SYDNEY CHILDREN'S HOSPITALS NETWORK

DATA DEFINITIONS FOR ALLIED HEALTH

V3

DOCUMENT CONTROL

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BACKGROUND

Allied health data definitions are important to ensure activity reported is:

- Accurate
- Reproducible
- Standardised between and within professions and service locations

This document has been developed from a number of sources including Ministry of Health definitions (where available) and in consultation with allied health clinicians, managers and performance/costing units. The document focuses exclusively on Allied Health workflows specific to the Cerner eMR system and as such should not be extrapolated to other professions or systems. The data definitions are not intended as an instruction manual for completing Allied Health statistics, for detailed instructions please visit the learning.kids website.

OVERARCHING LOGIC FOR DECISIONS

In considering the way forward it is important to keep in mind the overarching and often implicit logic of the document:

1) All activity (time and OOS) that can be recorded against a specific patient should be. This is good clinical practice. It allows us to track where our services are provided, right down to patient level.

2) The data definitions must suit a number of purposes:
    a. Allied health department management, benchmarking and workforce planning
    b. Costing, performance and ABF requirements
    c. Information required for external submission (e.g.CHA, health round table, externally funded programs etc)
    d. Mandatory reporting requirements

    At times it is difficult to ensure all these requirements are met and some decisions may be a compromise across all these areas.

3) In large part, we are taking the very prescriptive definitions from the Ministry of Health WebNAP data dictionary (outpatients) and applying them across inpatient and outpatient settings. This is not always an ideal fit. However a separation of definitions for inpatient and outpatient statistics will likely cause significant confusion and cause greater issues with data integrity.

4) The Allied Health Data Definitions Document will form the new 'gold standard' for Allied Health statistics entry across the network. The definitions should not be dictated by the functionality (or lack thereof) of the Cerner eMR system. In fact, we hope that the definitions will drive system reform and functionality. If the logic behind a decision is sound we can use that to pinpoint where improvements to the system or workflow can be made. System functionality is likely to change over time; the logic for the definitions should not. However, where time can be saved and the impact on end data is likely to be minimal, the faster data process has been used.

GOAL

Standardised consistent data entry within and between disciplines and sites.

ACKNOWLEDGEMENT

This document is based on previous versions of allied health data definitions and follows extensive consultation with a range of clinicians and managers. The network data committees and those involved in providing examples and clarification of data definitions are recognised and thanked for their contribution.

EXECUTIVE SUMMARY

In order to accurately capture all relevant patient level data, the following general rules should be observed.

1. All activity/time that can be attributed to a specific patient (MRN) should be recorded against that patient, except where the intervention time, including writing notes, is less than 10 minutes. Clinicians are able to record interventions of less than 10 mins, however we do not want clinicians spending more time entering data than seeing patients.
2. An occasion of service is recorded on initial contact and subsequent review(s) of the patient and/or their family/carer. Follow up activities related *directly* to the initial and review contacts (e.g. report writing, orthosis modification, collecting equipment, analysis of results etc) are not recorded as additional OOS however *all* time should be recorded.
3. All occasions of service must contain clinical content and be verified by documentation in the patient's medical record.
4. OOS are NOT to be recorded by students. Student intervention time is only to be recorded when not under direct 1-to-1 supervision (i.e. 1 supervisor with multiple students). Supervisors are to record OOS on behalf of their students and any time not spent in direct 1-to1 supervision is to be recorded as department activity; teaching and training.
5. At the discretion of the department manager, activities that cannot be attributed to specific patients should, wherever possible, be recorded as department activities.

PATIENT ACTIVITY DATA DEFINITIONS

OCCASION OF SERVICE

Definition: "Any examination, consultation, treatment or other service provided by a health service provider … to a client/patient or their family/ carer on each occasion such service is provided."[1]

The service must contain clinical content and a record made in the patient's medical record, clinical file or information system.

Includes:

- Individual and group activity
- Telephone calls initiated by the patient/carer or service provider where significant new clinical information is discussed
- Family conference or case conferences where patient and/or carers may or may not be present
- Case management, this may include any activity attributable to an MRN which meets the above definition

Excludes:

- Services provided where an MRN cannot be identified
- Planning/preparation and administrative tasks associated with the service provision
- Medical note documentation/report writing related to a previous OOS
- Transport/travelling time of the service deliverer to or from the venue of the service
- 'Failure to attend' or 'did not wait'

Time should always be recorded against a patient, even in the absence of an OOS.

EXAMPLES

Example 1

A physiotherapist sees a patient on the ward, and after reading the patient medical record, performs the following activities: assessment of respiratory status related to immobility/bedrest, deep breathing exercises, range of motion exercises, and documentation of all of the above.

Record: 1 OOS.

Example 2

The physiotherapist performs the above activities in the morning, and returns in the afternoon to repeat the interventions and also walk the patient. Both interventions are documented in the medical record.

Record: 1 OOS for morning + 1 OOS for afternoon. Total 2 OOS.

Example 3
An occupational therapist travels in a hospital vehicle to visit a stroke patient who is at home, and while there performs the following interventions: assessment/evaluation, environmental modifications, equipment prescription, and documentation. The occupational therapist returns to the hospital and makes a phone call to the equipment supply company to arrange delivery of the equipment.
Record: 1 OOS (all activities are directly related to the provision of the OOS).

Example 4
A speech pathologist performs a swallowing assessment on a patient and has a second therapist to assist because of the difficulties with this particular patient.
Record: 1 OOS for the primary clinician, 0 OOS for the assistant clinician (however, the assistant should record the intervention time with zero OOS).

Example 5
A child life therapist sees a patient on the ward in the morning and performs the following interventions: reads the patient medical record, performs a medical play session and documentation . The patient attends a therapy group session in the afternoon. The group attendance is recorded in the medical notes.
Record: 1 OOS for morning + 1 OOS for afternoon. Total 2 OOS.

Example 6
A dietitian visits a patient on the ward and performs the following activities/interventions: reads the patient medical record, interviews the patient, calculates and prescribes an enteral feeding regime, discusses with the medical team and liaises with the kitchen to deliver the feed.
Record: 1 OOS.

Example 7
A social worker visits a patient on the ward and performs the following activities/interventions: reads the patient medical record, performs interventions such as an assessment and relationship counseling. Then afterwards on the same day, rings the patient's family to clarify some issues and documents in the file. Later, the social worker writes a report.
Record: 1 OOS total, however total time should also be recorded for these activities.

Example 8
A psychologist provides counselling to a patient's mother and father together (or separately) on a home visit. The intervention is documented in the patient's records i.e. only the patient is a registered client.
Record: 1 OOS.

Example 9
An occupational therapist provides advice to two siblings on the same home visit, so that both receive a separate individual service, and this is documented separately in each of their individual records i.e. they are both registered clients.

Record: 2 OOS total. One for each patient.

Example 10
A dietitian enters the ward, reads the medical notes, talks to the medical team, goes to see the patient but they are not in their bed. Nothing is documented in the medical notes.
Record: 0 OOS. However, time should be recorded.

Example 11
A physiotherapist attends a case conference and discusses the progress of their 5 patients. The NUM records which therapists were present at the case conference and provides an overview of the new care plan in the patient's medical record.
Record: 5 OOS. One for each patient discussed.

Example 12
A psychologist attends a case conference for an hour where 10 patients are discussed. However the psychologist is only actively involved in 4 of the 10 patient's care. The NUM records which therapists were present at the case conference and provides an overview of the new care plan in each of the patient's medical record.
Record: 4 OOS, one for each patient that the psychologist is actively involved with. NB Total case conference time should be divided by the number of OOS recorded (e.g.in this case 15 mins each).

Example 13
A speech pathologist attends a case conference. The team prioritises the patients so that the 3 patients involved with speech pathology are discussed first. These 3 patients are discussed and the speech pathologist leaves. The remaining 7 patients are then discussed.
Record: Speech pathologist records 3 OOS. Other staff record OOS for each patient they are actively involved in.

Example 14
An orthotist reviews a patient's orthosis on the ward, and takes the orthosis to the department for adjustment, they return the orthosis to the patient upon completion of that adjustment.
Record: OOS 1.

Example 15
An infant is brought to a multi-disciplinary clinic and assessed by the physiotherapist, occupational therapist, dietitian and speech pathologist. The attendance is noted in the infant's medical record.
Record: 1 OOS for each clinician (i.e. physiotherapist 1 OOS, occupational therapist 1 OOS etc).

INTERVENTION TIME

Definition: The total time, measured in minutes attributable to a specific patient's care and related activities. Intervention time is used in combination with the primary contact type/modality of care. Time is generally rounded to the nearest 5 minutes.

Includes:

- Medical note reading/writing
- Discussions specific to the patient with other members of the multi-disciplinary team (e.g. medical, nursing, other allied health and support staff)
- Time spent in case conferences discussing specific patients
- Planning/preparation time
- Entering statistics
- Clinician travel time (include as part of the primary contact type/modality of care)

Excludes:

- Time spent for patient fail to attend or waiting for patient to attend

EXAMPLES

Example 16

A physiotherapist spends:

- 10 minutes reading a patient's medical notes
- 25 minutes assessing the patient
- 5 minutes outlining fall risks for this patient to the NUM
- 15 minutes writing medical notes and completing statistics

Record: 55 minutes intervention time and 1 OOS.

Example 17

A dietitian spends:

- 10 minutes reading a patient's medical notes
- 15 minutes talking to the patient
- 10 minutes discussing the enteral feeding plan with nursing staff
- 15 minutes writing medical notes
- 10 minutes liaising with kitchen and arranging the feed

Record: 60 minutes total intervention time and 1 OOS.

Example 18

A psychologist spends:

- 120 minutes interviewing the patient
- 30 minutes summarising the interview
- 180 minutes writing a report
- 20 minutes discussing the report with the GP and other service providers (nil new information is gained or change of plans)

Record: 350 minutes total intervention time and 1 OOS.

Example 19

An occupational therapist attends a case conference for 60 minutes and discusses 4 patients:

- 15 minutes is spent on each of 2 patients
- 20 minutes is spent on 1 patient
- 10 minutes is spent 1 patient

Record: 4 OOS. 1 with 20 minutes of intervention, 2 with 15 minutes and 1 with 10 minutes of intervention **OR** total time in the case conference can be divided by the number of patients where the clinician is actively involved (in this case 15 minutes per patient).

Example 20

A music therapist spends:

- 15 minutes reading a patient's medical notes
- 10 minutes discussing the patient with nursing staff
- 45 minutes with the patient
- 15 minutes writing medical notes
- 10 minutes retrieving resources for the patient

Record: 95 minutes total intervention time and 1 OOS

Example 21

An orthotist fits a custom made orthosis made from a cast taken at a previous encounter (cast modification completed by the orthotist 120 minutes, Technicians manufacture 180 minutes). The orthotist fits and adjusts the orthosis, provides information and education and writes in the patient medical notes (total time on day of fitting is 90 minutes).

Record: 1 OOS, Face to face 90 minutes.
120 minutes Manufacture Orthosis
180 minutes Technicians Manufacture

FACILITY

Definition: The hospital where the intervention was provided. It is important the correct facility is selected and that the facility and the service Unit are consistent. i.e. If the Facility is Sydney Children's Hospital, the service unit cannot be Allied Health Orthopaedic CHW, likewise the Facility and the Ward need to be consistent, if you select Children's Hospital at Westmead, the ward location needs to be a CHW ward.

REFERRAL DATE AND REFERRAL RECEIVED DATE

The referral date is the date on which the patient was referred to you for treatment. The referral received date is the date the department received the referral. There are many occasions when these dates will be the same. This field carries through once it has been filled out for the first time, so if you have a new referral for an existing patient it is important to ensure this is updated.

CONTACT TYPE/MODALITY OF CARE

Definition: Modality of care refers to the primary method of service delivery provided to a patient in a given consultation context. The allied health powerform allows clinicians to select from 13 possible modality of care types.

When selecting a modality of care, it is preferable to collate all time under the primary contact type rather than recording a consultation process as separate 'chunks' of time. In all cases where an OOS is recorded, there must be a corresponding entry made in the patient's medical record.

Face to face

Definition: "Any examination, consultation, treatment or other service provided by a health service provider to a patient of a health service establishment" [1].

Generally, all inpatient interventions will be attributed as 'face to face' time.

Group Session

Definition: A group of patients, not from the same family, who receive a service from a health care employee at the same time.

Phone

Definition: "Patient and provider not in same physical location and communicating by telephone" [1] .Service provider is talking directly to the patient or carer.

Note: where phone calls are being made *without the patient present* but contain significant clinical content for the patients health and well-being (e.g.discussion with GP, FACS, external agencies etc), these should be counted as case management rather than phone or tele-medicine.

Telehealth videoconference – Consultant End
Definition: as above for phones but communication occurring via secure telecommunication or video communication mediums.

Telehealth videoconference – Patient End
Definition: as above but the patient or carer is with you. This option can be used for example in another LHD if they are with the patient and we are doing a telehealth session with them and the patient.

Email medicine/Email
Definition: Email containing clinical content pertinent to the patient's care which is filed in the patient medical record.

Case Conference
Definition: Process whereby patient's history, needs and outcomes required by each team member is discussed. Patient or carer(s) may or may not be present.

Case Management/Case Planning
Definition: "Services provided by a worker who has been formally designated as responsible for ensuring co-ordinated and appropriate services to a client with complex care needs" [1].

EXAMPLES

Example 22
A dietitian goes to the ward, reads the patient's notes, is unable to talk with the patient due to the patient's age, and the parents are not on the ward, calls the patient's mother, then their GP, discusses the patient's plan with the medical team and documents in the notes and updates the patient's diet order in eMR. The entire process takes 90 minutes.
Record: 1 OOS, 90 minutes face to face time (generally all inpatient time is considered 'face to face' even though different modalities have been used in this example).

Example 23
An occupational therapist calls the patient's family to confirm the home visit is still convenient, collects equipment, travels to the patient's home, conducts an ADL assessment, makes equipment and home modification recommendations, returns to the hospital, calls a care/equipment provider and documents in the patient's notes. Total time 3 ½ hours.
Record: 1 OOS, 210 minutes face to face time.

Example 24

The following day (from example above), the occupational therapist calls the patient's family to inform them of the outcome of their discussion with the equipment provider. Total time 20 minutes.
Record: 0 OOS, 20 minutes phone
NB additional time with zero OOS allocated via ad hoc chart if relevant.

Example 25
The following month (from example above), the occupational therapist contacts the patient by phone to discuss their progress with the new equipment and home modifications and documents the outcome in the patient's medical record. Total time 30 minutes.
Record: 1 OOS, 30 minutes phone.

Example 26

A mother calls the hospital and speaks to a speech pathologist regarding teat recommendations for bottle feeding her premature infant. The speech pathologist provides advice and recommendations over the phone and arranges for the infant and mother to attend an appointment in 2 weeks. The speech pathologist makes a record of clinical recommendations in the patient's record. Total time 20 minutes.

Record: 1 OOS, 20 minutes phone

NB this intervention is recorded against the infant as the patient, not the mother.

Example 27

A psychologist attends the ward and provides advice to the medical team around capacity issues specific to the patient. While there they request the medical team to collect some information prior to an assessment being scheduled. A note is made in the patient's file regarding advice provided. The process takes 45 minutes.

Record: 1 OOS, 45 minutes case planning/ no client contact

Clinical Area

Definition: The clinical specialty area responsible for the patient's care during admission or the patient's outpatient referral.

Typically, Clinical Area will be the designated department/unit of the current admitting medical officer. The exception to this rule is for ICU/HDU where Critical Care should be used.

EXAMPLES

Example 28
A patient in the renal ward under the care of a nephrologist.
Record: Nephrology.

Example 29
A patient admitted under a paediatrician as an 'outlier' to the gastro surgical ward.
Record: Gen medicine.

Example 30
A patient admitted in Emergency by an Emergency Unit doctor.
Record: Emergency.

Example 31
A patient is admitted under a cardiologist but deteriorates and is admitted to ICU. In ICU they are seen by a physiotherapist for chest physiotherapy.
Record: Critical Care.

Example 32
The same patient (example above) improves and returns to the cardiology ward where they continue to receive chest physiotherapy.
Record: Cardiology.

Example 33
The same patient (example above) is then admitted to a rehabilitation ward prior to returning home.
Record: Rehabilitation.

SERVICE TYPE [INPATIENT, OUTPATIENT OR EMERGENCY]

Definition: A reporting classification designed to assist with reporting non-admitted patients (Outpatient), admitted patients (Inpatient) and non-admitted Emergency Patients (Emergency).

NB A Service type list exists for inpatients (I/P Service Type)

Patients seen in Emergency are generally non-admitted whilst in Emergency – select Emergency and "Outpatient" for Ward.
If a patient is seen as an admitted patient in the Emergency department, or is seen in EMU at the Westmead site Service Type would be: Inpatient and I/P Service Type will be: IP - Emergency

EXAMPLES

Example 34
An occupational therapist conducts a 'discharge home visit' for a patient admitted for a SEMLS. The medical team is holding the bed open, awaiting clearance of the patient from the OT before they are discharged. The patient is picked up from the ward and transported by hospital vehicle to their home (the trip takes 30 minutes) where their equipment is set up and demonstrated. The occupational therapist, calls the medical team and confirms the patient is clear for discharge, returns to the hospital and makes a note in the patient's medical record. Total time 2 hours.
Record: 1 OOS, 90 minutes face to face contact. Inpatient service type: IP - Acute.

NB This example assumes the patient's bed is held open. i.e. there is the option to return the patient to hospital if the home visit fails. IF the patient has already been discharged prior to leaving the hospital the intervention should be counted as an outpatient service.

Example 35
A physiotherapist on a rehabilitation ward performs a sit to stand assessment, walks the patient and documents in the medical notes. Total time 30 minutes
Record: 1 OOS, 30 minutes face to face time, I/P service type: IP – Rehab/ Ext care.

SERVICE UNIT

A service unit is defined as a health professional or group of health professionals who work in cooperation and share common facilities or resources to provide services to clients/patients for the assessment, diagnosis and treatment of a specific set of health related problems/conditions in a hospital (outpatient, admitted or outreach) or in the community. Service units may deliver their services at a variety of settings and via a variety of modalities (e.g. In Person, Telephone, Videoconference).

The Service Unit determines where the activity is attributed, and what NWAU value is assigned to it. The service unit chosen should most accurately reflect what is happening in reality.

The service unit entered will vary depending on where the activity is and the clinical discipline/ specialty of the lead service provider i.e. the member of the team with the responsibility for clinical governance. If you are seeing a patient in your department, select your department as the service unit.

If you are seeing a patient in a medical led clinic select the medical clinic as the service unit i.e. gastroenterology, this will ensure the appropriate multi-disciplinary loading is added and costed to that clinic. This can also be done by copying the ID number from the appointment into your powerform.

If you are providing a specialist allied health service in an allied health led clinic select the appropriate Allied Health Clinical specialty i.e. Allied Health Orthopaedics

EXAMPLES

Example 36

A physiotherapist, funded either by the physiotherapy department or the orthopaedics department attends the orthopaedic clinic for the duration of the 3 hour clinic, and is required to see 10 patients.

Record: 10 OOS, assign correct time to each patient. Service Unit: Orthopaedic Clinic

Example 37

Later that day the physiotherapist attends the Ponseti clinic, there are no medical staff present as this is an allied health led clinic.

Record: Service Unit: Allied Health Orthopaedics

Example 38

A physiotherapist sees a patient referred by an orthopaedic surgeon for hydrotherapy. The patient has an appointment in the physiotherapy department for the hydrotherapy session.

Record: Service Unit: Allied Health Hydrotherapy

Example 39

A child life therapist is seeing children in the palliative care service as part of the multidisciplinary team led by the medical staff in the clinic at the time.

Record: Service Unit: Palliative Care Service

Example 40
From the example above one of the patients from the clinic returns the following week to see the child life therapist in a standalone appointment **within the palliative care unit**. The child sees no staff other than the child life therapist during the visit.
Record: Service Unit: Allied Health Palliative

WHEN THINGS GET COMPLICATED

Should you encounter difficulty in interpreting how a statistic should be recorded, please refer to the flow chart located at the end of this document. If you are still unsure of how to record your time and OOS please contact your immediate manager. Managers are encouraged to send the example to other HODs for comment and further clarification if required. The result of the enquiry should be used to provide further education to all allied health staff to ensure consistency in data capture.

Some questions to help you in how/where to enter your stats may be:

- Can I identify an MRN for this activity?
- Where did the activity take place?
- Whose medical record is this being documented in? That person is the patient (even if you have been talking to someone else about an issue)
- Should I create an MRN and register this patient and commence a medical record for them? If the parent/carer is likely to require ongoing intervention aside from the progress of the patient then they should be registered as a patient themselves

COMPLICATED EXAMPLES

Example 41
A physiotherapist is running a rehab exercise group for 10 patients. 2 patients require individualized attention during the group and the physiotherapist spends 10 minutes with each of them. All patients have an entry in their medical record for attending the group and specific entries are made for the 2 patients receiving individualised attention.
Record: 10 x group OOS for the duration of the group and 2 x individual OOS of 10 minutes each.

Example 42
A social worker provides bereavement support via email to the adolescent sibling of a recently deceased patient. The email correspondence takes 20 minutes to write. An MRN and medical record is created for the adolescent (with their permission), they are now a registered patient. An entry is made in the adolescent's medical file.
The email contains clinical content and is included in the medical file of the adolescent sibling.
Record: 1 OOS, 20 minutes email medicine.

ALLIED HEALTH ASSISTANT STATISTICS

Allied health assistants (AHA) should record ALL their therapy time against specific patients wherever possible.

AHA can also record an OOS where:

- They are providing an intervention/therapy independent of other staff
- Their intervention/therapy is documented separately in the patient's medical record

Where AHAs are assisting an allied health professional (AHP) in their task then the AHP records total time and OOS, the AHA records total time and zero OOS.

AHA EXAMPLES

Example 43

A physiotherapist conducts an exercise program for a patient and is assisted by an AHA. The patient's intervention takes 60 minutes.

Record: Physiotherapist – 1 OOS, 60 minutes face to face; AHA 0 OOS, 60 minutes face to face.

Example 44

An AHA assists a patient to complete some paper based memory retraining activities set by the occupational therapist. The session takes 30 mins and the occupational therapist is not present.

Record: 1 OOS, 30 mins face to face.

Example 45

A physiotherapist provides supervision for 2 AHAs who take 2 patients through an exercise program for 30 minutes.

Record: Physiotherapist – 2 OOS, 15 mins face to face for each patient; each AHA records 0 OOS and 30 minutes face to face for their respective patients.

Example 46

An OT assistant carries out one handed dressing practice in the bathroom for 1 hour. The assistant also educates the carer on how best to assist the child to complete the tasks during this time.

Record: 1 OOS, 60 mins face to face.

Example 47

The OT has requested that the OT assistant takes a patient to the ADL unit and demonstrate how to use modified kitchen aids. The physiotherapist attends at the same time to assess the patient's balance using a walking stick in the kitchen environment. The session takes 20 minutes. The AHA then provides some documentation to the patient regarding suppliers and options of models/styles. This takes 10 mins.

Record: AHA - 1 OOS, 30 mins face to face Physio = 1 OOS, 20 mins face to face.

STUDENT STATISTICS

Student statistics cause a number of issues around what can and cannot be counted in terms of costing, WebNAP and department statistics. There is no method of student statistics capture that will meet all our requirements. Accordingly the following model is proposed.

1. If supervision of the student occurs in a one-to-one environment (i.e. student & supervisor provide intervention together) then the supervisor is to record all time and OOS, the student records no stats.
2. If the student is providing therapy independent of direct supervision* the student is to record :
    - zero OOS, and
    - all therapy time where the supervisor is not directly supervising in a one-to-one environment.

    The supervisor is to record
    - all OOS, and
    - any time spent in direct contact with the patient.
    - The remaining time (i.e. discussing the case, countersigning the notes etc) is to be recorded by the supervisor as department activity – teaching and training.

    This is to avoid 'doubling up' of patient therapy time provided by student and supervisor.

STUDENT EXAMPLES

Example 48

A physiotherapist is supervising 5 students during an exercise rehabilitation class. Each student provides an hour of therapy to one patient each (total 5 patients). The physiotherapist divides their attention evenly between the 5 students. The students write the medical note entry and this is countersigned by the supervisor.

Record: Each student records 0 x OOS and 60 minutes intervention per patient. The supervisor records 1x OOS and 1 minute of intervention for each patient. The remaining time (55 mins) is recorded by the supervisor as department activity, teaching and training.

Example 49

An occupational therapist introduces themselves and their student to the patient. The supervisor discusses the treatment plan briefly with the patient (10 minutes) then allows the student to complete the treatment while the supervisor observes (20 minutes).

Record: The supervisor records 1xOOS, 30 minutes. The student records no stats.

Example 50

* Direct supervision in this case refers to the supervisor directly overseeing the work of the student in a one-to-one scenario.

A dietitian allows a student to conduct a nutritional assessment of a patient while they see another patient. The student takes 60 minutes to complete the assessment. The dietitian and student spend 20 minutes discussing the case, ensuring the care plans are accurate and the supervisor countersigns the notes.
Record: The student records 0xOOS, 80 minutes intervention time. The supervisor records 1xOOS & minimal time (1 minute) and 20 minutes department activity, teaching and training. The supervisor also accounts for time and OOS for the other patient.

Example 51
An assessment is conducted on a patient by a student with the orthoptic supervisor observing. The student takes 45minutes to complete the assessment. The orthoptist and student spend 15 minutes afterwards discussing the assessment and documenting in the medical record; the supervisor countersigns the notes.
Record: The student does not record any statistics. The supervisor records 1xOOS, and 60 minutes face-to-face intervention time.

NON-PATIENT ACTIVITY DATA DEFINITIONS

DEPARTMENT ACTIVITIES

Definition: Activities performed which are not directly related to a particular patient such as teaching, research and administrative functions. There are four categories of Allied Health activity:

1. Clinical Care (CC)
2. Clinical Services Management (CSM)
3. Teaching and Training (TT)
4. Research (R)

EXAMPLES

Clinical Care

- **General** (CC – General)
  - Time spent developing a patient education program
  - Development of patient education materials/resources
  - Clinical caseload management – including time spent in consultation with medical/nursing staff to determine whether or not a patient should/shouldn't receive an intervention
  - Rapid rounds or team talks
  - Clinical planning – time spent reviewing, developing and evaluating clinical services
  - General enquiries
  - Health promotion

- **Patient Related Supervision** (CC – Patient Related Supervision)
  - Time spent in receiving and providing supervision regarding a specific client/patient

Clinical Service Management

- **General** (CSM – General)
  - Staff meetings
  - WHS activities
  - Staff Management
  - Financial management
  - Recruitment
  - Performance appraisal

- **Professional Development** (CSM – Professional Development)
  - Attending in-services, lectures, interest groups, seminars and conferences or any other means of receiving teaching and training
  - Journal reading and journal clubs

- **Quality** (CSM – Quality)
  - Meetings
  - Planning and conducting project work
  - Activities in preparation for accreditation

- **Provision of Supervision** (CSM – Provision of Supervision)
  - Supervision provided on clinical issues, or regarding a number of patients/clients.
  - Includes clinical supervision provided to staff from other hospitals or workplace
  - Does NOT include
    - Student supervision or clinical education
    - Specialist consultation or supervision provided, regarding workplace or career

- **Receipt of Supervision** (CSM – Receipt of Supervision)
  - Supervision received on clinical issues, or regarding a number of patients/clients Includes clinical supervision provided to staff from other hospitals or workplaces
  - Does NOT include
    - Student supervision or clinical education
    - Specialist consultation or supervision provided, regarding workplace or career

Teaching and training

- **General** (TT – General)
  - Administration for general teaching and training activities
  - Supervision of work experience placements

- **Undergraduate** (TT – Undergraduate)
  - Imparting knowledge, skills and clinical competency to undergraduate students

- **Postgraduate** (TT – Postgraduate)
  - Imparting knowledge, skills and clinical competency to postgraduate students

- **Own discipline** (TT – Own discipline)
  - Imparting knowledge, skills and clinical competency to practitioners within ones own discipline

- **Other discipline** (TT – Other discipline)
  - Imparting knowledge, skills and clinical competency to practitioners from another discipline

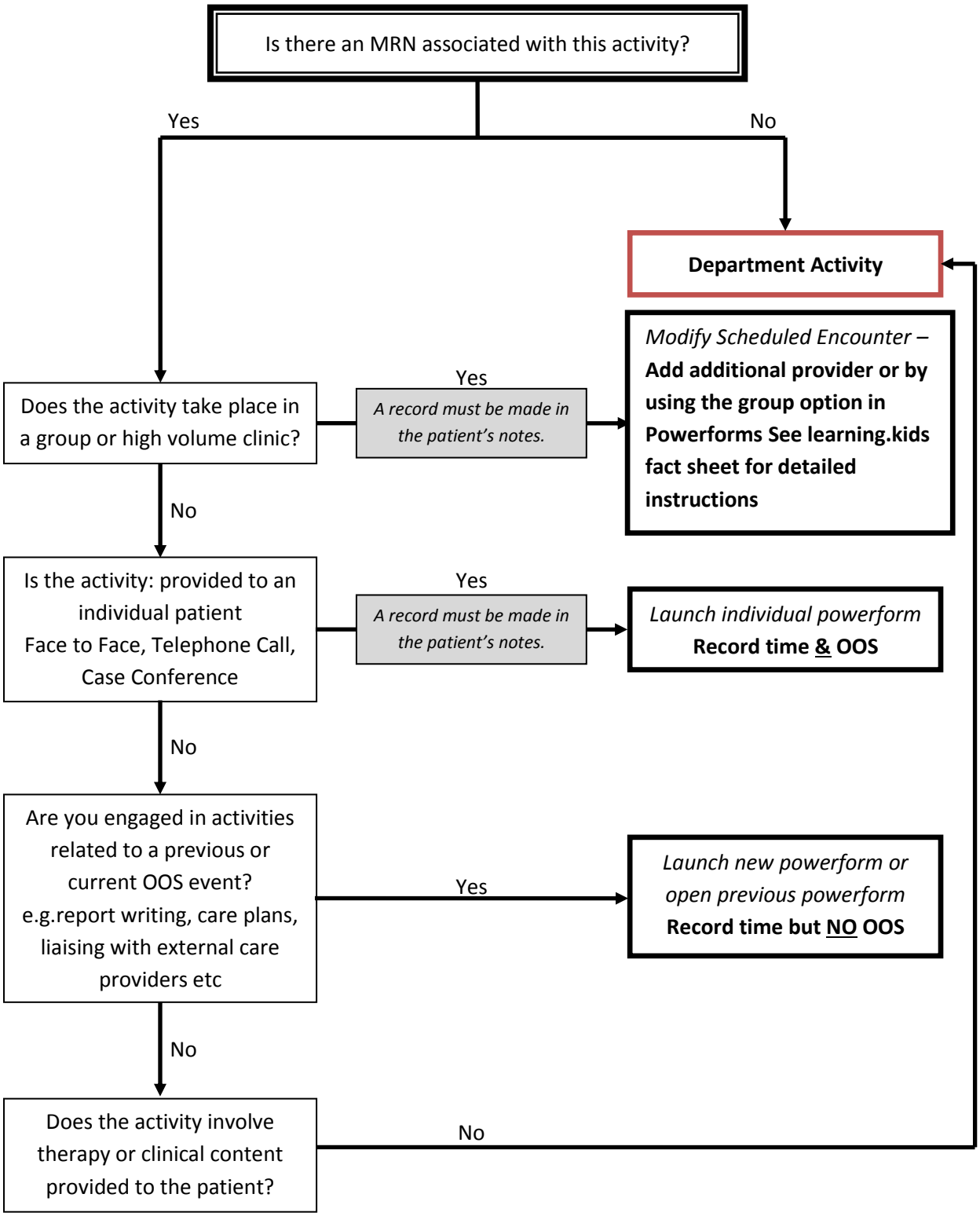
Research

- Activities undertaken to advance the knowledge of the delivery of care to an individual, group or community. Research is limited to activities that lead to and follow formal approval of the project by a research committee or equivalent body
- Includes all time spent on research activities including meetings, telephone calls, administrative activities, consultation, preparation, planning, ethics committee approval and activities associated with the implementation phase of the research project, including the documentation and final reports of the project

Leave

- Includes all forms of leave (annual leave, FACS leave, sick leave, study leave, military leave, conference leave, leave without pay)
- ADO, time in lieu & meal breaks are not entered as leave

CERNER EMR ALLIED HEALTH STATISTICS ACTIVITY FLOWCHART



REFERENCES

1) NAP Data Collection Data Dictionary v2.2 (June 2012)