



# Allied Health Activity Data Set

## Mental health

Version 2.0

January 2021

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TAS for the District Health Boards  
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*Change History*

Version	Effective from	Effective to	Change summary
1	Jan 2020	Jan 2021	First national release
2.0	Jan 2021	Jan 2022	Updated national release

**Key of changes made**

Type of change	Acronym
Change	C
New	N
Deleted	D

# Contents

- Contents .....i
- Introduction.....1
- Purpose.....1
- Scope .....1
- Data set structure.....1
- Activity content .....2
  - Inter / transdisciplinary .....2
  - Occupational therapy.....3
  - Psychology.....3
  - Social worker .....3
- Definitions .....3
  - Reasons for activity not met.....3
  - Inter / transdisciplinary .....5
  - Occupational therapy.....6
  - Social worker .....7
  - Psychology.....7
  - Therapy assistant.....7

## 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<sup>1</sup>, published 2018.

## Scope

This activity data set has been developed specifically for mental health acute 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, occupational therapy, psychology and social work. The codes are classified by occupational group, but an allied health professional should not be restricted from using other codes, if relevant. Role context is allied health practitioner, assistant and student.

There is also a Physical Health Activity Data Set, which provides further codes that may be relevant for other professional disciplines who provide in-reach services to mental health. 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.

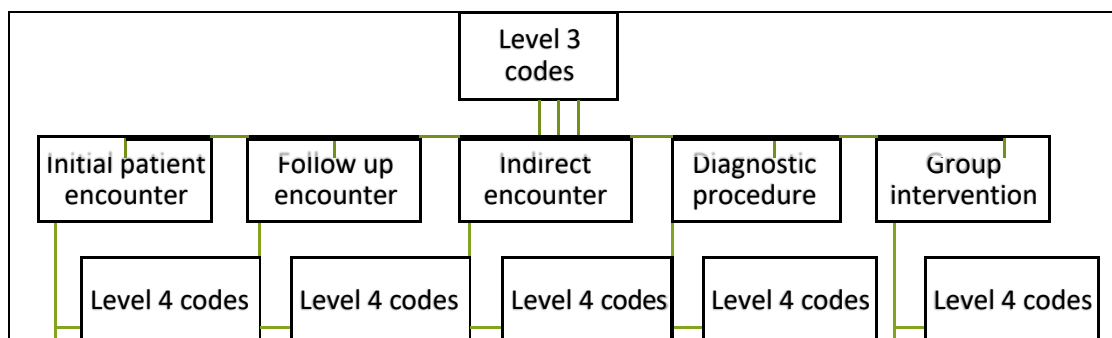
Level 3 codes are broad activity descriptors. Level 4 codes are a sub-set of level 3 codes, which describe the activity in more specific detail. Diagram 1 below, illustrates this.

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.

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<sup>1</sup> HISO 10065:2018 Allied Health Data Standard, Ministry of Health, 2018

Diagram 1: Activity data set structure and mapping of level 3 codes to Allied Health Standard (HISO)



## Activity content

### Inter / transdisciplinary

Activity content code	Level	V2
Initial patient encounter	3	
Follow up encounter	3	
Mental health assessment	4	
Alcohol & drug assessment	4	
Cognitive assessment	4	
Family meeting	4	
Sensory modulation	4	
Talking therapy	4	
NASC assessment	4	
Relapse prevention	4	
Counselling	4	
Family counselling	4	
Behavioural management plan	4	
Home visit	4	N
Off-site visit	4	N
Indirect encounter	3	
Documentation	4	
Liaising with agency	4	
Discussion with family	4	
Screening	4	
Liaising with MDT	4	
Transition planning	4	
Seclusion debrief	4	
Legal system procedure	4	
Group intervention	3	
Cultural	4	
Drug & alcohol	4	
Community	4	
Skill development	4	
Psycho-educational	4	
Social/leisure	4	
Talking therapy	4	
Cultural	4	

## Occupational therapy

Activity content code	Level
Sensory profiling	4
Occupational performance	4
Vocational liaison	4
Driving screening	4

## Psychology

Activity content code	Level
Psychological assessment	4
Neuropsychological assessment	4

## Social worker

Activity content code	Level
Psychosocial assessment	4
Domestic partner abuse prevention	4
Child protection procedure	4
Elder abuse prevention	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 a count.

### 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 would usually result in discharge from the service.	Optional	May result in limited or delayed therapeutic input which may impact on patient and system outcomes.
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 client. This may include assessment, examination, consultation, treatment and/or education.
Follow up encounter	Every direct client interaction (after the first contact) that the clinician has with the client. This may include re-assessment, treatment, intervention and/or education.
Mental health assessment	Assessment involving supporting the initial and transition mental health assessment including risk assessment and care plan development etc.
Alcohol & drug assessment	Specific assessment relating to drug and alcohol concerns and specific care plan development.
Cognitive assessment	Cognitive screen: MOCA, Rudas, ACE III. Rivermead, Cognistat, inclusive of a performance in occupation assessment i.e. Percieve, Recall, Plan & Perform (PRPP).
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 client must be present, otherwise use 'discussion with family' code.
Sensory modulation	Development and implementation of sensory modulation as an intervention technique. Education around sensory triggers and responses.
Talking therapy	One on one intervention involving one or more of the talking therapies e.g. Motivational interviewing, CBT, ACT, DBT, narrative therapy, etc.
NASC assessment	Short and long-term assessment for ongoing packages of care and support.
Relapse prevention	Specific to the clients' presentation and sits alongside transition planning. Educating clients on techniques to manage wellness.
Counselling	Therapeutic counselling provided to the client. Includes pregnancy counselling.
Family counselling	Therapeutic counselling provided to the client's whanau/family.
Behavioural management plan	Time spent working with client and family/whanau and the team around developing a safe management plan.
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.
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 client notes, assessment documents or preparing written materials for client or family/whanau. 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 client'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 to determine client status or priority, when not completed as part of the initial assessment or follow up.
Liaising with MDT	Time spent liaising with colleagues regarding a client 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.
Transition planning	Time spent specifically planning and coordinating a client's discharge, includes liaison with external agencies, family members and support services, include time spent completing discharge summaries and active coordination and implementation of plan.
Seclusion debrief	Time spent involved in or leading a team debrief related to a client's seclusion.
Legal system procedure	Completion of legal paperwork, i.e. 2 <sup>nd</sup> health professional report. Court appearance on behalf of a client.
Group intervention	
Cultural	Relates to whanau and peer support.
Drug & alcohol	Relates to working and education with A&D services, community.
Community	Support to transition to community groups.
Skill development	Developing life and social skills to support post transition
Psycho-educational	Educational sessions, i.e. managing your medication, sleep hygiene, nutrition, exercise, effects of drugs and alcohol, supports available in the community.
Social/ leisure	Social/leisure/physical: Café club, games night, pool and gym sessions.
Talking therapy	Group work involving the use of talking therapies e.g. Motivational interviewing, CBT, ACT, DBT, and narrative therapy.
Cultural	Relates to whanau and peer support.

## Occupational therapy

Activity code	Definition
Sensory profiling	Standardised sensory assessment tool or structured interview: Winnie Dunn Sensory Profile 2 or Tina Champagne.
Occupational performance	Performance in occupation: Activities of daily living, education, work, play or leisure.
Vocational liaison	Liaising with the employer to retain employment Referral to NGO for on-going vocational support; graduated return to work or workplace assessment.
Driving screening	To provide baseline recommendations on driving and need for a full-on road /off road OT driving assessment.

## Social worker

Activity code	Definition
Psychosocial assessment	First psycho-social assessment. Includes: gathering information, reading notes, talking to staff, seeing client 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.

## Psychology

Activity code	Definition
Psychological assessment	Standardised tests, questionnaires or tasks designed to assess some aspect of a person's cognitive abilities, behaviour, skill, or personality.
Neuropsychological assessment	Assessment of the extent of impairment of a particular skill or cognitive ability that may be affected or damaged following brain injury or neurological illness.

## Therapy 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.