

Community palliative care VINAH: extended guide for use

Effective from 1 October 2013

Purpose of the document

There has been inconsistent use of the VINAH code sets for community palliative care due to specific scenarios that are not well described in the VINAH manual or captured with existing VINAH data elements. This document aims to:

- provide additional information specific for the community palliative care program that is to be read in conjunction with the VINAH manual
- describe the mandatory use of some VINAH data elements and codes for specific scenarios.

Contact client present status

Principles

This VINAH data element has caused confusion for community palliative care programs that interact with more than just the client, and who use carers and family members as a means of acquiring the information they require.

There are three principles that guide the use of 'contact client present status' for community palliative care:

1. If the interaction does not directly include the client but the interaction content includes information that could be beneficial / further assessed because the client is available within the immediate location (i.e. within the house) this is recorded as the client being present.

The nature of the information / assessment must align with the clinical responsibilities of the health professional undertaking the contact. That is, if a counsellor undertaking counselling with a carer becomes aware of a physical symptom of the client, even though the client is accessible to the health professional, the type of assessment is not in line with the clinical responsibility of the health professional or the main purpose of the contact. This contact would not include the client as present even though the patient was accessible.

2. If the interaction uses the carer / family member as a proxy for acquiring information that would otherwise be collected directly from the patient except this is not possible due to the client's physical, mental, emotional or medical condition. This is recorded as client present with carers(s)/relative(s).
3. The mode of contact is not relevant to distinguish between whether the client is present or not and therefore the same principles apply for face-to-face or phone call based contacts.

Scenario

Home visit to see the client but he/she is not home, so the health professional only speaks with the carer (i.e. no contact with client), and the client is not available for an assessment

- Contact client present status – 20 Carer(s)/Relative(s) of the client/client only

Scenario

Home visit to see the client but he/she refuses to interact directly or indirectly with the health professional, so the health professional only speaks with the carer (i.e. client does not consent and is competent)

- Contact client present status – 20 Carer(s)/Relative(s) of the client/client only

Scenario

Home visit to see the client but he/she refuses to interact directly with the health professional, but agrees (implicitly or explicitly) for the carer to act as a proxy and relay relevant information

- Contact client present status – 12 Client/Client present with carers(s)/relative(s)

Scenario

Home visit to see the client but he/she is asleep in the house so the health professional speaks with the carer and the client is physically accessible to make an assessment.

- Contact client present status – 12 Client/Client present with carers(s)/relative(s)

Scenario

Home visit to see the client but he/she is unconscious so the health professional only speaks with the carer and the client is physically accessible to make an assessment.

- Contact client present status – 12 Client/Client present with carers(s)/relative(s)

Scenario

Phone call to the client's home is answered by the carer. The client is accessible for assessment, but unable to speak on the phone. The health professional asks the carer for information that is consistent with the health professional's clinical role and the main purpose of the contact, and the carer provides information back to the health professional (i.e. carer relays information on client's behalf / is a proxy for the client)

- Contact client present status - 12 Client/Client present with carers(s)/relative(s)

Scenario

Phone call to carer to provide carer support and client present (i.e. intent is to support carer)

- Contact client present status - 20 Carer(s)/Relative(s) of the client/client only

Scenario

Counsellor phones the carer to provide carer support. The client is in the house at the time, but is not the focus of the contact. During the course of the discussion, the carer advises the counsellor the client is medically unwell. The counsellor passes on the information to a nurse and makes a note in the client's medical history (i.e. the client accessible but not main purpose of contact and not within the clinical role of the health professional).

- Contact client present status - 20 Carer(s)/Relative(s) of the client/client only

Scenario

Counsellor phone call to the carer to provide carer support and the client is in the house. The intent of the contact is to support the carer. During the course of the discussion, the carer advises the client wants to discuss their situation and receive counselling. The carer provides this information to the counsellor and documents the interaction in the medical history (i.e. the client was accessible and the clinical role of the health professional was aligned with main purpose of the contact and the clinical role of the health professional).

- Contact client present status - 12 Client/Client present with carers(s)/relative(s).

Scenario

Carer attends the palliative care service to receive counselling. The carer advises that the client is unwell.

- Contact client present status - 20 Carer(s)/Relative(s) of the client/client only

The client has recently died

Principles

1. If the purpose of a client visit is targeted at the client (not the carer or family member) and the contact date is less than 24 hours after the date of death, then the client is present.
2. The bereavement phase will generally have started more than 24 hours after the date of death. This principle is included because the client cannot be present at the contact while in the bereavement phase. If this is submitted to VINAH, an error will be shown. Therefore:
 - day of death = terminal phase
 - day after death = terminal or bereavement phase (what dictates this is whether the main purpose relates to the client or not)
 - second day after death = bereavement phase.

Scenario

A staff member is visiting the client's home and the client has died while the staff member is on the way to see the client, or the client dies while the staff member is at the client's home:

- Contact client present status = 11 Patient/Client present only or 12 Patient/Client present with carer(s)/relative(s)

Note: The situation where the patient has a date of death the day before or the day of the contact, if the client present status is recorded as "present", VINAH in the past has delivered an error message for this scenario. This has been changed in the VINAH validation process.

Multiple health professionals involved

Principles

To harmonise how contacts are recorded when multiple health professionals are present, some new 'rules' have been introduced.

The rules are specific for the different client present status at the contact:

- Direct (client and/or carer present): the number of health disciplines present at the contact = number of contacts e.g. if more than one registered nurse is present, this will still equal one health discipline and is recorded as one contact
- Indirect = number of health professionals is not relevant; the count is based on the number of clients that are discussed or the focus of the indirect interaction.

Indirect scenario

Three health professionals (different disciplines) discuss clients in a formal/team meeting and each health professional provides a clinically significant contribution (i.e. one entry in each medical record / team meeting with outcomes). This results in one contact for each client discussed.

- Contact client present status – indirect
- Contact purpose – case conference
- Contact professional group – (internal organisational decision as to the one profession that is reported e.g. disciplines take it in turn, primary contributor etc)

Indirect scenario

Meeting about one client (who is NOT present) with three health professionals (different disciplines)

- Contact purpose - case conference (includes family meetings)
- Number of contacts – 1
- Contact session type – individual

- Contact professional group – (internal organisational decision as to the one profession that is reported e.g. disciplines take it in turn, primary contributor etc)

Direct scenario

Two health professionals of different disciplines visit a client (joint or sequential visit is not material to the counting) and provide clinically significant interventions which result in two separate entries in the medical record. Each contact may have a different contact purpose but still have different health professionals recorded.

- Number of contacts – 2 (one for each health professional)
- Contact client present status – present

Direct scenario

Two health professionals of the same discipline visit a client to achieve one purpose (e.g. personal care). The palliative care organisation has decided the interaction requires two professionals or the contact includes a senior nurse supervising a junior nurse. Regardless of how many entries are in the record (one or two), this is one contact as there is one contact purpose and one health discipline present. The entries in the record will reflect the reason two staff were required

- Number of contacts – 1
- Contact client present status – present

Direct scenario

Family meeting about one client (who is present) with three health professionals of different disciplines,

- Contact purpose - #41 case conference (includes family meetings)
- Number of contacts – 3 (one for each different discipline)
- Session type – individual

Scenario

A nurse is at the client's home with the client and then the nurse phones a specialist health professional who is not part of the organisations team providing palliative care (e.g. GP or nurse practitioner).

- Number of contacts – 2
 - Direct (client present) to the client
 - Indirect to the other health professional

Scenario

A nurse is at the client's home and then phones a different discipline (e.g. a nurse practitioner not a nurse) within the same palliative care service (e.g. discussion clinical issue). This will result in two contacts which can be recorded in two different ways.

- Number of contacts – 2
 - direct contact with the client by the nurse
 - indirect contact by the nurse OR an indirect contact by the other professional (nurse practitioner)

Note: this scenario is similar to a case conference combined with a client visit. Therefore it does not matter if the nurse at the client's house calls multiple other providers who are part of the same palliative care service, it will only result in one indirect contact. Each health professional cannot count a contact as this would be double counting and be different to how case conferences are recorded. Both disciplines may make notes in the medical record.

Scenario

Staff (including clinical staff) phone a client to confirm an upcoming appointment/advise name of volunteer. This is an administrative interaction and does not meet the definition of a contact, which requires clinical content to be part of the interaction. This activity should not be part of the VINAH extract to the department.

- Number of contacts – N/A

Scenario

Staff (e.g. volunteer coordinator) phones a client to advise the name of the volunteer who will work with them. The conversation subsequently evolves into a discipline-related clinical intervention/assessment during the phone call which results in an entry in the client's record.

- Number of contacts – 1

Scenario

Nurse phones to confirm upcoming appointment with the client. During the course of the conversation, the nurse is made aware of medical symptoms that require the nurse to provide further advice. This information is recorded in the medical history. This is recorded as a contact because the interaction included clinical content.

- Number of contacts – 1

Scenario

Staff member (e.g. OT) visits client to conduct assessment, leaves to collect equipment, returns on same day with the equipment to complete the task (i.e. the purpose of the contact has not changed, it was interrupted).

- Number of contacts – 1
- Contact end time – not monitored

Scenario

Client receives two nursing visits (same discipline), on the same day (e.g. morning and night), which have been pre-arranged as part of their care plan.

- Number of contacts - 2

Scenario

Client receives a nursing visit. Subsequent to this visit, on the same day, the client deteriorates and requires another unplanned visit/intervention by the same health discipline.

- Number of contacts - 2

Contact delivery setting

Principles

VINAH is from the client's (person with a life-limiting illness) perspective. Therefore, when a contact occurs with the carer/family only, VINAH data elements will be from their perspective.

Scenario

A phone call is made by a nurse at their office, to a client and/or their carer who is at their home.

- Contact delivery setting – home

Scenario

Client/carers attend office to see staff (community palliative care service is part of a health service and co-located on the hospital campus).

- Contact delivery setting - #21 Community Based Health Facility

Scenario

Staff member visits client/carers while they are attending hospital clinic.

- Contact delivery setting - #12 Hospital Setting - Clinic/Centre

Scenario

Staff member visits client/carers while they are admitted to palliative care unit at a hospital.

- Contact delivery setting - #15 Hospital Setting - Palliative Care Unit

Scenario

Phone call from staff member to carer (who can be anywhere) about how the carer is managing/to provide information etc. Client (i.e. person with life-limiting illness) is admitted to hospital or is elsewhere.

- Contact delivery setting – home or other (if unsure)

Note: in this scenario the person experiencing the contact is the carer and therefore the perspective of the contact is from the carer who is at home and not with the client.

Scenario

Phone call from staff member to carer (who can be anywhere) about the client (i.e. person with life-limiting illness) who is admitted to hospital/elsewhere.

- Contact delivery setting – home or other (if unsure)

Episode start/end date

Principles

The decision to end an episode or not (e.g. a client is admitted to hospital while receiving community palliative care) is based on the service's intention to interact with the client in the future. When deciding whether to end an episode, health professionals should ask:

- if ongoing contact with hospital, client/carer is anticipated and the community palliative care service still has a clinical reason to be involved from hospital = NO (i.e. do not end episode)
- if no further contact to client/carer is envisaged; that is there is no anticipated clinical reason for an ongoing relationship with the client/carer (e.g. discharge will be to a nursing home or the client has moved out of area) = YES (i.e. do end episode)

Note: In VINAH the terminology is different to the regular language used by services. The common use of the word 'discharge' by services is defined in VINAH as the 'episode end date'.

Scenario

If a staff member has contact with client or carer or other health professional after the episode end date there are two choices about how to deal with this. The decision rests on whether it is worthwhile to open a new episode. It is not possible to 'cancel' the previous episode end date and artificially re-open it. The service must decide to either open a new episode or if it is thought this is not warranted, the contact will not be recorded.

- Number of contacts – 0

or

- create new episode start date (i.e. open new referral and create new episode). Number of contacts = 1.

Scenario

If a staff member has contact with client or carer or other health professional prior to episode start date (i.e. prior to client being accepted/registered with community palliative care service).

- Number of contacts – 0

Note: VINAH has no capacity to capture the activity between a referral being received and the episode starting. The timing of when an episode starts is based on the information in Section 2 of the VINAH manual. In most circumstances the episode start date is the same as the referral date as long as the referral is requesting appropriate intervention from the palliative care service and the client has consented to the involvement of the palliative care service.

Contact purpose - assessment

Principles

There are no 'rules' about how many times the three 'assessment' based purposes can be used in a client's episode. As a guide the following information is provided:

- #11 Initial Needs Assessment is the initial screening work to understand the client's eligibility for the service and service requirements.
- #12 Comprehensive Assessment is usually conducted on the first or admission visit. It usually occurs once per episode, but can be more. This assessment is likely to be very broad/multidimensional but not necessarily providing great detail on each dimension.
- #13 Specialist Assessment - can be recorded on multiple occasions by health professionals for specific reasons (e.g. counsellor and a nurse can conduct separate specialist assessments for issues such as bereavement risk assessment and assessment of a single and specific symptom, such as nausea). This assessment is typically a very in-depth assessment with a narrow focus.

Contact care model

Principles

The contact care model describes the overall mode of care for the client that is occurring at the time of the contact.

There are three broad categories (note: the full definitions for VINAH are below) but these points appear to capture the main differences:

- #1 Direct care/ complete care – this is used, when in the opinion of the community palliative care service, the patient would see the palliative care service as the organisation who is making the decisions about how to meet their palliative care needs (this may not be all needs). The client may be receiving care from other organisations, but all palliative care interventions are directed by the community palliative care service. When an organisation brokers their services to another organisation, they are acting as if they were the palliative care service themselves.
- #2 Shared care – this model of care describes the situation where the client's palliative care needs are jointly being met by the decisions of two or more organisation. This may be the case when a highly engaged GP is making decisions about client medication levels in partnership with the community palliative care service and not simply taking advice.
- #3 Consultancy care– this is used when community palliative care service is asked to assist another organisation/person with specialist palliative care input to the client's care plan that has been decided upon and implemented by the other organisation.

VINAH manual definitions

- #1 Direct care/ complete care: The patient/client or carer/family/friend identifies this service as the service that is responsible for meeting their palliative care needs at this time. While other services or health professionals may be involved, the patient/client does not identify them as being responsible for meeting their palliative care needs at this time.
- #2 Shared care: The patient/carer identifies this service as one of at least two services or health professionals that are sharing responsibility for meeting their palliative care needs at this time. Partners in the patient's/client's care may include their general practitioner, primary care nurses or other specialist services.
- #3 Consultancy care with ongoing patient/client follow-up: The patient/client identifies another service or health professional (eg general practitioner, hospital, primary care nurse) as the service that is responsible for meeting their palliative care needs at this time. The community palliative care service is providing advice, backup and/or support. The community palliative care service has ongoing planned involvement with a patient/client and/or their treating clinicians.
- #4 Consultancy care with no further planned follow-up; The patient/client identifies another service or health professional (eg general practitioner, hospital, primary care nurse) as the service that is responsible for meeting their palliative care needs at this time. The community palliative care service is

providing advice, backup and/or support. The community palliative care service undertakes a comprehensive palliative care assessment and there is no planned review or involvement with the patient/client and/or their treating clinicians.

- #8 Unknown, not stated or question not asked: Report this code in the instance where a clinician is unavailable or it is not possible to determine the phase of care.
- #9 Not applicable - patient/client not present: Report this code when the value of Contact/Client Service Event Client Present Status is not '11' and not '12'

Bereavement card

Sending bereavement cards is an important part of the care of carers and family members. However, due to the largely administrative and routine nature of the process, there should not be a contact in VINAH for each card sent unless the content of the card is individualised to the client's circumstances and clinical needs (this is more than just addressing the card by hand and including the client's name).

- Number of contacts – 0 (in the majority of cases)