Allied Health Activity Data Set

Mental Health

Version 3.0

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Prepared by:

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

Developed through the Allied Health Advisory Group:
Sue Waters (Co-chair of Advisory group, Auckland DHB)
Sue McCullough (Co-chair of Advisory group, PSA)
Tamzin Brott/ Becca Hammond (Waitematā DHB)
Nicola Westend/Hilary Exton (Nelson Marlborough DHB)
Gabrielle Scott (Midcentral DHB)
Paul Rigby/Chris King (Hutt Valley DHB)
Jacqui Lunday Johnstone/ Helen Little (Canterbury DHB)
Carl McDonald (Hauora Tairāwhiti DHB)

Please direct any questions or queries to:
Stuart White/ Lynda Wheeler, Safe Staffing Healthy Workplaces Unit
stuart.white@tas.health.nz or lynda.wheeler@tas.health.nz

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
3.0	Jan 2022	Jan 2023	Re-formatted 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 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 all discipline, 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 the highest-level code and are broad activity descriptors. Level 4 codes are a sub-set of level 3 codes. These describe the activity in more granular detail. A level 4 code **must** always map to a level 3 code.

Local decisions should dictate whether level 3 codes, level 4 codes, or a combination of both are applied. This will depend on the level of detail required by the DHB or service and staff capacity to accurately record activity data. Level 3 data will limit any reporting to a broader, more general level. Level 4 data adds a significantly greater level of detail and can be rolled up to a higher level if reporting requires this.

Figure 1 shows the activity dataset hierarchy. There are five codes available at level 3. These should be used by all professions. A range of level 4 codes exist and always map back to one of the level 3 codes. Level 4 codes can be selected from the 'all professions' table and/ or from the appropriate 'profession specific' table which relate to initial and follow-up clinical activities.

A list of definitions for all codes is available at the end of this document.

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

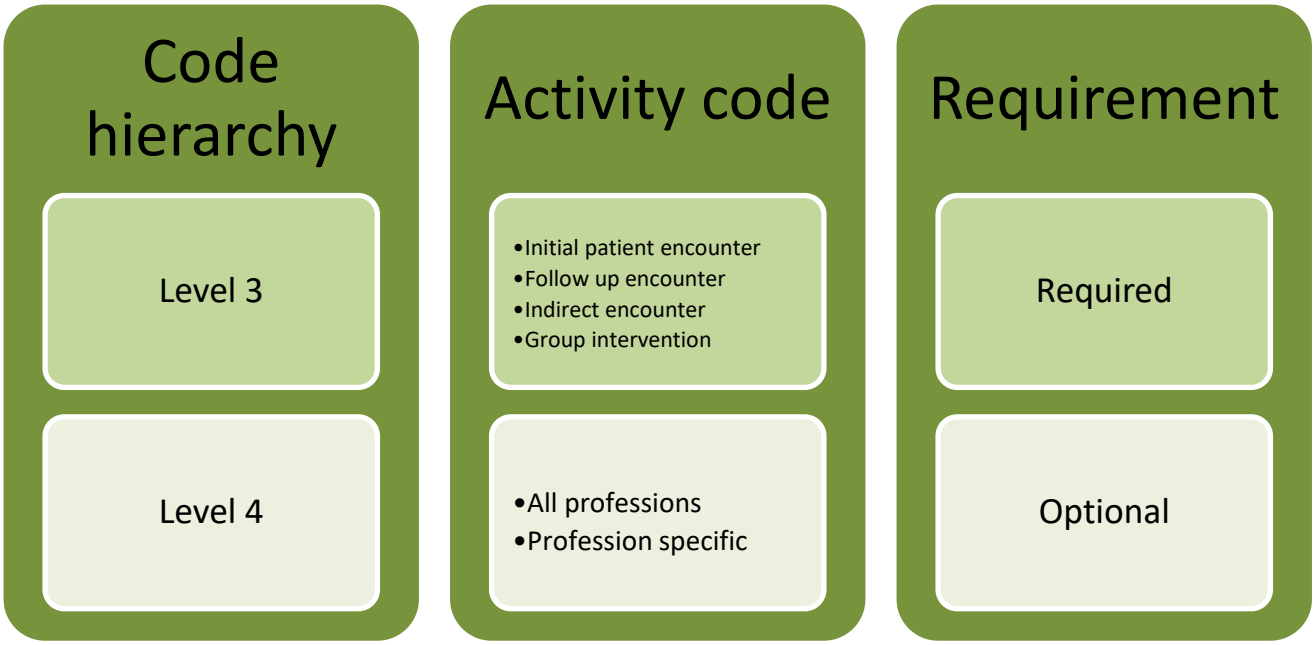

Figure 1 - Activity data set structure and requirements

Activity content

All professions (any profession can select from this table)

Activity code	Level	Requirement	V5
Initial patient encounter	3	Required	
Mental health assessment	4	Optional	
Alcohol & drug assessment	4	Optional	
Cognitive assessment	4	Optional	
Family meeting	4	Optional	
Sensory modulation	4	Optional	
Talking therapy	4	Optional	
NASC assessment	4	Optional	
Relapse prevention	4	Optional	
Counselling	4	Optional	
Family counselling	4	Optional	
Behavioural management plan	4	Optional	
Home visit	4	Optional	
Off-site visit	4	Optional	
Follow up encounter	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	
Indirect encounter	3	Required	
Documentation	4	Optional	
Liaising with agency	4	Optional	
Discussion with family	4	Optional	
Screening	4	Optional	

Liaising with MDT	4	Optional	
Transition planning	4	Optional	
Seclusion debrief	4	Optional	
Legal system procedure	4	Optional	
Group intervention	3	Required	
Cultural	4	Optional	
Drug & alcohol	4	Optional	
Community	4	Optional	
Skill development	4	Optional	
Psycho-educational	4	Optional	
Social/leisure	4	Optional	
Talking therapy	4	Optional	
Cultural	4	Optional	

Occupational Therapy

Activity code	Level	Requirement	V5
Initial patient encounter	3	Required	
Sensory profiling	4	Optional	
Occupational performance	4	Optional	
Vocational liaison	4	Optional	
Driving screening	4	Optional	
Follow up encounter	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	

Psychology

Activity code	Level	Requirement	V5
Initial patient encounter	3	Required	
Psychological assessment	4	Optional	
Neuropsychological assessment	4	Optional	
Follow up encounter	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	

Social Worker

Activity code	Level	Requirement	V5
Initial patient encounter	3	Required	
Psychosocial assessment	4	Optional	
Domestic partner abuse prevention	4	Optional	
Child protection procedure	4	Optional	
Elder abuse prevention	4	Optional	
Follow up encounter	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	

Therapy Assistant

Activity code	Level	Requirement	V5
Initial patient encounter	3	Required	
Delegated task	4	Optional	
Joint session with therapist	4	Optional	
Follow up encounter	3	Required	
Level 4 options as per 'Initial patient encounter' above	4	Optional	

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.

Activity Code Definitions

All professions

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. Perceive, 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. 2nd 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.

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.

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.

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.