PCOC V2 Data Definitions and Guidelines

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Introduction to PCOC

PCOC is a voluntary, quality initiative which aims to assist palliative care service providers to measure the standard and quality of care which is a stated goal of the National Palliative Care Strategy. This will be achieved by collecting and analysing data, reporting findings to service providers, and facilitating benchmarking activities between like services.

This document is designed to assist service providers who agree to collect PCOC data. There are definitions of data items and guidelines for collecting some data items. To collect reliable data requires consistency in practice and interpretation and it is important that PCOC provide appropriate training for all those with responsibility for collecting PCOC data. Once service providers join PCOC, plans for staff training will be developed with that service. It is a requirement that staff with responsibility for collecting PCOC data complete training modules.

The development of the PCOC data set has evolved after broad consultation with service providers and representatives of peak organisations. Where possible, National Health Data Dictionary definitions have been used. Many of the data items are consistent with those used by the Australian-National Sub-Acute and Non-Acute Patient classification (AN-SNAP) which is a national Casemix classification for Sub-Acute and Non-Acute care.

Developing a national data set for palliative care that can be used in both inpatient and community settings requires a gradual process of developing and refining the data set. The PCOC Version 1 data set was collected by a small number of services for approximately 18 months. The Version 2 data set evolved based on the experiences collecting Version 1 and following broad consultation with services around Australia. It was approved for implementation by PCOC's Scientific and Clinical Advisory Committee (SCAC) in May 2007.

To facilitate consistency in the language throughout this document please note the term patient/client/customer/consumer is referred to as patient.

1. Palliative care and palliative care service definitions

1.1 Health service or facility

An organisation with its own unique establishment code issued by the relevant authority. By definition, each hospital or hospice (whether public or private) is a separate facility. A community health service is a community-based health service that reports as one service, unit or facility to a central service. The definition of a community health facility varies from jurisdiction to jurisdiction.

For the purposes of PCOC, a health service may provide one or more palliative care services, that is inpatient, community and/or outpatient.

1.2 Palliative care

Palliative care is:

- provided for a person with an active, progressive disease with little or no prospect of cure and
- for whom the primary treatment goal is quality of life
- which is evidenced by:

  + multidisciplinary assessment and/or management of the physical, psychological, emotional and spiritual needs of the person

  + a grief and bereavement process for the person and their carers/family

Inclusions:

- Palliative care provided in both community and hospital settings
- Grief and bereavement support services for the family and carers during the life of the person and continuing after death.

1.3 Palliative care service

A palliative care service provides palliative care (see 1.2 above) in which:

- there is a unique (unit) record number for each palliative care patient;
- if there is more than one physical (written) medical record for each patient, staff have access (if required) to information contained in all of the physical records held for that patient.

For the purposes of defining a palliative care service, PCOC uses the Palliative Care Australia's *Standards for providing Quality Palliative Care for all Australians* as a guideline.

Some health services have multiple medical record systems and therefore may have multiple palliative care services. For example, a community health service may have separate medical record systems for each separate community health centre within the service.

Some palliative care services include multiple facilities. For example, an area, consortia or district palliative care service may consist of several hospitals or two or more community centres, each of which is a separate facility. However, if they are one palliative care service for the purposes of submitting data to PCOC, they will have (by definition) a shared medical record numbering system and each patient will have the same unique record number at each facility.

There are some regional palliative care services that include separate facilities, each of which has their own medical record system. In these cases, PCOC will not know that the patient is the same person because the person will have different record numbers in each facility. Even though these are one area-wide service, they are not one palliative care service for the purposes of PCOC data

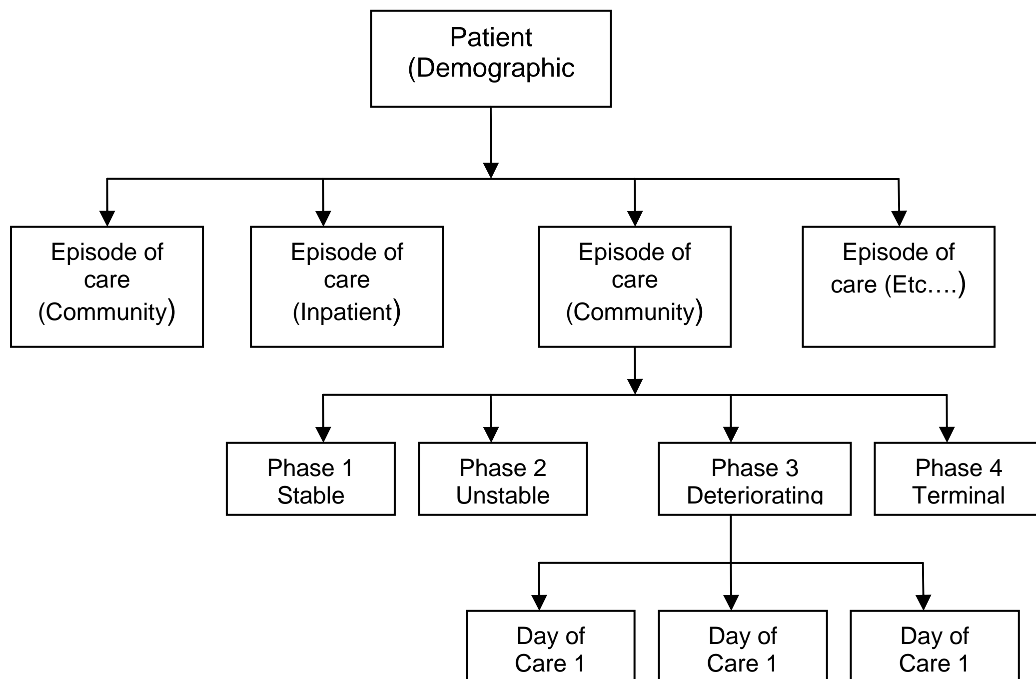
analysis. PCOC requires a unique and common record number for each patient receiving care from the service so that it can link all episodes together.

1.4 PCOC information architecture

Figure 1 below shows the PCOC information architecture. The focus of PCOC, at least during its first stages of development, is on the collection of data at the patient, episode of care and phase levels. As shown in the figure, information collected at the phase level can be bundled to form a picture of each episode of care.

PCOC aims to collect, analyse and report data to assist services achieve improvements in quality and outcomes. Data items collected at phase level reflect the patient's clinical changes and will provide much of the data for the analysis of outcomes.

Figure 1 PCOC Architecture



2. Level 1: Patient (demographic) items

2.1 Patient

A patient for whom a palliative care service accepts responsibility for assessment and/or treatment as evidenced by the existence of a medical record.

Family/carers are included in this definition if interventions relating to them are recorded in the patient medical record. For the purpose of palliative care this includes the bereaved family of the deceased patient.

- **Overnight admitted** – a patient undergoes a formal hospital admission process with the intent of discharge on different dates.
- **Not overnight admitted** – a patient who does not undergo a formal overnight or inpatient hospital admission process. Not overnight admitted patients may be same day admitted, community or outpatient. Not overnight admitted patients may be treated in outpatient, community and domiciliary settings by either hospital or community health services.
    - A same day admitted patient is a patient who is admitted with the intent of being discharged on the same day.
    - An outpatient is a patient who receives care in a hospital outpatient clinic
    - A community patient is a patient who receives care in the home or other non-hospital site (including residential aged care facilities).

PCOC collects the following patient level items:

2.1.1 Person identifier

2.1.2 Date of birth

2.1.3 Sex

2.1.4 State identifier

2.1.5 Postcode

2.1.6 Indigenous status

2.1.7 Main language spoken at home

2.1.8 Country of birth

2.2 Level 2: Episode items

Episode

An episode of care is a period of contact between a patient and a palliative care service that is provided by one palliative care service and occurs in **one setting (either overnight admitted patient or not overnight patient)**. When a patient moves from their home to a residential aged care facility (RACF) it is considered their home and the episode continues.

An episode of care refers to the care received between admission and separation within one setting.

An episode of palliative care begins:

- on the day the patient is assessed face to face by the palliative care provider and there is agreement between the patient and the service.
- An episode of palliative care ends when:

- 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.

Concurrent Episodes of Care

This data item allows for concurrent episodes of care in the following circumstances:

When a patient is receiving two episodes of care but different episode types (eg overnight admitted and community)

If a community patient is admitted to hospital for 7 days or less, there is no need to end the not admitted episode. The patient can have two overlapping episodes. If the community team sees the patient while they are in hospital, this should be recorded as an occasion of service.

However, if a community patient is admitted to hospital for 8 days or more, the community episode should be ended and the overnight episode becomes the episode of care. If the community team visits the patient while they are in hospital, this should be recorded as a consultation episode

PCOC collects the following episode items:

2.2.9	Referral date for this episode
2.2.10	Referral source for this episode
2.2.11	Mode of episode start
2.2.12	Date of first contact with patient for this episode
2.2.13	Episode start date
2.2.14	Proposed model of care at episode start
2.2.15	Episode type
2.2.16	If consultation service - Reason for consultative service
2.2.17	If consultation service - Location of consultative service
2.2.18	If consultation service - Mode of consultative service
2.2.19	Diagnosis
2.2.20	Accommodation at episode start
2.2.21	Level of support at episode start (If episode start is private residence)
2.2.22	Episode end date
2.2.23	Mode of episode end
2.2.24	Accommodation at episode end (If episode end is discharge)
2.2.25	Level of support at episode end (If episode end is private residence)
2.2.26	Place of death (not overnight admitted patients)

2.3 Level 3: Phase Level Items

Phase
The palliative care phase is the stage/condition of the patient's illness within the episode of care. There may be more than one phase of care within the episode. Palliative care phases are not sequential and a patient may move back and forth between phases. Phase changes occur based on the patient's stage/condition during the episode. Palliative Care Phases provide a clinical indication of the type of care required.

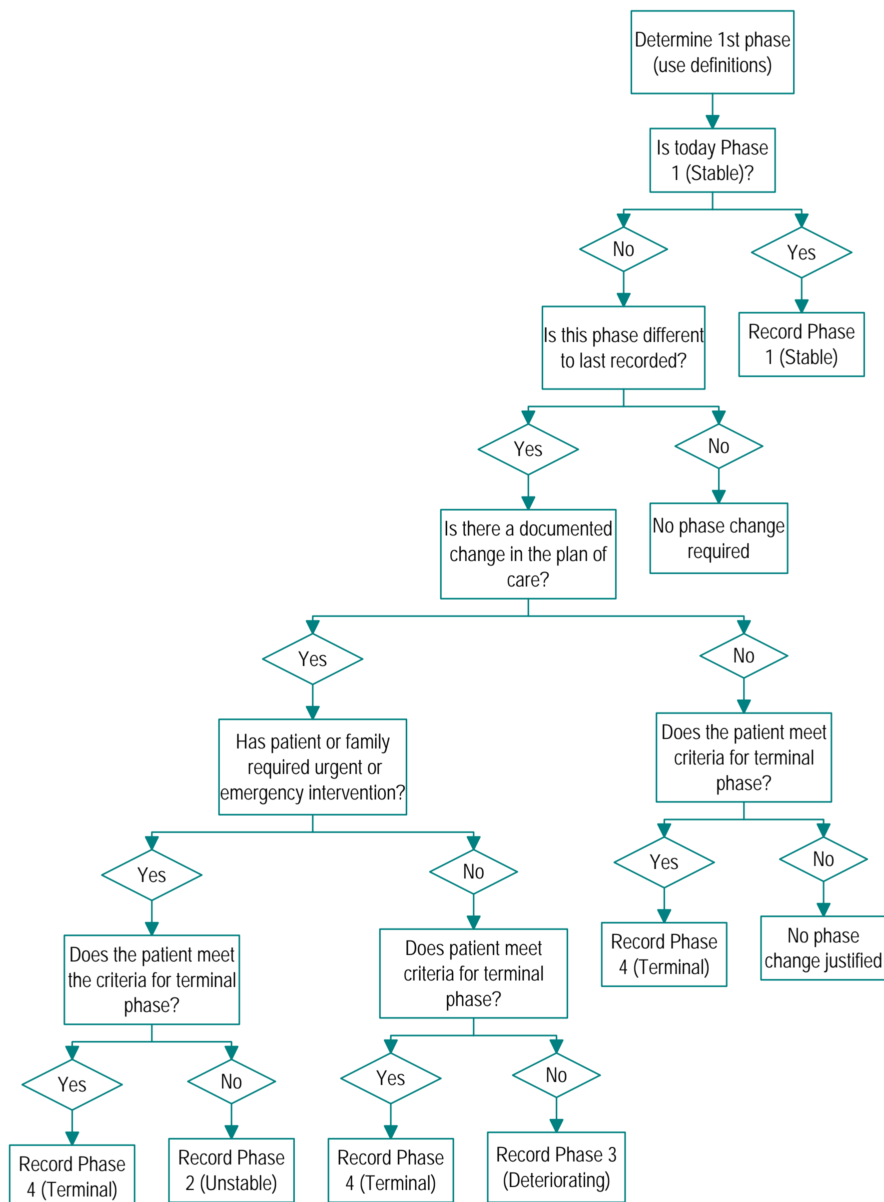
For example a patient may be admitted in an unstable phase with neuropathic pain. Within three days the pain is controlled, the patient is classified as stable and discharged home. The episode of care is 3 days with 2 phases of care.

PCOC collects the following phase level items:

2.3.27 Date of phase start
2.3.28 Palliative care phase
2.3.29 RUG-ADL functional scores at phase start
2.3.30 Symptom Assessment Score at phase start
2.3.31 Palliative care problem severity pain at phase start
2.3.32 Palliative care problem severity other symptoms at phase start
2.3.33 Palliative care problem severity psychological/spiritual at phase start
2.3.34 Palliative care problem severity family/carer at phase start
2.3.35 Australian Modified Karnofsky Status (AMKS) performance scale at phase start
2.3.36 Model of care at phase end
2.3.37 Date of phase end
2.3.38 Reason for phase end
2.3.39 Number of days seen in phase (not overnight admitted episode)
2.3.40 RUG-ADL functional scores at phase end
2.3.41 Symptom Assessment Score at phase end
2.3.42 Palliative care problem severity pain at phase end
2.3.43 Palliative care problem severity other symptoms at phase end
2.3.44 Palliative care problem severity psychological/spiritual at phase end
2.3.45 Palliative care problem severity family/carer at phase end
2.3.46 Australian Modified Karnofsky Status (AMKS) performance scale at phase end

When recording phase use the algorithm shown in figure 2 to assist with the assessment of the phase of the patient.

Figure 2 Algorithm for the assignment of a palliative care phase



In the example below, **Phase 1 – stable** is changed to **Phase 2** – **unstable** with the selection of unstable confirmed as follows:

Question	Answer
Is this day Phase 1 (stable)?	No
Is the phase different to last recorded?	Yes
Is there a documented change in the plan of care?	Yes
Has patient or family required urgent or emergency intervention?	Yes
Does the patient meet criteria for terminal phase?	No

The question 'Has the patient or family required urgent or emergency intervention?' is where the decision trigger between using **Phase 2 – unstable** or **Phase 3 – deteriorating** occurs.

2.4 Models of care

Two workshops, a consultative services and community services workshop were held in July and September 2008 respectively with the aim of agreeing on a common language to describe the different types of palliative care provided and data items to be collected.

The following represents work to date on defining models of palliative care that classify the broad type of care provided to each patient.

1. Direct care
The palliative care service is the primary provider and provides palliative care in the inpatient setting, the community setting or both.

2. Shared care
The palliative care service works with the patient's GP, primary care nurses or other specialist service providers in a **formal** shared care arrangement that includes joint care planning and the exchange of relevant clinical information. In shared care both parties have an ongoing involvement with the patient throughout the episode of care and both have direct contact with the patient.

Notes:

- While most patients have a General Practitioner or other medical, nursing or allied health clinicians involved in their palliative care, they are not necessarily participating in formal shared care.
- If unable to distinguish between direct and shared care, classify based on the patient/carer perception about who is responsible for meeting their palliative care needs at this time.

3. Consultative care

The patient is under the clinical care of another service (eg, GP, hospital, primary care nurse or RACF) and the palliative care service is providing consultation and liaison services to that service.

- **Consultative: Comprehensive ongoing care**
  Having undertaken an initial assessment, the palliative care service has an ongoing involvement with a patient and/or their treating clinicians.

- **Consultative: Comprehensive assessment**
  The palliative care service undertakes a comprehensive PC assessment. There is no planned review.

- **Consultative: Brief assessment or intervention**
  The palliative care service sees the patient for advice on a specific problem or for care planning. There is no planned review.

- **Consultative: Informal service contact**
  A member of the palliative care team provides informal advice (eg, a phone conversation).

Model of care and its role in defining episodes
With one exception, each patient reported in the PCOC collection may only undergo one direct care episode at any one time by any one palliative care service.

The one exception is when a patient may have **concurrent episodes of care** when the patient is receiving **two Episodes of Care, each of which is a different model of care, at the same time**.

A patient may have two overlapping Direct Care episodes if, and only if, an ambulatory (community) patient is admitted to hospital for 7 days or less. In this case, there is no need to end the ambulatory (community) episode.

If an ambulatory patient is admitted to hospital for 8 days or more, the ambulatory direct care episode should be ended from the episode end date being recorded as the date that the patient was admitted to hospital. The overnight episode becomes the Direct Care episode from that point. If the ambulatory team sees the patient while they are in hospital, this can be recorded as a new consultation episode.
If two ambulatory services are providing shared care for a patient, each service will report a shared care episode. Duplication of information collection and assessments should be avoided by sharing information.

If two ambulatory services are providing care for a patient (eg, a day hospital and a community program), but there is no shared care arrangement, the Direct Care episode is the one that provides the most services. In the event that this is equal, the Direct Care episode is the one that provides the case management and care coordination role. The other is a consultation episode.

If a patient is on leave from an Inpatient Unit and is seen by a community palliative care service whilst at home on leave, this is a concurrent consultative episode. Note that, under the national standard, the maximum leave days for an inpatient before discharge is required is 7 days which fits in with definition. When discharged from the inpatient setting, both episodes end and a new community episode begins.

A change in the Model of Care does not trigger a new episode of palliative care. PCOC collects the ‘Proposed Model of Care at episode start’ and the ‘Model of Care in place at Phase end’. This allows PCOC to track changes in the Model of Care over the course of a palliative care episode.

3. Version 2 Dataset

3.1 Level 1: Patient (Demographic) items

2.1.1	**Person identifier**
Definition:	Unique person identifier established by the palliative care service. A person for whom a health care provider accepts responsibility for a health assessment and/or treatment as evidenced by the existence of a medical record. This is usually a medical record number which is generated for each patient within a service. Family/carers are included in this definition if interventions relating to them are recorded in the patient medical record. For the purpose of palliative care this includes the bereaved family of the deceased patient.
Data Domain:	Maximum 12 characters
Justification:	The positive and unique identification of health care patients is a critical event, with direct implications for the safety and quality of health care. The process of positively identifying people within a health care service delivery context entails matching data supplied by those individuals against data the service provider holds about them To ensure that each person's health record is associated with that individual and no other.
Guide for use:	This number must be used at all times when recording patient episode and/or phase level information for PCOC
Source:	National Health Data Dictionary Version 14, 2008

2.1.2	**Date of birth**
Definition:	The patient's date of birth.
Data Domain	dd/mm/yyyy
Justification:	Used for demographic analysis.
Guide for use:	The date of birth must be less than admission date. Where the patient's date of birth is unknown it is to be estimated as accurately as possible.
Source:	National Health Data Dictionary Version 14, 2008

2.1.3	**Sex**

Definition: The term sex of the patient refers to the biological differences between males and females

Data Domain;
1 Male
2 Female
3 Indeterminate
99 Not stated/ inadequately described

Justification: To enable standardisation of the collection of information relating to sex.

Guide for use:

Source: National Health Data Dictionary Version 14, 2008
The Australian bureau of statistics advises the correct terminology for the data element is sex

2.1.4	**State identifier**

Definition: The Australian state or territory or other country the patient usually resides in

Data Domain:
1 New South Wales
2 Victoria
3 Queensland
4 South Australia
5 Western Australia
6 Tasmania
7 Northern Territory
8 Australian Capital Territory
9 Other Australian territories (Australian Antarctic Territory, Cocos (Keeling) Islands, Christmas Island and Jervis bay Territory
10 Other country

Justification: A geographic analysis of service utilisation and state cross border flow activity.

Guide for use: Document the state or territory the patient usually resides.

Source: Australian Bureau of Statistics 2005.
National Health Data Dictionary Vol 12 2003

2.1.5	**Postcode**

Definition: The numeric descriptor for a postal delivery area, aligned with locality, suburb or place for the address of patient as defined by Australia Post. The postcode of usual place of residence of the patient.

Data Domain: Four digit code for usual residence of the patient. Valid Australia Post Postal Code
_ _ _ _

Justification: Analyse data for utilisation patterns and need for services.

Guide for use: Use four digit postcodes. Leave blank if State identifier is 9 or 10.

Source: Australian Bureau of Statistics 2005.

2.1.6 Indigenous status

Definition: A measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin.

Data Domain:
- 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

Justification: Australia's Aboriginal and Torres Strait islander peoples occupy a unique place in Australian society and culture. Accurate and consistent statistics about Aboriginal and Torres Strait islander peoples are needed in order to plan deliver and evaluate appropriate palliative care services in this area.

Guide for use: Record the measure according to response by the patient.

Source: National Health Data Dictionary Version 14, 2008
Australian Bureau of Statistics (ABS)

2.1.7 Main language spoken at home

Definition: The language reported by a person as the predominant language other than English spoken by a person in his/her home (or most recent private residential setting occupied by thee person) on a regular basis, to communicate with other residents of the home or setting and regular visitors.

Data Domain: Standard digit code

Justification: Identify those people more likely to experience disadvantage in terms of their ability to access services due to language and/or cultural difficulties

To effectively target the geographic areas or population groups that may need those services. It may be used for further quality projects in the use and access of interpreter / translation services.

Guide for use: The main language spoken by the patient in their home (or most recent private residential setting occupied by the patient) on a regular basis, to communicate with other residents of the home or setting and regular visitors.

Where language spoken at home is not 'English', record 'Other Language' and record the name of the language.

Source: Australian Bureau of Statistics 2005

2.1.8 Country of birth

Definition: The country in which the patient was born.

Data Domain: 4 digit code
Standard Australian Classification of Countries (SACC)

Justification: Identifies access to services by different population subgroups. Country of birth may be used with other data items such as place of residence in different population subgroups. This assists in identifying population subgroups that may not be accessing palliative care.

Guide for use: Where the patient's country of birth is not Australia, chose 'other country' and record the name of the country in which the patient was born.

Source: National Health Data Dictionary Version 14, 2008

3.2 Level 2: Episode Data Items

2.2.9	**Referral date**
Definition:	The date a service receives a **referral for this episode**, either written or verbal from another service provider.
Data Domain:	dd/mm/yyyy
Justification:	To understand the process of care from date of receipt of referral to the commencement of the episode of care.
Guide for use:	Referral date is only captured when an episode of care commences.
Source:	Palliative Care Outcomes Collaboration July, 2007

2.2.10	**Referral source**
Definition:	The service/organisation from which the patient was referred for this episode.
Data Domain:	1 Public hospital – other than inpatient palliative care unit/hospice 2 Private hospital – other than inpatient palliative care unit/hospice 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 service 8 Community-based service 9 Residential aged care facility 10 Self, carer(s), family or friends 11 Other
Justification:	To understand referral patterns and processes for referral. To assist in service planning with information of referral patterns.
Guide for use:	Document the source of referral for this episode of care. Referrals made by medical practitioners on behalf of community-based palliative care services, inpatient facilities and residential aged care services is to be recorded as a referral from that particular service/organisation and not as a referral from the medical practitioner.
Source:	Palliative Care Outcomes Collaboration 2007

2.2.11 Mode of episode start

Definition: How the episode of care commenced.

Data Domain:

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 case type
7 Statistical admission from leave
9 Other

A First visit following new referral
B First visit after discharge from being an overnight admitted palliative care patient

Justification: To provide information how a patient's episode begins.

Guide for Use: An episode of care starts in one of the following ways:

1 The patient is admitted from their place of residence, which could be a residential aged care facility.
2 The patient is admitted from a family member/carer's home or holiday accommodation.
3 The patient is admitted to a hospital/hospice following discharge/transfer from another hospital.
4 The patient completes an acute episode of care in another ward in the same hospital and starts a palliative care episode.
5 Completes an acute episode of care and begins a palliative care episode, in the same ward.
6 Completes a sub-acute or non-acute episode and starts a palliative care episode in the same hospital. For example a patient receiving a rehabilitation episode ends and a palliative care episode begins.
7 Statistical admission following leave of absence exceeding seven consecutive days.
9 Other

A The patient has first contact following a referral (including self-referral)

B Completes a palliative care episode as an overnight admitted patient and begins a palliative care episode as a same day patient, outpatient or community patient.

Source: The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study.

2.2.12	Date of first contact

Definition: The date of first contact with the patient (telephone or face to face) by palliative care service following receipt of referral.

Data Domain: dd/mm/yyyy

Justification: Determine time interval between the receipt of the referral and first contact with the patient either by telephone or face to face. This will depend of service model.

Guide for use: Document the date the service contacts the patient.

Source: Palliative Care Outcomes Collaboration 2007

2.2.13	Episode start date

Definition: The date of the patient's first palliative care face to face assessment by the palliative care health care provider and is accepted by the service for ongoing palliative care.

Data Domain: dd/mm/yyyy

Justification: The date is required to determine the length of stay for each episode of care and will also determine the time period from date of first contact to 1st assessment.

Guide for use: Record the date first face to face assessment is completed.

Source: The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study.

2.2.14	Proposed model of care at episode start

Definition: The provision of care planned by the service at the start of the episode. This care may be direct care, shared care or consultative.

Direct care
The palliative care service is the primary provider and has responsibility for the provision of care.

Shared care with another service provider/s
The palliative care service shares the care with another service (cancer care, respiratory, GP, MND, community health care providers) in a formal shared care arrangement that includes joint care planning and the exchange of relevant clinical information. In shared care both parties have an ongoing involvement with the patient throughout the episode of care and both have direct contact with the patient.

Consultation/liaison with another service provider

	The patient is under the clinical care of another service and the palliative care service provides consultation and liaison services. This includes a 'second opinion'; advice on a particular problem; case review; or patient/carer education. The other service, and not the palliative care service, is the primary provider for this episode.
Data Domain:	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
Justification:	Provide an understanding of the type of care proposed at the start of the episode based on the condition and trajectory of the patient's illness.
Guide for use:	The proposed model of care is documented at the start of the episode.
Source:	Palliative Care Outcomes Collaboration 2007

2.2.15 Episode type

Definition:	It is the type of clinical event for this episode. **Overnight admitted patient in a designated palliative care bed:** admitted to a designated palliative care inpatient bed with the intent of discharge on a different date. **Overnight admitted patient in a non-designated palliative care bed:** admitted to a non-designated palliative care inpatient bed/unit with the intent of discharge on a different date. **Ambulatory (Same day admitted/outpatient):** receives care on a same day basis. **Community patient:** receives care in the community (home or non hospital site). **Consultation Service:** Consultative palliative care service reviews and assesses a patient.
Data Domain:	0 O'night admitted patient in a non-designated palliative care bed/unit 1 O'night admitted in a designated palliative care bed 3 Ambulatory patient 4 Community patient 5 Consultation service
Justification:	Provide information on the type of care provided
Guide for use:	Record the type of service provision
Source:	Palliative Care Outcomes Collaboration 2007

2.2.16 Reason for consultative service

Definition: The type of consultative service provided

Data Domain:
1 Advice only
2 One-off consultation
3 Recurring consultation
4 Not stated/inadequately described

Justification: Describes the care provided by the consultative service.

Guide for use: Complete only if Episode Type is 5 – Consultation Service. Otherwise leave blank.

Source: Palliative Care Outcomes Collaboration 2007

2.2.17 Location of consultative service

Definition: The setting where the consultative service is provided

Data Domain:
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

Justification: Describes where consultative service is provided

Guide for use: Complete only if Episode Type is 5 – Consultation Service. Otherwise leave blank.

Source: Palliative Care Outcomes Collaboration 2007

2.2.18 Mode of consultative service

Definition: How the consultative service made contact with the patient

Data Domain:
1 Face to face
2 Telephone/electronic communication

Justification: Enables analysis of the different modes of service delivery.

Guide for use: Complete only if Episode Type is 5 – Consultation Service. Otherwise leave blank.

Source: Palliative Care Outcomes Collaboration 2007

2.2.19 Diagnosis

Definition: The broad diagnostic group for the patient's episode of palliative care

Data Domain: Numeric

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

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

Justification: Provide information on diagnoses for outcome analysis and service planning.

Guide for use: Record the primary diagnosis for the patient's episode of palliative care.

Source: Palliative Care Outcomes Collaboration 2007

2.2.20 Accommodation at episode start

Definition: The place where the patient normally resides.

Data Domain:

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

Justification: Describes the patient's residential accommodation at the start of this episode.

Guide for use: Record the type of accommodation the patient has been living in for the most amount of time over the past three months

Source: The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study

2.2.21 Level of support at episode start

Definition: Level of support - A family member/friend may or may not be living in the same residence and is identified as providing regular care and assistance. Support may also be provided on a paid basis and may include community care, meals on wheels or other support organisations.

Data Domain:

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

Justification: Identify if level of support influences type of episode

Guide for use: Record the level of support the patient is receiving at the start of this episode. This support may be on a voluntary or paid basis.
External support relates to a community service providing care in the patient's home. These services may be received on a voluntary or paid basis.

Source: AROC version 3 inpatient clinical data set

2.2.22	Episode end date
Definition:	Date that the location of care changes. Discharge from the palliative care service, death or completion of bereavement phase
Data Domain:	dd/mm/yyyy
Justification:	Identifies the period in which the episode of care occurs.
Guide for use:	The episode start date is before episode end date.
Source:	The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study

2.2.23 Mode of episode end

Definition: The reason the episode of care ends

Data Domain:

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
7 Discharged at own risk
8 Other

Not Overnight 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
F Not known

Justification: Describes the reasons for the end of an episode.

Guide for use: An episode of care ends in one of the following ways:

Overnight admitted patients

1 Discharged to their usual accommodation after a hospital admission
2 Discharged to interim accommodation (including nursing home, hostel, group home, holiday accommodation) after a hospital admission
3 Death in a hospital
4 Discharge or transfer to another acute or non-acute hospital

5 Completion of a sub-acute or non-acute care episode and the start of an acute in another ward of the same hospital
6 Completion of a sub-acute or non-acute episode in this hospital and the start of an acute episode of care remaining in the same ward

7 Discharged self at own risk against medical advice
9 Other

Not overnight admitted
A Discharge/case closure
B Death ***(complete 2.2.26 – Place of death)****
C Completion of an ambulatory sub-acute or non-acute episode and admitted/transferred to inpatient palliative care as an overnight stay patient.
D Completion of an ambulatory sub-acute or non-acute episode and admitted/transferred to inpatient acute care as an overnight stay patient.
E Completion of an ambulatory sub-acute or non-acute episode and the start of another ambulatory sub-acute or non-acute episode of care in another palliative care service or in primary care.
F Not known.

*** If recording B Death item 2.2.26 (Place of death) is required to be completed**

Source: The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study and Palliative Care Outcomes Collaboration

2.2.24 Accommodation at episode end

Definition: The accommodation of the patient at the end of the episode.

Data Domain:

1 Private residence (including unit in retirement village)
2 Residential Aged Care Facility, low level (hostel)
3 Residential Aged Care Facility, high level (nursing home)
4 Community Group Home
5 Boarding House
6 Transitional Living Unit
7 Other

Justification: Analysis of the residential accommodation for patients at the end of an episode.

Guide for use: Record the patient's accommodation at the end of the episode. For inpatient Units it is where the patient is being discharged to. For community patients it will be their current accommodation at episode end.
Do not record this item if the patient is deceased.

Source: The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study

2.2.25	**Level of support at episode end**

Definition: Level of support available to the patient at the end of the episode.

Data Domain:

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

Justification: Review the differences in level of support at end of episode for patients being discharged from hospital/hospice to home.
This item could be a trigger to be considered for discharge planning.

Guide for use: Complete only if 'Accommodation at episode end' is private residence. Otherwise leave blank.

Source: AROC version 3 inpatient clinical data set

2.2.26	**Place of death**

Definition: The type of setting in which the patient dies.

Data Domain:

1 Private residence
2 Residential aged care setting
3 Other location

Justification: Assist with service planning and monitoring.

Guide for use: **ONLY** to be completed for not overnight patients.

Private residence – includes a caravan, a mobile home, houseboat or a unit in a retirement village.

Residential aged care setting – includes high and low residential aged care facilities. It does not include units in a retirement village.

Other location –

Source: Palliative Care Outcomes Collaboration 2007

3.3 Level 3: Phase/Clinical items

2.3.27	**Date of phase start**
Definition:	Date phase of care commences
Data Domain:	dd/mm/yyyy
Justification:	Identifies the start of a phase of care
Guide for use:	**NOTE**: The first phase start date is equal to the 'Episode begin date'. Subsequent phase begin dates are equal to the previous 'Phase end date'
Source:	The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study.

2.3.28	**Phase**
Definition:	Stage of the patient's illness

Phase 1: Stable

All patients not classified as unstable, deteriorating, or terminal.

The patient symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned.

The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

Phase 2: Unstable

The patient experiences the development of a new unexpected problem or a rapid increase in the severity of existing problems, either of which require an urgent change in management or emergency treatment

The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team.

Phase 3: Deteriorating

The patient experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment.

The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary.

Phase 4:Terminal

Death is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:

Profoundly weak

- Essentially bed bound
- Drowsy for extended periods
- Disoriented for time and has a severely limited attention span
- Increasingly disinterested in food and drink
- Finding it difficult to swallow medication

This requires the use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues.

The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

Phase 5: Bereaved

Death of the patient has occurred and the carers are grieving. A planned bereavement support program is available including referral for counselling as necessary. Record only one bereavement phase per patient - not one for each carer/family member.

Data Domain:

1	Stable
2	Unstable
3	Deteriorating
4	Terminal
5	Bereaved

Justification: Used to assign Palliative Care patients to AN-SNAP classification

Guide for use: Record the phase at episode start. The palliative care provider then reviews the patient daily (or at each visit) and records phase changes if and when they occur during the episode.

The palliative care phase is the stage of the patient's illness. Palliative care phases are not sequential and a patient may move back and forth between phases. Palliative Care phases provide a clinical indication of the type of care required and have been shown to correlate strongly with survival within longitudinal prospective studies.

Note: Record only one bereavement phase per patient – not one for each carer/family member.

Source: The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study.

2.3.29 RUG-ADL: Functional scores at phase start

Definition: The RUG-ADL is a 4 item scale measuring motor function for activities of daily living including bed mobility, toileting, transfer and eating. The 4 scores are totalled: minimum 4 and maximum 18

Bed Mobility: Ability to move in bed after the transfer into bed has been completed

1 Independent or Supervision only:	Able to readjust position in bed, and perform own pressure area relief, through spontaneous movement around bed or with prompting from carer. No hands-on assistance required. May be independent with the use of a device.
3 Limited Physical Assistance:	Able to readjust position in bed, and perform own pressure area relief, with the assistance of one person
4 Other than two persons physical assist	Requires the use of a hoist or other assistive device to readjust position in bed and provide pressure relief. Still requires the assistance of one person for task.
5 Two or more persons physical assist:	Requires 2 or more assistants to readjust position in bed, and perform pressure area relief.

Toileting: Includes mobilising to the toilet, adjustment of clothing before and after toileting and maintaining perineal hygiene without the incidence of incontinence or soiling of clothes. If level of assistance differs between voiding and bowel movement, record the lower performance.

1 Independent or Supervision only:	Able to mobilise to toilet, adjusts clothing, cleans self, adjusts clothing, has no incontinence or soiling of clothing. All tasks are performed independently or with prompting from carer. No hands-on assistance required. May be independent with the use of a device:
3 Limited Physical Assistance:	Requires hands on assistance of one person for one or more of the tasks.
4 Other than two persons physical assist	Requires the use of a catheter /uridome/urinal and/or colostomy/bedpan /commode chair and/or insertion of enema /suppository. Requires the assistance of one person for management of the device.
5 Two or more persons physical assist:	Requires 2 or more persons to perform any step of the task.

Transfer: Includes the transfer in and out of bed, bed to chair, in and out of shower/tub. Record the lowest performance of the day/night

1 Independent or supervision only:	Able to perform all transfers independently or with prompting of carer. No hands-on assistance required. May be independent with the use of a device.

3 Limited physical assistance:	Requires hands-on assistance of one person to perform any transfer of the day/night.
4 Other than two persons physical assist	Requires the use of a device for any of the transfers performed in the day/night. Requires only one person plus a device to perform the task
5 Two or more persons physical assist:	Requires 2 or more persons to transfer of the day/night.

Eating: Includes the tasks of cutting food, bringing food to mouth and chewing and swallowing food. Does not include preparation of the meal.

1 Independent or Supervision only:	Able to cut, chew and swallow food, independently or with supervision, once meal has been presented in the customary fashion. No hands-on assistance required. If individual relies on parenteral or gastrostomy feeding that he/she administers him/herself.
2 Limited Assistance:	Requires hands on assistance of one person to set up or assist in bringing food to the mouth and/or requires food to be modified (soft or staged diet.
3 Extensive assistance/ total dependence/tube feed:	Person needs to be fed meal by assistant, or the individual does not eat or drink full meals by mouth but relies on parenteral/ gastrostomy feeding and does not administer feeds by him/herself.

Data Domain:

Bed Mobility, Toileting and Transfer Scores:

1 Independent or supervision only. No hands on assistance are required.
3 Limited physical assistance. The patient requires hands on assistance from one person only.
4 Other than 2 person physical assist. The patient uses a device and requires hands on assistance from one person.
5 2 person physical assist. The patient requires hands on assistance from 2 persons.

The Eating Score:

1 Independent or supervision only.
2 Limited assistance
3 Extensive assistance/total/dependence/tube fed/feeds by him/herself.

The score for each of the 4 domains are added to give a total Score: Minimum 4. Maximum 18

General Rules:

- For palliative care episodes record score at episode start, at episode end if discharge and for every phase change. Record what the person actually does, not what they are capable of doing. Do not leave any spaces blank except if the person is deceased.

Note:

- A score of 2 is not valid on the bed mobility, toileting or transfer domains.

- A score of 0 if not valid for the eating domain.
- A score of 3 is recorded for the eating domain when the patient is in the terminal phase or unconscious.

Justification: May be used as a predictor in resource allocation, Documented in medical record explains to staff the functional ability of the patient

Guide for use: Complete and record the score:
- On admission or on first visit
- score at every phase change
- score at discharge
- no score for deceased

Source: The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study

2.3.30 Symptom Assessment Score (SAS) at phase start

Definition: A seven-item patient rated, valid and reliable tool to measure symptom distress in cancer or palliative care patients.

Comprises seven key symptoms:

1 insomnia
2 appetite problems
3 nausea
4 bowels
5 breathing
6 fatigue
7 pain

Data Domain: None at all ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Worst Possible

0 1 2 3 4 5 6 7 8 9 10

Justification: Analysis of patient outcomes and service quality.

Guide for use: Ratings recorded demonstrate the patient's progress and changes in condition
Other symptoms can be added.
Assess symptoms from the patient's perspective
Identifies the patient's priorities in terms of distress
Allows you to track individual symptoms over time for each patient
Helps staff to identify the effectiveness of clinical interventions.
Changes in symptoms, improvements or deterioration can be measured.

Record separately for the 7 key symptoms: insomnia, appetite problems, nausea, bowels, breathing, fatigue, pain

SAS is primarily designed to be used by the person who is experiencing the symptoms. It is used at episode start to identify symptom needs and plan care. SAS should be recorded at phase start, at discharge with no score recorded for deceased patients. Use the SAS as follows:

A score of zero (0) would indicate that you are not having any problems with that symptom.

None at all	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worst Possible
	0	1	2	3	4	5	6	7	8	9	10	

A score of ten (10) would indicate you are having the worst possible experience with that symptom.

If the patient identifies additional symptoms to those listed on the scale, add these symptoms to the scale in the same manner
If the patient identifies more than one pain it is important to assess each one separately.
If the patient experiencing symptoms is unable to rate symptom distress, a proxy can be used.
A proxy is someone who can answer the SAS items from the patient's perspective.
If a proxy needs to be used on more than one occasion it is preferable to use the same person each time.
Each person's ratings are unique.
The patient's degree of distress may not relate to the clinical severity of a symptom.
Therefore one patient's ratings should not be compared with ratings from other patients.

2.3.31 Problem Severity Score – Pain at Phase Start

Definition: A global measurement of the level of distress for pain.

The descriptors are absent, mild, moderate and severe

Data Domain:
0 – absent
1 – mild
2 – moderate
3 – severe

Justification: To establish and monitor a level of patient's distress from pain

Guide for use: From a clinicians perspective rate the degree of overall pain

Source: The Australian national Sub-Acute and non-Acute patient Classification (AN-SNAP): report of the national Sub-Acute and Non-Acute Casemix Classification Study.

2.3.32 Problem Severity Scores – Other Symptoms at Phase Start

Definition: An overall measurement of the level of symptom distress other than pain

Data Domain:
0 – absent
1 – mild
2 – moderate
3 – severe

Justification:	To establish and monitor the level of the patient's distress from symptoms for example such as nausea or vomiting, anorexia, itch/skin irritation, weakness/fatigue, dyspnoea, incontinence, oedema, confusion/delirium, constipation/ diarrhoea.
Guide for use:	From a clinicians perspective rate the degree of distress related to the experience of these symptoms
Source:	The Australian national Sub-Acute and non-Acute patient Classification (AN-SNAP): report of the national Sub-Acute and Non-Acute Casemix Classification Study.

2.3.33 Problem Severity Score – Psychological / Spiritual at Phase Start

Definition:	An overall measurement of the level of psychological/ spiritual distress
Data Domain:	0 – absent 1 – mild 2 – moderate 3 – severe
Justification:	To establish and monitor a global measure of the patient's distress of psychological/ spiritual worry or concern
Guide for use:	From a clinicians perspective rate the degree of overall patient distress related to psychological/ spiritual worry or concern. The following list may be used as a guide – anxiety/fear, a request to die, anger, depression/sadness, unrealistic goals, confusion, and agitation.
Source:	The Australian national Sub-Acute and non-Acute patient Classification (AN-SNAP): report of the national Sub-Acute and Non-Acute Casemix Classification Study.

2.3.34 Problem Severity Score – Family/Carer at Phase Start

Definition:	An overall measurement of the level of family/carer distress
Data Domain:	0 – absent 1 – mild 2 – moderate 3 - severe
Justification:	To establish and monitor the level of the patient's distress of psychological/ spiritual worry or concern
Guide for use:	From a clinicians perspective rate the degree of distress the family/carer may experience. The following list may be used as a guide: Denial, anger/caregivers fatigue, sensory impairment, unrealistic goals, financial family/carer conflict, difficult communication, Non-English speaking, cultural issues, family/carer anxiety, and accommodation concerns.

Source:	The Australian national Sub-Acute and non-Acute patient Classification (AN-SNAP): report of the national Sub-Acute and Non-Acute Casemix Classification Study.

2.3.35	**Australian Modified Karnofsky Performance Score - at phase start**
Definition:	The Australian-modified version. First developed in the 1940s, the original Karnofsky Performance Scale allows patients to be classified as to their functional impairment on six activities of daily living relating to activity, work and self-care: bathing, dressing, feeding, transferring, continence of urine and stool, ability to ambulate independently to the bathroom. The tool is applicable to both inpatient and community palliative care The tool is an ordered categorical scale with 11 levels ranging from normal functioning (100) to dead (0).
Data Domain:	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 of 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 needs 50 Requires considerable assistance and frequent medical care 40 In bed more than 50% of time 30 Almost completely bedfast 20 Totally bedfast and requiring extensive nursing care by professionals and/or family 10 Comatose or barely rousable 0 Dead
Justification:	Provides information on the stage of a patient's illness. Comparison of episode and phase beginning data and episode and phase end.
Guide for use:	Score and record at episode start; within 24 hours of a hospital (overnight patient) admission and on first visit for community and consultative service. Then score at phase change or every visit in community if appropriate and if episode end is discharge
Source:	Abernathy et al (2005) BMC Palliative care The Australia-modified Karnofsky Performance status (AKPS) scale: a revised scale for contemporary palliative care clinical practice

2.3.36	**Model of care at phase end**
Definition:	The type of care provided by the service at the end of the phase. This care may be direct care, shared care or consultative. **Direct care** The palliative care service is the primary provider and has a responsibility for the provision of care in the inpatient and/or community. **Shared care with another service provider/s**

The palliative care service shares the care with another service (cancer care, respiratory, GP, MND, community health care providers) in a formal shared care arrangement that includes joint care planning and the exchange of relevant clinical information. In shared care both parties have an ongoing involvement with the patient throughout the episode of care and both have direct contact with the patient. Examples include shared care with paediatrics in the care of a child and shared care in a residential aged care facility.

Consultation/liaison with another service provider
The patient is under the clinical care of another service and the palliative care service provides consultation and liaison services. This includes a 'second opinion'; advice on a particular problem; case review; or patient/carer education. The other service, and not the palliative care service, is the primary provider for this episode.

Data Domain:

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

Justification: Provide an understanding of the type of care required at the end of the phase based on the condition and trajectory of the patient's illness.

Guide for use: The proposed model of care is documented at the start of the episode and at the end of each phase.

Source: Palliative Care Outcomes Collaboration 2007

2.3.37 Date of phase end

Definition: Date on which a patient completes a phase of care. The date of phase end is also the date of the next phase start

Data Domain: dd/mm/yyyy

Justification: Required to identify the period in which the patient phase of care occurred and for derivation of length of phase.

Guide for use: Subsequent 'Phase start date' is the same as the previous 'Phase end date'

The last Phase end date is equal to the Episode end date

Source: The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study

2.3.38 Reason for phase end

Definition: Describes the reason for the palliative care phase end.

Data Domain:
1 Phase change
2 Discharge/case closure
3 Died or bereavement phase
4 Bereavement phase end

Justification: Enables analysis of phase progression

Guide for use: This item must be completed each time there is a change in palliative care phase.

Source: The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study

2.3.39 Number of Days Seen (Not overnight patients only)

Definition: For Palliative Care phases of care, the number of days is calculated by counting the number of days that a patient is seen in the community during each phase.

Data Domain: Numeric: number of days patient is assessed in assigned phase.

Justification: Analysis of service utilisation and information for service planning.

Guide for use: Multiple visits on one day are counted as ‘1 day seen’.

Source: Palliative Care Outcomes Collaboration

2.3.40 RUG-ADL: Functional scores at phase end

Complete if reason for phase end is phase change or episode end is discharge or case closure.

Definition: The RUG-ADL is a 4 item scale measuring motor function with activities of daily living including bed mobility, toileting, transfer and eating.

Data Domain:

Bed Mobility, Toileting and Transfer Scores:
1 Independent or supervision only. No hands on assistance are required.
3 Limited physical assistance. The patient requires hands on assistance from one person only.
4 Other than 2 person physical assist. The patient uses a device and requires hands on assistance from one person.
5 2 person physical assist. The patient requires hands on assistance from 2 persons.

The Eating Score:
1 Independent or supervision only.
2 Limited assistance

	3	Extensive assistance/total/dependence/tube fed
Source:	Palliative Care Outcomes Collaboration	

2.3.41 Symptom Assessment Score (SAS) at phase end

Complete if reason for phase end is phase change or episode end is discharge or case closure.

Please see **2.3.32** for detail information about this item **Problem Severity Score – pain at phase start**

2.3.42 Problem Severity Score – Pain at phase end

Complete if reason for phase end is phase change or episode end is discharge or case closure.

Please see **2.3.31** for detail information about this item **Problem Severity Score – pain at phase start**

2.3.43 Problem Severity Score – Other Symptoms at phase end

Complete if reason for phase end is phase change or episode end is discharge or case closure.

Please see **2.3.32** for detail information about this item - **Problem Severity Score – Other Symptoms at phase start**

2.3.44 Problem Severity Score – Psychological / Spiritual at phase end

Complete if reason for phase end is phase change or episode end is discharge or case closure.

Please see **2.3.33** for detail information about this item **- Problem Severity Score – Psychological / Spiritual at phase start**

2.3.45 Problem Severity Score – Family/Carer at phase end

Complete if reason for phase end is phase change or episode end is discharge or case closure.

Please see **2.3.34** for detail information about this item **- Problem Severity Score – Family/Carer at phase start**

2.3.46 Karnofsky Performance Score at phase end

Complete if reason for phase end is phase change or episode end is discharge or case closure.

Please see **2.3.35** for detail information about this item - **Karnofsky Performance Score- at phase start.**

Mandatory Data Items Required for Services using Snapshot

Provider Type

Definition: The service is provided by a number of members of a multidisciplinary team or the service is provided only by a nursing staff.

Data Domain:
1 Multidisciplinary
2 Nursing only

Justification: Describes the professional discipline(s) that the patient receives treatment.

Guide for use: Required for Casemix classification for community patients

Source: Palliative Care Outcomes Collaboration 2007

Sole Practitioner

Definition: The service is provided by a number of members of a multidisciplinary team or the service is provided only by a nursing staff.

Data Domain:
1 Multidisciplinary
2 Nursing only

Justification: Describes the professional discipline(s) that the patient receives treatment.

Guide for use: Required for Casemix classification for community patients

Source: Palliative Care Outcomes Collaboration 2007