Allied Health Activity Data Set

Physical health

Version 4.0

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TAS for the District Health Boards
By the Safe Staffing Healthy Workplaces (SSHW) Unit

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Change History

Version	Effective from	Effective to	Change summary
1.4	Sept 2016	Dec 2018	First national release
2.0	Jan 2019	Dec 2019	Updated national release
3.0	Jan 2020	Jan 2021	Updated national release
4.0	Jan 2021	Jan 2022	Updated national release

Key of changes made

Type of change	Acronym
Change	C
New	N
Deleted	D

Contents

Introduction

This document sets out patient-level activity content data to classify and describe clinical activities undertaken for patients/clients by allied health services in New Zealand.

Purpose

The activity data set was developed for District Health Board (DHB) allied health services to provide a standardised code set. Standardised activity-level data set will generate information to support DHB's with service development and workforce planning. It will also support the progression of a national staffing methodology. It is intended that the activity data set compliments the HISO Allied Health (AH) Standard[1], published 2018.

Scope

This activity data set has been developed specifically for physical health inpatient settings but may have wider application. This data set is by no means exhaustive. The Allied Health Advisory Group (SSHW Unit) will undertake annual reviews to ensure its continued relevance for the sector.

The professional disciplines included in this data set are inter/ transdisciplinary, dietitian, occupational therapy, physiotherapy, social work and speech and language therapy. Role context is allied health practitioner, assistant and student.

Codes (where possible) meet SNOMED CT terminology.

Data set structure

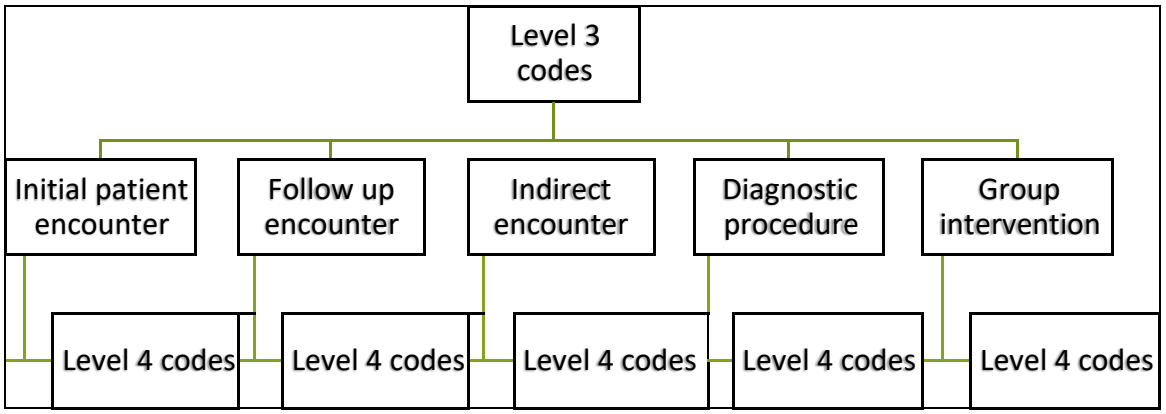
The activity data set has been structured into two tiers, to accommodate the various requirements stipulated by DHB allied health services.

Level 3 codes are broad activity descriptors. Level 4 codes are a sub-set of level 3 codes, which describe the activity in more specific detail. Diagram 1 below, illustrates this.

Dependent on the level of detail required by the DHB / allied health service, local decisions should be made whether level 3 codes, level 4 codes or a combination of both are applied.

[1] HISO 10065:2018 Allied Health Data Standard, Ministry of Health, 2018

Diagram 1: Activity data set structure



Activity content

Inter / transdisciplinary

Activity content code		Level	V4
Initial patient encounter		3	
Follow up encounter		3	
	Family meeting	4	
	Keyworker activity	4	
	Home visit	4	
	Off-site visit	4	N
	Patient/whanau/caregiver education	4	
	Discharge planning	4	
Indirect encounter		3	
	Documentation	4	
	Liaising with agency	4	
	Discussion with family	4	
	Screening	4	
	Liaising with MDT	4	
	Keyworker activity	4	
	Discharge planning	4	
Diagnostic procedure		3	
Group education		3	
	Upper limb training	4	
	Stroke education	4	
	Exercise education	4	
	Falls education	4	
	Fatigue management	4	
	Playroom session	4	
	Hydrotherapy	4	
	Leisure	4	
	Trunk control	4	
	Breakfast session	4	
	Pulmonary rehabilitation	4	

Allied Health Assistant

Activity content code	Level	V4
Delegated task	4	
Joint session with therapist	4	

Dietitian

Activity content code	Level	V4
Initial assessment - Food and/or nutrient delivery	4	
Initial assessment - Nutrition education/counselling	4	
Follow up - Food and/or nutrient delivery	4	
Follow up - Nutrition education/counselling	4	
Food service liaison	4	

Occupational therapy

Activity content code	Level	V4
Initial assessment - Developmental	4	
Initial assessment - Occupational performance	4	
Initial assessment - Assessment of seating needs	4	
Initial assessment - Positioning: wheelchair	4	
Initial assessment - Neurology	4	
Initial assessment - Postural management	4	
Initial assessment - Cognition	4	
Follow up - Developmental	4	
Follow up - Occupational performance	4	
Follow up - Assessment of seating needs	4	
Follow up - Positioning: wheelchair	4	
Follow up - Neurology	4	
Follow up - Postural management	4	
Follow up - Cognition	4	

Physiotherapy

Activity content code	Level	V4
Initial assessment - Mobility	4	
Initial assessment - Neurological	4	
Initial assessment - Musculoskeletal care	4	
Initial assessment - Orthopaedic	4	
Initial assessment - Cardiorespiratory	4	
Initial assessment - Neurodevelopmental	4	
Initial assessment - Surgical	4	
Initial assessment - Respiratory	4	
Initial assessment - Postural management	4	

Follow up – Mobility	4	
Follow up - Neurological	4	
Follow up - Musculoskeletal care	4	
Follow up - Orthopaedic	4	
Follow up - Cardiorespiratory	4	
Follow up - Neurodevelopmental	4	
Follow up - Surgical	4	
Follow up - Respiratory	4	
Follow up - Postural management	4	

Social worker

Activity content code	**Level**	**V4**
Psychosocial assessment	4	
Domestic partner abuse prevention	4	
Child protection procedure	4	
Elder abuse prevention	4	
Counselling	4	
Family counselling	4	
Legal system procedure	4	

Speech & language therapy

Activity content code	**Level**	**V4**
Initial assessment - Communication	4	
Initial assessment - Feeding/swallowing	4	
Initial assessment - Tracheostomy weaning	4	
Follow up - Communication	4	
Follow up - Feeding/swallowing	4	
Follow up - Tracheostomy weaning	4	
FEES	4	
VFSS	4	

Definitions

Activity not met/ unmet need

Due to staffing capacity or other circumstances, patient related intervention that is *indicated and planned for the day* may not be completed. Planned intervention should be in line with organisational prioritisation guidelines.

The primary reason for capturing this information is to help with capacity and demand management. This data provides a more complete picture of the demand on services and helps identify where capacity is insufficient to meet the total demand.

There are a range of reasons why planned intervention may not occur. These can also be useful to collect when considering outcomes and impacts at a patient and system level.

it is just as important to capture the activities that were planned but not able to be completed, as it is to capture the work that is completed.

Collection & Frequency

Recorded for a patient once a day. Data is captured as both a count and planned intervention time that was undelivered.

Reasons for activity not met/ unmet need

Reason	Definition	Requirement	Comment
Work exceeds usual staffing	There is normal rostered staffing (clinical and assistants) and you have not been able to see this patient today due to the volume of work.	Required	Staffing capacity is not able to meet the demand. VRM procedures would normally be evoked. Can cross reference with VIS and prioritisation guidelines.
Staff vacancy/leave	There is reduced staffing for the ward/ service due to leave or vacancy (planned or unplanned and not covered by casual staff) and you have not been able to see this patient today.	Required	Staffing capacity is not able to meet the demand. Unplanned or planned leave can leave roster gaps, especially where vacancy exists.
Patient not available	The patient may be off the ward in x-ray etc. or being visited by another staff member each time you have tried to see them today.	Optional	May result in limited or delayed therapeutic input which may impact on patient and system outcomes.
Patient unable to participate	The patient may be too sick, e.g. their blood pressure may be too high/low for the activity required, the patient may be delirious or may not be able to communicate sufficiently to complete the activity.	Optional	May result in limited or delayed therapeutic input which may impact on patient and system outcomes.
Patient declined	The patient declines your input on this occasion. This code may also be used if a patient declines input from your discipline altogether which	Optional	May result in limited or delayed therapeutic input which may impact on patient and system outcomes.

	would usually result in discharge from the service.		
Resources not available	Resources could include equipment, interpreter, medical notes, or procedural availability.	Optional	May result in limited or delayed therapeutic input which may impact on patient and system outcomes.
Patient discharged prior to session	The patient was due to be seen today but has been discharged from hospital prior to being seen.	Optional	May have negative impact on patient outcome and system level measures (i.e. acute readmission).
Unable to access caregiver	The patient's care plan / treatment requires access to a caregiver (i.e. hoist training, counselling, family meeting, education), which was not possible as they were unavailable or did not attend a scheduled appointment.	Optional	May result in limited or delayed therapeutic input/ training which may impact on patient and system outcomes.

Inter / transdisciplinary

Activity code	**Definition**
Initial patient encounter	The first direct contact that the clinician has with the patient. This may include assessment, examination, consultation, treatment and/or education.
Follow up encounter	Every direct patient interaction (after the first contact) that the clinician has with the patient. This may include re-assessment, treatment, intervention and/or education.
Family meeting	Time spent in formal family meetings. If you are involved in coordinating the meeting include time spent organising, making phone calls, confirming meeting arrangements, documenting. The patient must be present, otherwise use 'discussion with family' code.
Keyworker activity	For wards with a Key Worker model of care only. Time includes specific tasks e.g. coordinating meetings, coordinating stroke folders, generic inter-disciplinary discharge planning conversations (not specifically related to your profession).

Home visit	Direct time spent with patient outside hospital grounds whilst they are still an inpatient, e.g. time spent with them during a home assessment visit.
Off-site visit	Direct time spent with patient outside hospital grounds (not at the home) whilst they are still an inpatient, e.g. time spent attending an appointment with them or rehabilitation activity.
Patient/whanau/caregiver education	Education provided to the family members or carers of the patient. 'Family' includes those identified as the patient's primary support person/ group, and also includes paid carers.
Indirect encounter	Discrete activity that occurs in the absence of a direct contact with the patient. This may include communication with the MDT or external agency, interaction with the patient's family/ carer, and screening activities. Includes documenting the indirect encounter type.
Documentation	Time spent recording clinical notes, assessment documents or preparing written materials for patient and/or family. Only select this code if the activity occurs in isolation of a direct or indirect contact type.
Liaising with agency	Any communication (discussion, email, phone call) with external service, including other DHB, ACC, Non-Government Organisations (NGOs) or other health agency, when not completed as part of the initial assessment or follow up.
Discussion with family	Time spent communicating with the patient's family/ carer either directly or indirectly when not completed as part of the initial assessment or follow up.
Screening	Time spent reviewing notes and talking to staff, in order to determine patient status or patient priority for assessment/ review when not completed as part of the initial assessment or follow up.
Liaising with MDT	Time spent liaising with colleagues regarding a patient when not completed as part of the initial assessment or follow up. Most MDT liaison will be completed as part of an initial assessment/ follow up.
Keyworker activity	For wards with a Key Worker model of care only
Discharge planning	Time spent specifically planning and coordinating a patient's discharge, which includes liaison with external agencies, family members and support services. Include time spent completing discharge summaries.
Diagnostic procedure	Time spent conducting an examination or test to help diagnose a disease or condition.
Group education	Patient attends a group education session. A 'group' is when two or more patients receive the same service, at the same time from the same health provider(s)
Upper limb training	Patient attends an upper limb therapy group
Stroke education	Patient attends stroke education / support group
Exercise education	Patient attends an exercise or orthopaedic exercise class
Falls education	Patient attends falls prevention group
Fatigue management	Patient attends a fatigue management group
Playroom session	Patient attends a playroom session
Hydrotherapy	Patient attends a hydrotherapy session
Leisure	Patient attends a leisure group
Trunk control	Patient attends a trunk control group
Breakfast session	Patient attends a breakfast therapy group
Pulmonary rehabilitation	Patient attends a pulmonary rehabilitation group

Allied Health Assistant

Activity code	Definition
Delegated task	Carrying out a delegated activity under the direction of a registered health professional.
Joint session with therapist	Assisting a therapist with a joint treatment session.

Dietitian

Nutrition care - initial	Undertaken for the first time after referral: Includes all 4 steps of the Nutrition Care Process: Nutrition assessment, nutrition diagnosis, nutrition intervention (includes determining intervention and prescription, formulating goals, and determining and implementing action) and nutrition monitoring and evaluation (includes selecting and identifying quality indicators and monitoring and evaluating resolution of diagnosis). Includes all documentation relating to the above. Includes routine Food Service liaison.
Initial assessment - Food and/or nutrient delivery	First assessment for patients who require any dietetic intervention, for the provision of meals and snacks, enteral and parenteral feeding and supplements. This includes: gathering data, reading notes, talking to staff, seeing patient for first time, assessment, organising intervention and education, MDT liaison, making phone calls related to first assessment and clinical documentation.
Initial assessment - Nutrition education/counselling	First assessment, treatment and/or intervention for patients who require instruction or training in a skill or knowledge related to food and nutrition, including enteral and parenteral nutrition and supplements.
Nutrition care - follow up	Includes all 4 steps of the Nutrition Care Process: Nutrition Reassessment, nutrition diagnosis, nutrition intervention (includes determining intervention and prescription, formulating goals, and determining and implementing action) and nutrition monitoring and evaluation (includes selecting and identifying quality indicators and monitoring and evaluating resolution of diagnosis). Includes all documentation relating to the above. Includes routine Food Service liaison.
Follow up - Food and/or nutrient delivery	Follow up assessment, treatment or intervention for patients who require any dietetic intervention, for the provision of meals and snacks, enteral and parenteral feeding and supplements. Includes all time spent – re-assessment, organising intervention, education, MDT liaison and clinical documentation.
Follow up - Nutrition education/counselling	Follow up assessment, treatment and/or intervention for patients who require instruction or training in a skill or knowledge related to food and nutrition, including enteral and parenteral nutrition and supplements.
Food service liaison	Food service feedback completion where errors with meal provision have been identified

Occupational therapy

Initial assessment - Developmental	Time spent completing initial paediatric assessment. May include use of standardised assessments, e.g. Hammersmith.
Initial assessment - Occupational performance	First assessment with patient in relation to a functional task, e.g. washing and dressing, shopping, toileting.
Initial assessment - Assessment of seating needs	Initial assessment of seating needs

Initial assessment – Positioning: wheelchair	Initial assessment of patient in relation to correct positioning in seating and/or lying. May include static seating, wheelchair, cushion, etc. as well as assorted modifications required to customise equipment for the client.
Initial assessment - Neurology	First assessment with patient who has a neurological diagnosis such as stroke/ GBS/ MS/ MND/ Myasthenia gravis.
Initial assessment – Postural management	First assessment with patient who requires input predominantly for seating, lying and positioning.
Initial assessment - Cognition	Initial assessment of patient's cognition.
Follow up – Developmental	Follow up of patient in relation to an issue related to paediatric development.
Follow up – Occupational performance	Follow up with patient in relation to occupational performance. e.g. self-care, mindfulness, psycho-social intervention, leisure activities, and suggestions for links to community groups, cooking and use of dynamic functional splints for occupational performance.
Follow up - Assessment of seating needs	Follow up assessment of seating needs.
Follow up – Positioning: wheelchair	Follow up of patient in relation to correct positioning in seating and/or lying. May include static seating, wheelchair, cushion, etc. as well as assorted modifications required to customise equipment for the client.
Follow up - Neurology	Follow up with patient where their primary problem is neurological. e.g. transfer practice, upper limb assessment/rehab, self-care/productivity practice, handwriting practice, visual/perception intervention, use of pre-fabricated splints/orthotics.
Follow up – Postural management	Follow up with patient who requires input predominantly for seating, lying and positioning, e.g. wheelchair assessment, upper limb postural management, 24-hour postural management.
Follow up - Cognition	Follow up relating to a patient's cognition.

Physiotherapy

Initial assessment – Mobility	First assessment where the primary problem is related to mobility. Examples include; post fall (no #), deconditioning, social admission or other secondary medical issues
Initial assessment - Neurological	First assessment where the primary problem is neurological. Examples include; stroke, brain injury, MS etc.
Initial assessment – Musculoskeletal care	First assessment where the primary problem is a musculoskeletal issue e.g. knee pain, back paint etc. Includes use of pre-fabricated orthotics.
Initial assessment – Orthopaedic	First assessment where the primary problem is orthopaedic. Examples include; fractures, elective surgery, post-orthopaedic surgery e.g. management of #, shoulder reconstruction etc.
Initial assessment - Cardiorespiratory	First assessment where the primary problem is cardiorespiratory.
Initial assessment – Neurodevelopmental	First assessment of an infant or young child who presents with a neurological or developmental issue. Includes musculoskeletal conditions which impacts on development. May include a standardised assessment e.g. Hammersmith
Initial assessment - Surgical	First assessment where the primary problem is post-surgical.
Initial assessment – Respiratory	First assessment where the primary problem is respiratory e.g. COPD, bronchiectasis, chest infection.
Initial assessment - Postural management	First assessment where the primary intervention is for 24-hour postural management. Examples include; GMFCS Level III-V, night-time and daytime positioning needs and includes equipment provision.

Follow up – Mobility	Follow up intervention for primarily mobility issues.
Follow up - Neurological	Follow up intervention for primarily neurological issues
Follow up - Musculoskeletal care	Follow up intervention for primarily musculoskeletal issues.
Follow up - Orthopaedic	Follow up intervention for primarily orthopaedic issues.
Follow up - Cardiorespiratory	Follow up intervention for primarily cardiorespiratory issues.
Follow up - Neurodevelopmental	Follow up intervention for primarily neurodevelopmental issues.
Follow up - Surgical	Follow up intervention for primarily surgical issues.
Follow up - Respiratory	Follow up intervention for primarily respiratory issues.
Follow up - Postural management	Follow up intervention for primarily postural management.

Social worker

Psychosocial assessment	First psycho-social assessment. Includes: gathering information, reading notes, talking to staff, seeing patient for first time, making phone calls and documentation.
Domestic partner abuse prevention	Assessment and intervention related to family violence issues. Includes provision of emotional and practical support, e.g. assistance with Protection Orders, liaising with Refuge etc.
Child protection procedure	Assessment and intervention where child protection is the primary concern. Includes liaison with Oranga Tamariki and other agencies.
Elder abuse prevention	Activity related to older/vulnerable adult protection issues. Includes liaison with Age Concern and other agencies.
Counselling	Therapeutic counselling provided to the patient.
Family counselling	Therapeutic counselling provided to the family or caregivers of the patient.
Legal system procedure	Interventions relating to completion of legal paperwork / reports and any associated court appearance on behalf of a patient. Examples include: Enduring Power of Attorney (EPOA) / Protection of Personal and Property Rights Act (PPPR Act) applications, Request for Information (Freedom of Information Act).

Speech & language therapy

Initial assessment - Communication	First assessment for a communication disorder.
Initial assessment - Feeding/swallowing	First assessment for a feeding or swallowing disorder.
Initial assessment - Tracheostomy weaning	Initial assessment related to tracheostomy.
Follow up - Communication	Follow up activity for a communication disorder.
Follow up - Feeding/swallowing	Follow up activity for feeding/ swallowing.
Follow up - Tracheostomy weaning	Follow up activity related to tracheostomy.
FEES	Completion, review and reporting of FEES when done as one intervention.
SS	Completion, review and reporting of VFSS when done as one intervention.