Extract

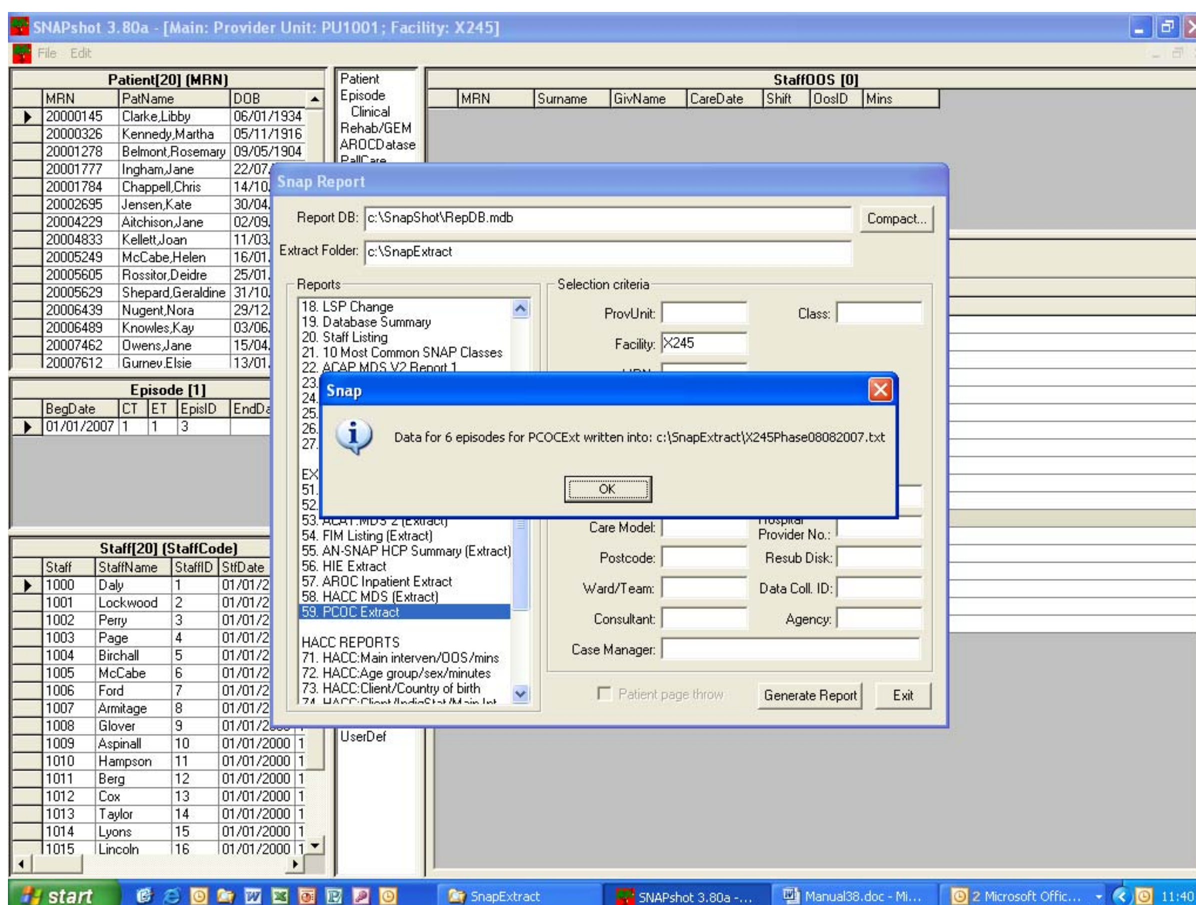
This extract produces three fixed format ASCII files that comprise the Version 2 PCOC dataset to be submitted to PCOC. To create the PCOC Extract, press Shift-F8 whilst positioned on any of the data lists in SNAPshot. Select Extract 59 'PCOC Extract' from the list of extracts, enter your Facility Code and then press Generate Report. This will generate a message as shown in Figure 3-1 that reads: 'Data for XX episodes for PCOCExt written into: C:\SnapExtract\FacilityNamePhaseDDMMYYYYHHMM.txt.' However, please note that three files will be generated as follows:

- FacilityNamePatientDDMMYYYYHHMM.txt
- FacilityNameEpisodeDDMMYYYYHHMM.txt
- FacilityNamePhaseDDMMYYYYHHMM.txt

FacilityName is the name as entered in the Facility screen, DDMMYYYY is today's date (the day the extract is created) and HHMM is the time the extract was generated. Do not change the name of the file created by SNAPshot.
Please note that 'from' and 'to' dates should not be selected when creating the PCOC Extract.

The PCOC Extract text file is written into the extract folder. The default location of the extract folder is c:\SnapExtract, however, you can specify another folder which can be on any computer including other than the one SNAPshot is installed (for further information please refer to either the SNAPshot V3.82(e) Manual or to 3.2.3 above). The file can now be emailed to PCOC at PCOC@uow.edu.au – *note that the extract contains 'client MRN' and 'date of birth', but does not include any other identifying data items.*

Figure 3-1 PCOC Extract Dialogue



4 Data Consistency

Once you have emailed the three text extracts to PCOC (see Section 3) you will receive a returned email reporting on data consistency. These reports come in two formats: Warning Reports and Fatal Reports. You will receive a Warning and Fatal Report for each of the three text extracts.

4.1 Warning reports

Warning reports are generated to highlight data missing from the PCOC Version 2 dataset. An example of a Warning Report is provided in Figure 4-1.

The line number and MRN are provided to help you identify the relevant record together with a list of the fields missing from the Version 2 Dataset. You may decide to review these records in your database and update them as necessary. If you do this it is recommended that you resubmit the three text extracts to PCOC. In doing this PCOC will be able to provide you with a more complete report on your data.

Figure 4-1 PCOC Warning Report

Report Date: 30/07/2008
Submission Report ID: 8
Submission Date: 29/04/2008
FacilityId: TEST
InFileName: TESTEpisode2904080919.txt

Palliative Care Outcomes Collaboration System

Compliance (Warning) Report on Episode File

Line#	MRN:	Episode Id:	Phase Id:	MissingFields:
53	08279X	189		Diagnosis code, First Assessment Date, Proposed Model of Care, Accommodation at Episode Start, Level of support at Episode End,
85	00974X	314		Accommodation at Episode Start, Accommodation at Episode End,
62	05363X	219		Diagnosis code, Referral Date, Referral Source, First Assessment Date, Proposed Model of Care, Accommodation at Episode Start, Accommodation at Episode End,
61	03967X	214		Level of support at Episode Start, Accommodation at Episode End,
59	09347X	206		Diagnosis code, Proposed Model of Care, Accommodation at Episode Start, Accommodation at Episode End,

4.2 Fatal Reports

Fatal reports are generated to highlight invalid data that cannot be processed into the PCOC database. In these cases the record is rejected and PCOC cannot therefore report on the record. An example of a Fatal Report is provided in Figure 4-2.

Again, the line number and MRN are provided to help you identify the relevant record together with a brief description of why the record has been rejected. You are strongly recommended to review these records in your database and update them as necessary. After doing this you will need to resubmit the three text extracts to PCOC. In doing this PCOC will be able to provide you with a more complete report on your data.

Figure 4-2 PCOC Fatal Report

Report Date: 30/07/2008
Submission Report ID: 8
Submission Date: 29/04/2008
FacilityId: TEST
InFileName: TESTEpisode290408091

Palliative Care Outcomes Collaboration System

Acknowledgement (Fatal) Report on Episode File

Line#	MRN:	Episode Id:	Phase Id:	Error Description:
99	095131X	363		Episode end mode must be either 1, 2, 3, 4, 5, 6, 8 or 99 for Overnight admitted
22	061993X	85		Episode start mode must be either A or B or null for Ambulatory patients
132	015727X	497		Episode end mode must be either 1, 2, 3, 4, 5, 6, 8 or 99 for Overnight admitted
131	079962X	494		Episode end mode must be either 1, 2, 3, 4, 5, 6, 8 or 99 for Overnight admitted
131	079962X	494		Episode start mode must either 1,2,3,4,5,6,7 or 9 for Overnight admitted
122	0003772X	459		First Assessment Date must be <= Episode Start Date
142	020045X	524		Episode end mode must be either 1, 2, 3, 4, 5, 6, 8 or 99 for Overnight admitted
81	075037X	299		Can't add, Related Patient Record does NOT exist in PCOC Database
66	015543X	235		First Assessment Date must be <= Episode Start Date
58	082710X	203		Episode start mode must be either A or B or null for Ambulatory patients

Appendix 1 Control Keys

Key	Action
Arrows	Move left, right, up or down.
Enter or Tab	Save field changes (if any) and move to the next field to the right or down.
Shift+Tab	Save field changes (if any) and move to the previous field to the left or up.
Alt+down arrow	For coded fields – open the drop down list.
Ctrl+A	Add a new record.
Ctrl+S	Save the current changes.
Esc	If the field in edit mode cancel field changes. In record edit mode, cancel record changes. If you are positioned in the EditView but are not currently editing, pressing the Esc key will move the cursor to the Date field and you can move forward to the Shift field by pressing the Tab key or back to the control buttons using Shift-Tab. Pressing the Tab key on the Shift field will move you to the EditView. If you press the Esc key on the Date field, you will jump to the SetList and you can move up and down the SetList without selecting a set by holding down the Shift key whilst you press the Up/Down arrow keys.
Shift+Up/Down	(on SetList) You can move up and down the SetList without selecting a set by holding down the Shift key whilst you press the Up/Down arrow keys. When you are positioned on the required set, release the Shift key and the set will be selected.
F6	The F6 key will move you forwards from segment to segment. Shift-F6 will move backwards.
F7	F7 is the 'Process' key and, for certain segments/data sets, provides additional processing options.

Appendix 2 Searching for a client by name or by mrn

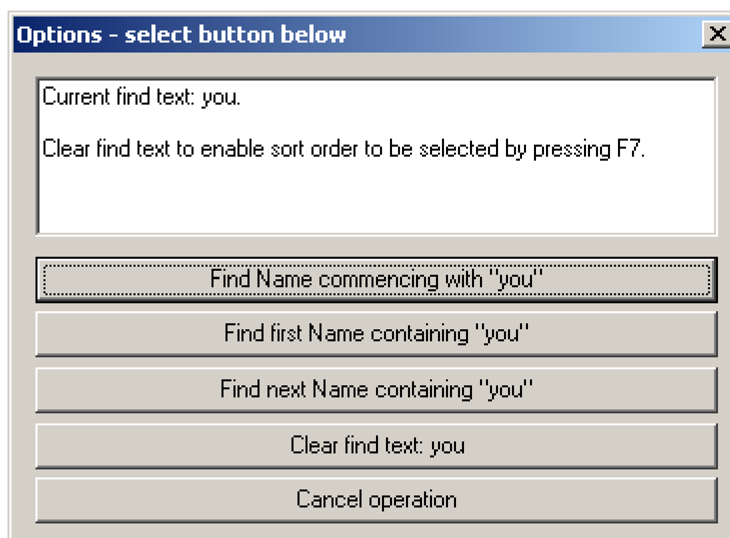
You can search for a client in the 'Patient list' by surname or by Medical Record Number (MRN).

- Click in the 'Patient List' (or press the F6 key to move the cursor to it).

  If the patient list ordering is by Name, then [Name] will appear in the caption bar. If the patient list ordering is by MRN, then [MRN] will appear in the caption bar.
- Press the F7 key to reorder the list of clients by MRN or Name as preferred.
- To search by Name, order the patient list by name.

  Type the family name (the whole name or the first few letters). The letters you type will appear immediately to the right of the of [name] in the caption bar. Press the F7 key. Choose from the 'Options' Window in Figure 4-3.

Figure 4-3 Searching for a client record



  Alternatively, press Shift+F7 at the same time. Snapshot will automatically search for the first record that matches your selection. If the first record found is not the required one, press F7 and choose the option 'Find next Name containing…'.
- To search by MRN, type the required MRN and follow the same procedure as for searching by Name.

Appendix 3 PCOC Data entry – 'cheat sheet' for entering <u>INPATIENTS</u>

1. Patient Screen

Click on 'Add'
Enter the data for:
- Medical record Number
- Date of Birth
- Sex
- Indigenous status
- Country of birth
- State
- Postcode

Click on 'Save'

2. Episode Screen

Click on 'Add'
Enter the data for:
- Episode Begin date
- Case Type (this field can be defaulted to 1 – Palliative Care [see Section 2.3])
- Episode type (this field can be defaulted to suit your service [see Section 2.3])
- Assessment only (this field can be defaulted to 2 – No [see Section 2.3])
- Mode of episode start
- Type of usual accommodation prior to admission
- Support provided prior to admission (*complete only if accommodation prior to admission is 1, Private residence*)
- Model of care (this field can be defaulted to 1 – Direct care [see Section 2.3])

Click on 'Save'

3. PallCare Screen

Click on 'Add'
Enter the data for:
- Phase begin date
- Phase end date – date of next phase or date of death if last phase
- PC Phase
- Reason for phase end
- Enter all 4 scores for RUG (Mobility, Toileting, Transfer and Eating)
- Enter all 4 scores for PSS (Pain, Symptoms, Psych/spiritual and Family/carer)
- Enter Karnovsky Rating Scale score
- Enter all 7 scores for SAS
- Model of Care Phase End

Click on 'Save'

4. PCOC Screen

Click on 'Add'
Enter the data for:
- Referral date
- PCOC Source of referral
- Date of first contact
- Proposed model of care
- PCOC Diagnosis
- Main language spoken at home

Click on 'Save'

5. Episode Screen

Enter the data for:

- Episode End date
- Mode of episode end
- Accommodation post discharge (if patient has not died)
- Support provided at episode end (if patient has not died)

Click on 'Save'

Appendix 4 PCOC Data entry – 'cheat sheet' for entering COMMUNITY PATIENTS

1. Patient Screen

Click on 'Add'
Enter the data for:
- Medical record Number
- Date of Birth
- Sex
- Indigenous status
- Country of birth
- State
- Postcode

Click on 'Save'

2. Episode Screen

Click on 'Add'
Enter the data for:
- Episode Begin date
- Case Type (this field can be defaulted to 1 – Palliative Care [see Section 2.3])
- Episode type (this field can be defaulted to 4 – Community patient [see Section 2.3])
- Assessment only (this field can be defaulted to 2 – No [see Section 2.3])
- Mode of episode start
- Type of usual accommodation prior to admission
- Support provided prior to admission (*complete only if accommodation prior to admission is 1, Private residence*)
- Model of care (this field can be defaulted to suit your service [see Section 2.3])
- Provider Type (this field can be defaulted to suit your service [see Section 2.3])
- Sole Practitioner

Click on 'Save'

3. PallCare Screen

Click on 'Add'
Enter the data for:
- Phase begin date
- Phase end date – date of next phase or date of death if last phase
- PC Phase
- Reason for phase end
- Enter all 4 scores for RUG (Mobility, Toileting, Transfer and Eating)
- Enter all 4 scores for PSS (Pain, Symptoms, Psych/spiritual and Family/carer)
- Enter Karnovsky Rating Scale score
- Enter all 7 scores for SAS
- Model of Care Phase End

Click on 'Save'

4. PCOC Screen

Click on 'Add'
Enter the data for:
- Referral date
- PCOC Source of referral
- Date of first contact
- Proposed model of care

- PCOC Diagnosis
- Place of Death
- Main language spoken at home

5. EpiOOS Screen

Click on 'Add'
Enter the data for:
- StaffID
- CareDate

Click on 'Save'

6. Episode Screen

Enter the data for:
- Episode End date
- Mode of episode end
- Accommodation post discharge (if patient has not died)
- Support provided at episode end (if patient has not died)

Click on 'Save'

Appendix 5 PCOC Data entry – 'cheat sheet' for entering CONSULTATIVE PATIENTS

1. Patient Screen

Click on 'Add'
Enter the data for:
- Medical record Number
- Date of Birth
- Sex
- Indigenous status
- Country of birth
- State
- Postcode

Click on 'Save'

2. Episode Screen

Click on 'Add'
Enter the data for:
- Episode Begin date
- Case Type (this field can be defaulted to 1 – Palliative Care [see Section 2.3])
- Episode Type (this field can be defaulted to 5 – Consultation Service [see Section 2.3])
- Assessment only (this field can be defaulted to 1 – Yes [see Section 2.3])
- Assessment type (This field can be defaulted to suit your model of care)
- Mode of episode
- Type of usual accommodation prior to admission
- Support provided prior to admission (*complete only if accommodation prior to admission is 1, Private residence*)
- Model of care (This field can be defaulted to suit your model of care [see Section 2.3])
- Provider type (This field can be defaulted to suit your model of care [see Section 2.3])
- Sole Practitioner

Click on 'Save'

3. PallCare Screen

Click on 'Add'
Enter the data for:
- Phase begin date
- Phase end date – date of next phase or date of death if last phase
- PC Phase
- Reason for phase end
- Enter all 4 scores for RUG (Mobility, Toileting, Transfer and Eating)
- Enter all 4 scores for PSS (Pain, Symptoms, Psych/spiritual and Family/carer)
- Enter Karnovsky Rating Scale score
- Enter all 7 scores for SAS
- Model of Care Phase End

Click on 'Save'

4. PCOC Screen

Click on 'Add'
Enter the data for:
- Referral date
- PCOC Source of referral
- Date of first contact

- Proposed model of care
- Reason for consultative service
- Location of consultative service
- Mode of consultative service
- PCOC Diagnosis
- Place of Death - Complete only if Mode of Episode End is B (Bereavement phase end or death). Otherwise leave blank
- Main language spoken at home

Click on ‘Save’

5. EpiOOS Screen

Click on ‘Add’

Enter the data for:

- StaffID
- CareDate

Click on ‘Save’

6. Episode Screen

Enter the data for:

- Episode End date
- Mode of episode end
- Accommodation post discharge (if patient has not died)
- Support provided at episode end (if patient has not died)

Click on ‘Save’

Appendix 6 PCOC Data Definitions Version 2

Level 1 - Patient Level Items

No.	Item	Item Description	Item Codes	Item Code-Set Description
2.1.1	Person/Client Identifier	Unique person identifier within the palliative care service		Any number that is unique for each patient. This number must be used at all times when recording patient, episode or phase details for this patient for PCOC. This number could be the patient record number
2.1.2	Date of Birth	Birth date of patient	dd/mm/yyyy	
2.1.3	Sex	Patient's gender	1	Male
			2	Female
			3	Indeterminate
			99	Not stated/inadequately described
2.1.4	State Identifier	State of usual place of residence	1	NSW
			2	VIC
			3	QLD
			4	SA
			5	WA
			6	TAS
			7	NT
			8	ACT
			9	Other Australian Territory (Australian Antarctic Territory, Cocos (Keeling) Islands, Christmas Island and Jervis Bay Territory)
			10	Other country
2.1.5	Postcode	Postcode of usual place of residence *Leave blank if State identifier is 9 or 10*		Four digit postcode
2.1.6	Indigenous status	Patient's indigenous status	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	Neither Aboriginal nor Torres Strait Islander origin
			99	Not stated / inadequately described
2.1.7	Main language spoken at home	The main language reported by a patient as the main language spoken in his/her home.	xx	Standard 2 digit code.
2.1.8	Country of birth	The country in which the person was born	xxxx	Standard Australian Classification of Countries (SACC) 4-digit (individual country) level. ABS catalogue no.1269.0 (1998)

Level 2 - Episode Level Items

No.	Item	Item Description	Item Codes	Item Code Set Description
2.2.9	Referral date	Date agency received a referral for this patient/client from another party for palliative care services	dd/mm/yyyy	
2.2.10	Referral source	Location of source of referral for this episode	1	Public hospital – other than inpatient palliative care unit
			2	Private hospital – other than inpatient palliative care unit
			3	Public palliative care inpatient unit/hospice
			4	Private palliative care inpatient unit/hospice
			5	General Medical Practitioner rooms
			6	Specialist Medical Practitioner rooms
			7	Community-based palliative care agency
			8	Community-based service
			9	Residential aged care facility
			10	Self, carer(s), family or friends
			11	Other
2.2.11	Mode of episode start	How this episode began	*Overnight Admitted Patients*	
			1	Admitted from usual accommodation
			2	Admitted from other than usual accommodation
			3	Admitted (transferred) from another hospital
			4	Admitted (transferred) from acute care in another ward
			5	Change from acute care to palliative care while remaining on same ward
			6	Change of sub-acute/non-acute care type
			7	Statistical admission from leave
			9	Other
			All other patients (same day admitted, outpatient and community)	
			A	First visit following new referral
			B	First visit after discharge from being an overnight admitted palliative care patient
2.2.12	Date of first contact with patient/client	First contact (telephone or face to face) by palliative care service following receipt of referral	dd/mm/yyyy	
2.2.13	Episode start date	The date a patient/client commences an episode of care	dd/mm/yyyy	For inpatients: date of admission
				For ambulatory patients: date of first face to face contact
2.2.14	Proposed model of care at episode start	The type of care planned at the start of this episode of care	1	Direct care
			2	Shared care with another service provider/s (cancer care, respiratory, GP, MND, community health care providers)
			3	Consultation/liaison with another service provider
2.2.15	Episode type	The location of the patient for this episode	0	Overnight admitted patient in a non-designated inpatient palliative care bed/unit Go to 2.2.19 (*Patient is admitted and discharged on different dates)*
			1	Overnight admitted patient in a designated inpatient palliative care bed/unit Go to 2.2.19 (*Patient is admitted and discharged on different dates)*
			3	Ambulatory Go to 2.2.19 *(Patient receives care on a same day admitted or outpatient basis)*
			4	Community Go to 2.2.19 (*Patient receives care in the home or other non-hospital site)*
			5	Consultation service (Patient is seen by a consultative service) If 5 is ticked answer 2.2.16, 2.2.17 and 2.2.18
2.2.16	Reason for consultative	Type of consultative service provided	1	Advice only
			2	One-off consultation

No.	Item	Item Description	Item Codes	Item Code Set Description
	service visit	*Complete only if Episode Type is 5 (Consultative). Otherwise leave blank*	3	Recurring consultation
			99	Not stated/inadequately described
2.2.17	Location of consultative service	Location where the consultative service was provided *Complete only if Episode Type is 5 (Consultative). Otherwise leave blank*	1	Inpatient – designated palliative care bed
			2	Inpatient – non-designated palliative care bed
			3	Hospital-based clinic or centre
			4	Community-based day centre
			5	Residential aged care facility
			6	Home
			99	Not stated/inadequately described
2.2.18	Mode of consultative service	How was this service was provided *Complete only if Episode Type is 5 (Consultative). Otherwise leave blank*	1	Face to face
			2	Telephone/electronic communication
2.2.19	Diagnosis	The broad diagnostic group established after study to be chiefly responsible for occasioning the patient's episode of palliative care.	1	**Malignant (neoplasm)**
				1.1 Bone and Soft Tissue
				1.2 Breast
				1.3 CNS
				1.4 Colorectal
				1.5 Gynaecological
				1.6 Haematological
				1.7 Head and Neck
				1.8 Lung
				1.9 Pancreas
				1.10 Prostate
				1.11 Skin
				1.12 Other GIT
				1.13 Other Urological
				1.14 Other Malignancy
				1.15 Unknown Primary
			2	**Non-malignant (other diagnosis)**
				2.1 Cardiovascular
				2.2 HIV/AIDS
				2.3 Kidney Failure
				2.4 Neurological Disease
				2.5 Respiratory Failure
				2.6 Other non-malignancy
2.2.20	Accommodation at episode start	Type of usual accommodation at the commencement of the episode	1	Private residence (including unit in retirement village)
			2	Residential aged care, low level care (hostel)
			3	Residential aged care, high level care (nursing home)
			4	Community group home
			5	Boarding house
			6	Transitional living unit
			7	Other
2.2.21	Level of Support at episode start	Level of support received at the commencement of the episode. *Complete only if Accommodation at episode start is 1 (Private residence). Otherwise leave blank*	1	Lives alone (no support/care provided)
			2	Lives with others (no support/care provided)
			3	Lives alone with external support(s)
			4	Lives with others (who provide support/care)
			5	Lives with others, external support(s)
			6	Other arrangements
			99	Not stated/inadequately described
2.2.22	Episode end date	The date of episode end	dd/mm/yyyy	The date of discharge, death or transfer
2.2.23	Mode of episode end	How this episode ended	*Overnight admitted patients*	
			1	Discharged to usual accommodation
			2	Discharged to interim accommodation
			3	Death
			4	Discharged to another hospital
			5	Change from palliative care to acute care – different ward
			6	Change from palliative care to acute care – same ward

No.	Item	Item Description	Item Codes	Item Code Set Description
			8	Discharged at own risk
			99	Other
			Ambulatory patients	
			A	Discharge/case closure
			B	Death (Complete 2.2.26)
			C	Admitted for inpatient palliative care
			D	Admitted for inpatient acute care
			E	Transfer to another palliative care service or to primary care
			G	Not known
2.2.24	Accommodation at episode end	Type of accommodation at episode end	1	Private residence (including unit in retirement village)
			2	Residential aged care, low level care (hostel)
			3	Residential aged care, high level care (nursing home)
			4	Community group home
			5	Boarding house
			6	Transitional living unit
			7	Other
2.2.25	Level of Support at episode end	Level of support received at episode end. *Complete only if Accommodation at episode end is 1 (Private residence). Otherwise leave blank*	1	Lives alone (no support/care provided)
			2	Lives with others (no support/care provided)
			3	Lives alone with external support(s)
			4	Lives with others (who provide support/care)
			5	Lives with others, external support(s)
			6	Other arrangements
			99	Not stated/inadequately described
2.2.26	Place of death	*Complete only if Mode of Episode End (item 2.2.23) is B (death). Otherwise leave blank*	1	Private residence
			2	Residential aged care setting
			3	Other location

Level 3 - Phase level items

No.	Item	Item Description	Item Code Set	Item Code Set description
2.3.27	Date of phase start	The date this phase began	dd/mm/yyyy	
2.3.28	Phase	Palliative Care Phase. *Note: The first phase begin date = episode begin date*	1	Stable
			2	Unstable
			3	Deteriorating
			4	Terminal
			5	Bereaved
2.3.29	RUG-ADL functional scores at phase start	RUG-ADL scores as recorded within 24 hours of the start of the phase. Note: a score of 2 is not valid on the bed mobility, toileting or transfer items	For bed mobility, toileting & transfers:	
			1	Independent or supervision only
			3	Limited physical assistance
			4	Other than two persons physical assist
			5	Two-person physical assist
			For eating:	
			1	Independent or supervision only
			2	Limited assistance
			3	Extensive assistance/total dependence/ tube fed
2.3.30	Symptom Assessment Score (SAS) at phase start	SAS as recorded within 24 hours of the start of the phase.		Insomnia, appetite problems, nausea, bowels, breathing, fatigue and pain (7 items)
			0-10	Not at all - Worst Possible
2.3.31	Palliative Care Problem Severity scores at phase start	Pain score as recorded within 24 hours of the start of the phase	0	Absent
			1	Mild
			2	Moderate
			3	Severe
2.3.32	Palliative Care Problem Severity scores at phase start	Other symptom score as recorded within 24 hours of the start of the phase	0	Absent
			1	Mild
			2	Moderate
			3	Severe
2.3.33	Palliative Care Problem Severity scores at phase start	Psychological/Spiritual score as recorded within 24 hours of the start of the phase	0	Absent
			1	Mild
			2	Moderate
			3	Severe
2.3.34	Palliative Care Problem Severity scores at phase start	Family/Carer score as recorded within 24 hours of the start of the phase	0	Absent
			1	Mild
			2	Moderate
			3	Severe
2.3.35	Karnofsky functional score at phase start	Score on the Australian Modified Karnofsky Scale as recorded within 24 hours of the start of the phase	100	Normal; no complaints; no evidence of disease.
			90	Able to carry on normal activity; minor signs or symptoms.
			80	Normal activity with effort; some signs or symptoms of disease
			70	Cares for self; unable to carry on normal activity or to do active work
			60	Requires occasional assistance but is able to care for most of his needs
			50	Requires considerable assistance and frequent medical care
			40	In bed more than 50% of the time.
			30	Almost completely bedfast.
			20	Totally bedfast and requiring extensive nursing care by professionals and/or family.
			10	Comatose or barely arousable
			0	Dead
2.3.36	Model of care at phase end	The type of care provided at the end of this phase of care	1	Direct care
			2	Shared care with another service provider/s (cancer care, respiratory, GP, MND, community health care providers)
			3	Consultation/liaison with another service provider
2.3.37	Date of phase end	The date on which a patient completes a phase of care	dd/mm/yyyy	*Default to new episode*

No.	Item	Item Description	Item Code Set	Item Code Set description
2.3.38	Reason for phase end	The reason this phase ended	1	Phase change
			2	Discharge/Case closure
			3	Died
			4	Bereavement phase end
2.3.40	RUG-ADL functional scores at phase end	RUG-ADL scores as recorded within 24 hours of the end of the phase. Note: a score of 2 is not valid on the bed mobility, toileting or transfer items ***Complete only if reason for phase end is (2) Discharge/Case closure***	For bed mobility, toileting & transfers:	
			1	Independent or supervision only
			3	Limited physical assistance
			4	Other than two persons physical assist
			5	Two-person physical assist
			For eating:	
			1	Independent or supervision only
			2	Limited assistance
			3	Extensive assistance/total dependence/ tube fed
2.3.41	Symptom Assessment Score (SAS) at phase end	SAS as recorded within 24 hours of the end of the phase *Complete only if reason for phase end is (2) Discharge/Case closure*		Insomnia, appetite problems, nausea, bowels, breathing, fatigue and pain (7 items)
			0-10	Not at all - Worst Possible
2.3.42	Palliative Care Problem Severity scores at phase end	Pain score as recorded within 24 hours of the end of the phase *Complete only if reason for phase end is (2) Discharge/Case closure*	0	Absent
			1	Mild
			2	Moderate
			3	Severe
2.3.43	Palliative Care Problem Severity scores at phase end	Other symptom score as recorded within 24 hours of the end of the phase *Complete only if reason for phase end is (2) Discharge/Case closure*	0	Absent
			1	Mild
			2	Moderate
			3	Severe
2.3.44	Palliative Care Problem Severity scores at phase end	Psychological/Spiritual score as recorded within 24 hours of the end of the phase *Complete only if reason for phase end is (2) Discharge/Case closure*	0	Absent
			1	Mild
			2	Moderate
			3	Severe
2.3.45	Palliative Care Problem Severity scores at phase end	Family/Carer score as recorded within 24 hours of the start of the phase *Complete only if reason for phase end is (2) Discharge/Case closure*	0	Absent
			1	Mild
			2	Moderate
			3	Severe
2.3.46	Karnofsky functional score at phase end	Score on the Australian Modified Karnofsky Scale as recorded within 24 hours of the end of the phase *Complete only if reason for phase end is (2) Discharge/Case closure*	100	Normal; no complaints; no evidence of disease.
			90	Able to carry on normal activity; minor signs or symptoms.
			80	Normal activity with effort; some signs or symptoms of disease
			70	Cares for self; unable to carry on normal activity or to do active work
			60	Requires occasional assistance but is able to care for most of his needs
			50	Requires considerable assistance and frequent medical care
			40	In bed more than 50% of the time.
			30	Almost completely bedfast.
			20	Totally bedfast and requiring extensive nursing care by professionals and/or family.
			10	Comatose or barely arousable
			0	Dead