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Introduction

The Condensed Data Dictionary (CDD) for ACAP MDS V2 is designed to assist ACAT staff to understand the new data definitions and codes contained in the MDSV2, and is not supposed to replace, enhance or augment the ACAP Data Dictionary v1 (AIHW).

The initial training sessions are critical to achieving a thorough understanding of the data set and the principles behind correct and consistent coding. However, ongoing discussions within teams, within states, and nationally, need to occur, particularly during the first year of the new MDS, to ensure that coding and data collection continue in a consistent manner. Further comments about how to ensure good quality data collection in the longer term are noted below.

Why is collecting the MDS important?

The objectives of the ACAP MDS are to:
- provide ACAP program managers, both Commonwealth and State/Territory, with access to data for policy and program development, strategic planning, and performance monitoring against agreed outcomes. Performance Indicators for the program are included in the Data Dictionary
- assist ACATs to provide high quality services to their clients by facilitating improved internal management and local/regional area planning and coordinated service delivery; and
- facilitate consistency and comparability of ACAP data with other relevant information in the health and community services field.

Reporting the MDS is a condition of Commonwealth funding and is a responsibility of the ACATs.

Why did the MDS change?

The MDS needed to be updated to provide more information about the clients and their circumstances and to achieve comparability and ‘mappability’ with national standards and data elements in other related data collections. The standards and data collections that were given particular attention during the MDS development process were:
- Australian Bureau of Statistics (ABS) standards;
- National Community Services Data Dictionary (NCSDD Version 2.0);
- National Health Data Dictionary (NHDD Version 9.0);
- Community Aged Care Packages (CACP) Draft data items;
- Home and Community Care Minimum Data Set (HACC MDS Version 1.0).

Version 2.0 has extended the scope of information about a client’s characteristics and circumstances in two main areas:
- information about informal carers; and
- information describing a client’s health profile and functional status.

What the MDS doesn’t do

The ACAP MDS Version 2.0 is designed to report only core work of ACATs. It does not report nor measure all the activity undertaken or information given to assist people. It also does not collect all the information that ACATs need in order to do their job.

The coverage of an ACAT comprehensive assessment excludes some forms of assistance and thus the people receiving this assistance from MDS reporting. Discipline specific assessments for example and reviews of care plans or follow-up monitoring is not recorded.

The MDS is not designed to report the provision of care or treatment, only assessment functions of ACATs.

The ACAP MDS Version 2.0 does not incorporate any reporting requirements related to the characteristics of the ACATs themselves or the environment in which they operate. It doesn’t record whether the recommended service is available or used.

For further information on the limitations of the MDS Version 2.0 please see the ACAP MDS Version 2.0 Data Dictionary Version 1. pp8-9.
Who needs to complete the MDS?

In meeting the ACAP aims and objectives, one of ACAT’s responsibilities is to report against the MDS. MDS reporting is a condition of Commonwealth funding. (ACAP Operational Guidelines 2002 ACAP Financial Guidelines 1997).

As such the MDS needs to be completed by ACAT staff or their nominated representative. Should other than ACAT staff be involved in the completion of the MDS, it is the responsibility of the ACAT and its delegates to ensure that their nominated representative is provided with the correct information and training in the data definitions and how elements are to be recorded. A process to ensure quality and accuracy of data needs to be in place.
Data elements for ACAP MDS V2.0

Accepted for ACAT comprehensive assessment
(see ACAT client and ACAT comprehensive assessment concepts in data dictionary)

Referral to ACAT

Not accepted for ACAT comprehensive assessment

Client ID
Letters of name
Sex
DOB
Suburb/town/locality name
Postcode
Country of birth
Indigenous status
DVA entitlement

Referral date
Priority category
First intervention date
First FTF contact date
First FTF contact setting
Assessor profession
Assessment end date
Health condition
Activity limitations

Community
codes 1-7 & 12

Accommodation setting (usual)

Institutional
codes 8-11
(residential aged care, other inst. care)

Living arrangements
Carer availability
Relat. of carer to care recipient
Carer co-residency status

Govt. program support at assessment
Respite care use
Current assistance with activities
Source of current assistance.

Reason for ending assessment

Recommended long term care setting

Complete
(code 1)

Incomplete
(codes 2-7)

End (Still included in ACAP MDS V2.0)

Recommended formal assistance
Govt. program support recommended
Respite care recommended

End

Key. Data elements in bold are to be collected and reported for all clients for whom an MDS record is required.

Data elements in bold & underlined determine whether dependent data elements are asked.

Data elements in italics are dependent on responses to bold and underlined data.
### Mapping of National ACAP MDS V1.0 to MDS V2.0

<table>
<thead>
<tr>
<th>MDS V1.0</th>
<th>MDS V2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment number</td>
<td>Client ID</td>
</tr>
<tr>
<td>Marital status</td>
<td>Sex</td>
</tr>
<tr>
<td>Major source of income</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Reason for referral</td>
<td>Country of birth</td>
</tr>
<tr>
<td>Ongoing support</td>
<td>(includes Indigenous Status)</td>
</tr>
<tr>
<td>Client ID</td>
<td>Indigenous Status</td>
</tr>
<tr>
<td>Sex</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Country of birth</td>
</tr>
<tr>
<td>Country of birth</td>
<td>Indigenous Status</td>
</tr>
<tr>
<td>(includes Indigenous Status)</td>
<td>Postcode</td>
</tr>
<tr>
<td>LGA/SLA of usual residence</td>
<td>Suburb/town/locality name</td>
</tr>
<tr>
<td>Usual residence</td>
<td>Accommodation setting—usual</td>
</tr>
<tr>
<td>Housing tenure</td>
<td>Accommodation setting—usual</td>
</tr>
<tr>
<td>Usual living arrangements</td>
<td>Living arrangements</td>
</tr>
<tr>
<td>Support services received before assessment</td>
<td>Current assistance with activities</td>
</tr>
<tr>
<td>Location at assessment</td>
<td>Government support at assessment</td>
</tr>
<tr>
<td>Primary diagnosis</td>
<td>Respite care at assessment</td>
</tr>
<tr>
<td>Mobility</td>
<td>First face-to-face contact setting</td>
</tr>
<tr>
<td>Continence</td>
<td>Health condition</td>
</tr>
<tr>
<td>Orientation</td>
<td>Health condition</td>
</tr>
<tr>
<td>Date of care plan/transfer/death/cancellation</td>
<td>Assessment end date</td>
</tr>
<tr>
<td>Recommended long term living arrangements</td>
<td>Reason for ending assessment</td>
</tr>
<tr>
<td>Inpatient care recommended during /after assessment</td>
<td>Reason for ending assessment</td>
</tr>
<tr>
<td>Support services recommended after assessment</td>
<td>Recommended formal assistance with activities</td>
</tr>
<tr>
<td>Support services recommended after assessment</td>
<td>Government support recommended</td>
</tr>
<tr>
<td>Government support recommended</td>
<td>Respite care recommended</td>
</tr>
<tr>
<td>Referral date</td>
<td>DVA entitlement</td>
</tr>
<tr>
<td>DVA entitlement</td>
<td>Priority category</td>
</tr>
<tr>
<td>Priority category</td>
<td>First intervention date</td>
</tr>
<tr>
<td>First intervention date</td>
<td>First face-to-face contact date</td>
</tr>
<tr>
<td>First face-to-face contact date</td>
<td>Carer availability</td>
</tr>
<tr>
<td>Carer availability</td>
<td>Carer co-residency status</td>
</tr>
<tr>
<td>Carer availability</td>
<td>Relationship of carer to care recipient</td>
</tr>
<tr>
<td>Relationship of carer to care recipient</td>
<td>Source of current assistance</td>
</tr>
<tr>
<td>Source of current assistance</td>
<td>Assessor profession</td>
</tr>
<tr>
<td>Assessor profession</td>
<td></td>
</tr>
</tbody>
</table>
Tools and processes for accurate data collection

ACATs have been collecting MDS data since the inception of the program in the mid 1980s. ACAT staff are familiar with the routine of data collection and data entry, and each team and each state will have developed its own processes for maintaining high quality data. The following processes have been found to have an effect on data quality:

1. **Have the correct coding materials on hand**
   
   To correctly code, the following are required:
   
   (a) *The ACAP Condensed Data Dictionary*
   
   This booklet is a stripped down version of the MDS Data Dictionary. It is designed to help you code as efficiently as possible, to remind you of the correct definitions and codes, and to guide you with difficult or unusual coding decisions.
   
   (b) *The ACAP Coding booklet.*
   
   This booklet contains all the disease/disorder definitions and codes as determined by the ACAP Data Dictionary v1.0. It also contains: Country of birth, language and health condition codes. All ACAT staff should have their own copy. These will be available through your Evaluation Unit.
   
   (c) *The Aged Care Client Record (ACCR)*
   
   This combines the MDS form and the Aged Care Application and Approval Form 2624 (2624). It has been developed by the Commonwealth Department of Health and Ageing in Canberra and is included as part of the MDSV2 training materials. ACATs will receive a supply of ACCR forms directly from the Commonwealth Department of Health and Ageing.
   
   (d) *The ACAP Data Dictionary v1.0 (AIHW)*
   
   The full version of the Data Dictionary as supplied by the Commonwealth Department of Health and Ageing. Each ACAT will receive at least one copy.

2. **Undertake regular within team training**

   Once the first round of training has occurred and all ACATs are using the new MDS, questions will arise with regard to the more unusual coding decisions. In the first instance, assessment staff could routinely use case conferences as an opportunity to get feedback on their coding decisions, particularly around the use of the ICDH10-AM codes for Health Condition. These and other opportunities for staff discussions are necessary in order to give staff the opportunity to query a coding decision and hear how others are doing it. This will ensure that the application of the coding guidelines is consistent within teams.

   To ensure consistency and standard practices in coding across teams within the state, any outstanding queries resulting from these discussions and any unusual coding decisions need to be discussed with the Evaluation Unit. The Evaluation Unit can then seek feedback from all state teams and nationally if appropriate to assist in determining appropriate and consistent coding.

3. **Establish a mechanism for inter-team communication**

   Some states have regular ACAP newsletters. These can be used as a mechanism for inter-team communication about the new data set.

4. **Examining data reports**

   Examination of MDS data reports and comparisons of MDS results across teams and across states will give some indication of coding consistency. The Evaluation Unit will examine the reports and investigate items that appear to be different to the average (i.e. different to the average for other ‘like’ teams). Team managers should also examine these reports. However, it is important to check that team-coding protocols are correct before assuming that your team (or client group) is ‘different’ to others.
Who is included in the MDS V2.0

Before we start working through the data it is imperative to understand which clients are included in the data set and for which type of activity.

The MDS is a data set containing information on ACAT clients. The MDS records activity as defined by two data concepts: **ACAT client** and **ACAT comprehensive assessment**. Clients included in MDSV2 are those clients who are accepted and registered as needing a comprehensive assessment.

MDS V2 will not necessarily record **all** ACAT activity or **all** client contacts. Clients included in the MDS V2 are those clients referred for Community Aged Care Packages (CACPs) and Extended Aged Care at Home (EACH) packages, and those who are referred for residential care respite and permanent residential care. Clients and their carers who are experiencing difficulty managing at home and who are considering residential care are also included.

Clients excluded from MDSV2 include:
- People seeking ad hoc advice or information from an ACAT.
- People who are assisted by members of an ACAT but who do not require a comprehensive assessment of their care needs.
- People who are currently receiving care or treatment, including rehabilitation.

**Definitions:**

**ACAT client:** A person who receives an evaluation of their care needs incorporating the restorative, physical, medical, psychological, cultural and social dimensions of care from an Aged Care Assessment Team (i.e. a comprehensive assessment).

**ACAT comprehensive assessment:** An evaluation of the care needs of the client incorporating the restorative, physical, medical, psychological, cultural and social dimensions of care. This definition is similar to that in MDS V1.

**Why is this important?**

In order to collect valid data within a national reporting framework, standardisation of the scope of ACAT activity to be reported in the MDS is necessary to ensure comparability of data across and within States and Territories.

**Getting it right:**

If a client is accepted and registered as needing a comprehensive assessment but dies or withdraws from the process before receiving the assessment, they are **included** in the MDS record. Face-to-face contact is considered to be a core element of any ACAT comprehensive assessment. At times, another person may act as an ACAT representative if face-to-face contact with an ACAT member is not possible. This may be relevant in remote areas. These clients are **included** in the MDS.

Examples of ACAT activity/clients **excluded** from MDS reporting are:
- Medical consultations that do not incorporate the physical, psychological, cultural and social aspects of comprehensive assessment. Eg. referrals from one ACAT member to another of a different discipline.
- Discipline specific assessments (e.g. an OT assessment that is not part of a comprehensive assessment).
- People who receive care or treatment from an ACAT without the physical, psychological, cultural and social aspects of a comprehensive assessment.
The following is a reference guide to assist with the identification of an ACAT client at the point of referral for inclusion in the MDS.

<table>
<thead>
<tr>
<th>ACAT CLIENTS INCLUDED IN THE MDS</th>
<th>ACAT CLIENTS NOT INCLUDED IN THE MDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clients referred for CACP/EACH</td>
<td>• Client is medically acute.</td>
</tr>
<tr>
<td>• Clients referred for residential respite.</td>
<td>• Client requires post acute support.</td>
</tr>
<tr>
<td>• Clients referred for permanent residential care.</td>
<td>• Client is undergoing a rehabilitation program.</td>
</tr>
<tr>
<td>• Clients and their carers experiencing difficulty managing at home and/or considering residential care or other aged care services.</td>
<td>• Client requires a discipline specific assessment only eg Medical opinion, OT assessment for aids and equipment etc.</td>
</tr>
<tr>
<td></td>
<td>• Client requires Day Hospital.</td>
</tr>
<tr>
<td></td>
<td>• Client is currently under the Mental Health Act as an involuntary patient</td>
</tr>
<tr>
<td></td>
<td>• There is another type of service/system that is more appropriate to meet their needs (eg younger people with disabilities).</td>
</tr>
</tbody>
</table>

Note: Your software program should enable you to select clients for ‘inclusion’ in the MDS record.

ABOUT REASSESSMENTS

Reassessments that generate a new MDS record.

Many ACAT clients (about 53% nationally) are ‘reassessments’ i.e. they are assessed more than once by an ACAT. Reassessments usually occur when there has been substantial change to the client or carer circumstances, such that another comprehensive assessment is required. 2624 renewals will usually trigger another assessment because of the 12 month period, which in most cases would be long enough for client or carer needs to have changed significantly.

If the reassessment generates a new MDS record, the date of referral would be the date the ACAT contacted the client to alert them to the fact that their 2624 was about to expire. Following this contact the ACAT would complete the priority category with priority rating appropriate to the client’s circumstances.

Activities that are not reassessments i.e., they do not generate a new MDS record include:

Reviewing or monitoring of a care plan. This activity should not be reported as another comprehensive assessment, but should be considered as part of the initial overall comprehensive assessment process. NB: The core activities of comprehensive assessment include reviewing and monitoring a care plan. However, an ACAT review of a client’s care plan that found that their circumstances and needs had changed, would result in another MDS record.

Internal ACAT referrals i.e., referral from one ACAT member to another of a different discipline.
WILL EVERY CLIENT IN THE MDS HAVE DATA RECORDED AGAINST ALL ITEMS?

No. Clients assessed in residential care do not require certain MDS items recorded. There will also be instances where assessments will be ‘incomplete’ because a client was referred and accepted for assessment, but was not assessed due to death or cancellation. These are called ‘incomplete assessments’ and their code regime is described for the following cases:

Case 1: A client withdraws before the assessment is completed

Some clients will withdraw/cancel after a referral is made but before the assessment is completed. In this instance the fact that the client was referred and accepted as an ACAT client plus an intervention of clinical nature was initiated, will mean that some data in Part 1 will have already been provided. The MDS record is completed by coding: First Intervention date (eg date of a clinical nature phone call to GP) Reason for ending assessment (Code 2: client withdrew) Assessment end date (date of withdrawal)

In this scenario, it is unlikely that many of the items in Parts 2 and 3 will be able to be completed. The recommendation items in Part 4 will definitely not be completed.

Case 2: No further contact following first intervention due to death

In this situation, a family member in a rural area rings the ACAT with an urgent need for assessment. An older person is at risk because her husband, who is her carer, has just been taken to hospital. The duty worker arranges emergency respite over the phone because the client is ‘at risk’ and an assessor cannot visit on that day. Arrangements for an assessment are put in place. The client takes up the emergency respite but dies before an assessment occurs. In this case:

Part 1 data is provided on referral
Some, but not all of Parts 2 and 3 can be completed
Some of Part 4 could also be completed, Recommended use of respite, Reason for ending assessment (code 3: client died), and Assessment end date.

Case 3: A client is referred to rehabilitation or the ACAT refuses to assess a referred client because the client is medically unstable.

In this case:
All Part 1 will be completed following referral
Items in Parts 2 and 3 will be completed, as the client would have been seen face-to-face before being referred to a rehabilitation unit, or being referred back to the acute sector for further nursing/medical attention
Some of Part 4 will be completed—Reason for ending assessment (code 5 or 6 depending on the circumstances), and Assessment end date (the date the client was transferred to rehab, or referred for further medical/nursing treatment), but none of the recommendation items in Part 4 will be recorded.

CODING ITEMS WHEN THE ASSESSMENT WAS ‘INCOMPLETE’

How are items in an MDS record coded where the assessment is ‘incomplete’?
Items which could not be coded due to an incomplete assessment should be left blank, including ‘First intervention date’ and ‘First face-to-face contact date’. (However as noted there are some items which must be recorded for every MDS record.

CODING MISSING DATA

If you are unable to find out the required information for a particular data element you have two coding options:
1. Code ‘Unable to determine’ if this code is provided for in the data element (not all data elements have this option).
2. If there is no ‘Unable to determine’ code provided, leave the item blank.
MINIMUM DATA REQUIREMENTS IN THE MDS EXTRACT

These scenarios serve to remind us that clients included in the MDS extract include all clients who are referred and accepted for a comprehensive assessment. This means that some clients who drop out of the process early, even before first face-to-face contact or first intervention, will still be included in the data extract as an ACAT client.

When assessments are incomplete, you should still try to code as many items as you can. For example, clients in your MDS database should have correct information for most of the data items in Part 1.

However, ALL clients in your MDS extract MUST have the following items recorded:
- Client ID
- Referral Date
- Family Name and Given Name
- Address, Suburb, Postcode
- Date of Birth
- Sex
- First Intervention Date
- Reason for Ending Assessment
- Assessment End Date.
Structure of the Condensed Data Dictionary

The CDD contains a brief summary of each MDS V2.0 data element, comprising:
• definition of the MDS V2.0 data item
• a brief note on the item’s rationale for inclusion; and
• notes for correct and consistent coding.

This information is drawn directly from the Aged Care Assessment Program Data Dictionary: Version 1.0 (AIHW, 2002). However references are also made to the MDS Definitions and Coding Guidelines Booklet WA EU, 2002) which will be your everyday reference guide to the MDS.

The MDS items in this training session (and in the MDS Definitions and Coding Guidelines Booklet) have been grouped into parts according to the sequence of the ACCR.

Part 1: Client registration

Part 2: Intervention/contact dates

Part 3: Carers

Part 4: Activity Limitations and Assistance

Part 5: Assessment Summary and Information for Service Providers

Part 6: Statement of application

Part 7: Approval
Part 1 - Client registration

Client ID
ACAT Co-ordinator

1. Referral date
2. First given name and family name/surname
3. Address, Suburb/ town/ locality name, Postcode, Telephone No.
4. Contact Telephone Number
5. Date Of Birth
6. Sex
7. Marital Status
8. Country Of Birth
9. Main Language Other than English
10. Indigenous status
11. DVA entitlement

Nb. Some of the items listed above will be collected at assessment and may not be available at referral or registration.
Client ID

Is this item applicable to all clients?
Yes

Definition:
This is the number assigned by the Aged Care Assessment Team (or the institution of which it is part) to uniquely identify each client registered for comprehensive assessment. Client ID is more commonly known as the URN or UMRN.

Why this is important:
In conjunction with ACAT ID and Referral Date, the Client ID uniquely identifies a record submitted to the ACAP MDS V2.0.

Getting it right:
The number is not standardised across ACATs.

ACAT Case Co-ordinator

Is this item applicable to all clients?
Yes

Definition:
This is the team member (or representative) responsible for ensuring all aspects of the assessment are co-ordinated and followed up.

Why this is important:
There may be times when service providers, Commonwealth/State officers or family members need to talk to the case coordinator for further information regarding the client.

Getting it right:
The case co-ordinators full name should be recorded.
1 Referral date

Is this item applicable to all clients?

Yes

Definition:

The date on which the referral of a person for a comprehensive assessment was received by the Aged Care Assessment Team.

Why this is important:

This data element marks the beginning of an assessment episode. The data elements First Intervention Date, Referral Date and Priority Category indicate whether clients are receiving timely responses from ACATs.

Getting it right:

- This is the date the referral was actually received by the ACAT (e.g. by phone, fax or letter), not the date the referral was registered or entered into the ACATs system, unless they happen to be the same date.
- Record the referral date as an eight-digit date with day, month and year, i.e. DD/MM/YYYY.
- Use zeros to ensure that days and months less than 10 have the required two digits.
- Record the year in four-digit format.
2 & 3 Family name/surname & first given name

Is this item applicable to all clients?
Yes

Definition:
The name a client has in common with other members of her/his family, as distinguished from her/his first name (given name). The client’s given name is that which identifies the client within the family group, or the name by which the client is uniquely socially identified.

Why this is important:
The client’s First Given Name and Family Name/Surname are not reported in the MDS but selected letters—in combination with the client’s date of birth and sex—are used to generate a linking key unique to each client. The software used to collect the MDS will generate the Statistic linkage key.

For this reason it is important that client names are recorded as accurately and consistently as possible.

Getting it right:
• As a matter of routine, use the name on the Centrelink Card, Pension Card or Medicare Card to ensure consistency. Also check referrals from another agency.
• Record the client’s full (formal) First Given Name and Family Name/Surname. These may be different to the name they prefer in everyday use.
• First Given Name and Family Name/Surname should be recorded in that order, regardless of the order they may be traditionally given.
• A client’s second name can also be recorded and will be useful in the case where two clients have the same name e.g. John Smith.
• Take care with Aboriginal client names, which may change during periods of mourning. Respect the culture of the individual concerned and use professional judgement on how best to record their name in such circumstances.
4 & 5 Address, Suburb, Postcode and Telephone Number

Is this item applicable to all clients?
Yes

Definition:
These items represent the geographic area in which the client usually lives.

Why this is important:
Suburb and Postcode are used to derive the Statistical Local Area in which the client lives. This provides information for planning, and reporting on the accessibility of ACATs at a regional level. Address and telephone number are not compulsory items but are necessary items for ACAT use, eg, contacting the client or posting correspondence.

Getting it right:
• For most clients this item will be the suburb, town or city and postcode, where the client usually lives. In regional areas it may be a commonly used location name, such as a large agricultural property or Aboriginal community.
• Other data elements—Living Arrangements and Usual Accommodation Setting—relate to the same location recorded for this item.
• If the client’s place of residence at the time of the assessment reflects their usual accommodation setting, the Address, Suburb/Town/Locality Name and Postcode of their current place of residence should be recorded.
• If the client’s place of residence at assessment is temporary, for example if the client is in hospital or other institutional or residential care, or staying with family or friends, the client should be asked to nominate their usual place of residence.

6 Contact Telephone Number

Is this item applicable to all clients?
No

Definition:
The contact number of the family member/friend who is considered the contact person if the client is not available.

Why this is important:
Although this is not a compulsory MDS item, it is another useful item for ACATs, especially in a situation where another person needs to be present at the comprehensive assessment of the client.
7 Date of birth

Is this item applicable to all clients?
Yes

Definition:
The date of birth of the client.

Why this is important:
- Date of birth is used for a number of purposes in the Aged Care Assessment Program, including:
  - Generating the Statistical Linkage Key used to uniquely identify ACAT clients;
  - Generating performance indicators; and
  - Planning processes.

Getting it right:
- Record as an eight-digit date—DD/MM/YYYY.
- If the client’s date of birth or age is not known, estimate the client’s year of birth and record the date as 1 July (Centrelink practice).
- If necessary, cross-check with any other documentation or with referral information. Be consistent with any information provided by other agencies.

8 Sex

Is this item applicable to all clients?
Yes

Definition:
The biological sex of the client.

Why this is important:
Sex is reported in the MDS V2.0 to identify the client through the Linkage Key, to generate a number of performance indicators and for planning processes.

Getting it right:
If there is uncertainty (e.g. for transvestites or transsexuals) record the sex nominated by the client, or base your coding decision on your own observation/judgement.
9 Marital Status

*Is this item applicable to all clients?*
Yes

*Definition:*
The current marital status of the client (applicant).

*Getting it right:*
If a client has been divorced but has since re-married, then they should be recorded as M. Married. The category Married (registered and de facto) should be generally accepted as applicable to all de facto couples, including those of the same sex.

10 Country of birth

*Is this item applicable to all clients?*
Yes

*Definition:*
The country in which the client was born.

*Why this is important:*
This item provides a measure of access of the ACAP to culturally and linguistically diverse people as well as providing data for planning services.

*Getting it right:*
- Code 0000 should be used when the country of birth has not been supplied by the client upon request or, where insufficient information has been supplied by the client to code the data element.
- Ask the question “were you born in Australia?” if the answer is “no”, then ask, “in what country were you born?” Asking a client whether they were born in an ‘English speaking’ or ‘non-English speaking’ country will not provide sufficient information.

11 Main Language other than English spoken at home

*Is this item applicable to all clients?*
Yes

*Definition:*
The language reported by the person as the main language other than English spoken by the client in her/his home.

*Getting it right:*
Record the language the client reports as being the language that is most often spoken in her/his home (or most recent private residential setting) on a regular basis, to communicate with other residents of her/his home and regular visitors. If more than one language is spoken, then record the language that is spoken most often.
12 Indigenous status

Is this item applicable to all clients?
Yes

Definition:
Whether or not the client identifies her/himself as being of Aboriginal and/or Torres Strait Islander descent.

Why this is important:
Given the gross inequalities in health status—and the likely impact on the need for and use of health and community services—it is important to collect information on the Indigenous Status of clients.

Getting it right:
• Clients can identify themselves as Aboriginal, Torres Strait Islander, or both.
• This question does not refer to people indigenous to other countries.
• There are three components to the definition of an ATSI client: descent, self-identification and community acceptance. In practice, ask clients if they are of Aboriginal or Torres Strait Islander origin.
• Record persons of both Aboriginal and Torres Strait Islander origin separately (code 3)
• Responses should only be based on the perceptions of the client or their advocate.

Codes:
1 Aboriginal but not Torres Strait Islander origin
0 Torres Strait Islander but not Aboriginal origin
1 Both Aboriginal and Torres Strait Islander origin
2 Neither Aboriginal nor Torres Strait Islander origin

13 DVA entitlement

Is this item applicable to all clients?
Yes

Definition:
Whether the client is receiving a Department of Veterans’ Affairs entitlement, and the level of the entitlement held by the client.

Getting it right:
• These are clients formally recognised by DVA as having any form of DVA entitlement.
• No DVA entitlement includes people receiving the Age Pension.

Codes:
1 DVA entitlement—gold card
2 DVA entitlement—white card
3 DVA entitlement—no card
4 No DVA entitlement
Page 2 Part 1 (Cont’d).

14 Accommodation setting – Usual
15 Living Arrangements

Page 2 Part 2

Intervention/contact Dates

16 Priority category
17 First intervention date
18 First face-to-face contact date
19 First face-to-face contact setting

Page 2 Part 3

Carers
20 Carer availability
21 Carer co-residency status
22 Relationship of carer to care recipient
14 Accommodation setting—usual

Is this item applicable to all clients?
Yes

Definition:
The setting in which the client usually lives.

Why this is important:
This data element combines the client’s type of accommodation and housing tenure and will be used to monitor the relationship between housing, care needs and long-term care setting recommendations. For example recent reviews have identified insecure housing as a risk factor in premature entry into residential care and the possibility that it may be associated with more limited access to community-based services.

Getting it right:
- Ask the client to nominate their ‘usual’ place of residence. Eg, ask: Do you consider this to be your usual place of residence? If no, ask Where is your usual place of residence?
- In most cases this will be the client’s current accommodation and be the setting related to the Suburb/Town/Location Name and Postcode previously recorded.
- If the client’s place of residence at the time of assessment is temporary, use the setting determined for Suburb/Town/Locality Name.
- The level of care received by the client reflects their accommodation setting, not the facility type where it is delivered. Eg. if a client is receiving high care in a low care facility their accommodation setting is high level care. This data item will not identify clients who are aging-in-place.

Codes
1 Private residence—owned/purchasing – includes private residences, which are owned, or being purchased either by the person or another member of their household or family (including a non-resident relative). Self-contained granny flats could also be included here if part of a private – owned/purchased property.
2 Private residence—private rental – includes private residences which are rented on the private rental market at competitive market rates. This includes dwellings rented through real estate agents and private landlords who are not part of the person’s family. Self-contained granny flats that are part of a privately rented property would be included here.
3 Private residence—public rental or community housing – includes private residences secured through State/Territory Housing Authorities or community or co-operative housing groups.
4 Independent living within a retirement village – includes self-care or independent living units within a retirement village irrespective of the type of tenure the person holds over the residence. If care services are provided code a Supported community accommodation.
5 Boarding house/rooming house/private hotel – the private rental of a room or suite of rooms, not the whole premises.
6 Short-term crisis, emergency or transitional accommodation – includes night shelters, refuges, hostels for the homeless, or to facilitate a transition between institutional-type settings and independent community living (e.g. half way houses).
Supported community accommodation – includes community living settings or accommodation facilities in which the clients are provided with support in some way by staff or volunteers e.g. group homes for people with disabilities, cluster apartments where a support worker lives on site, community residential apartments etc.

Residential aged care service—Low level care

Residential aged care service—High level care

Hospital – remote/regional hospitals with nursing home type beds.

Other institutional care – includes hospice and long-stay residential psychiatric institutions.

Public place/temporary shelter – includes bus shelters, parks, camps, streets or squats.

Other – includes prison, convent, and monastery.

15 Living arrangements

Is this item applicable to all clients?

No – code only for clients whose accommodation setting – usual is in the community.

Definition:

Whether the client lives with other related or unrelated persons.

Why this is important:

A client’s living arrangements contribute significantly to their ability to continue living in the community, and are an indicator of social support and social isolation.

Getting it right:

- Code in relation to their usual accommodation setting.
- If the household includes both family and non-family members, code as living with family, (which includes de facto and same sex relationships).
- Clients living in boarding houses, group homes, retirement villages, etc. are coded as ‘living alone’, except in those instances where they share their own private space/room within the premises with a significant other (e.g. partner, sibling, close friend, etc.).
- Clients living in a self-contained granny flat should be coded as to whom, if anyone, they share their own private space with. E.g. If they share the flat with a spouse (including same sex couples), sibling or other relative, they would be coded as “2” lives with family. Code 3 (others) depends on their relationship to the other person(s).

Codes:

0  Not applicable
1  Lives alone
2  Lives with family
3  Lives with others
16 Priority Category

Is this item applicable to all clients?
Yes

Definition:
The length of time within which the client needs contact of a clinical nature, (i.e. non-administrative), by an Aged Care Assessment Team (or their representative), based on the urgency of the person’s need as assessed by the Aged Care Assessment Team at referral.

Getting it right:
- Allocation of the priority category should be based on the information available to the ACAT at referral and should reflect client need. It should not reflect the priority with which the referrer would like the ACAT to respond.
- ‘Days’ refers to calendar days. Does it include holidays and weekends?

Codes:
1. Within 48 hours – Refers to a client who requires an immediate response as their safety is at risk (e.g. high risk of falls or abuse), or there is a likelihood that the person will be hospitalised or required to leave their current residence because they are unable to care for themselves or their carer is unavailable. This may be due to a crisis in the home involving either the client or the carer, or a sudden change in the clients or carers medical, physical, cognitive or psychological status.
2. Between 3 and 14 days – Should be used when information available at referral indicates that the client is not at immediate risk of harm. Referrals that indicate progressive deterioration in the clients physical, mental or functioning status or that he level of care currently available to the client does not meet their needs or is not sustainable in the long term should be allocated to this priority category.
3. More than 14 days – examples of when to use this code are: where the referral information indicates that the client has sufficient support available at present, but their carer is planning a holiday, which will result in the care recipient requiring the provision of substitute care or recognition that the person is having increased difficulty living independently and options for future care need to be discussed with the client and their carer or family.
17 First intervention date

Is this item applicable to all clients?
Yes

Definition:
The first date that contact of a clinical nature (i.e. non-administrative) is made between an Aged Care Assessment Team member (or their representative) and the client, their carer, a service provider or a clinician in response to the client’s referral for a comprehensive assessment.

Why this is important:
In conjunction with Referral Date and Priority Category, this data item provides a measure of the ACAT’s response time to a referral.

Getting it right:
- Records the first action that involves a clinical intervention. Eg, the date on which an interim care plan is developed such as emergency respite admission, or when a significant amount of telephone counselling is provided for the client or carer, or detailed discussions with a client’s GP regarding medical history, or when support services are put in place for a client before they can be seen by the ACAT.
- This date may be the same date as the First face-to-face contact date.
- The date of any administrative action, such as scheduling of appointments or requesting reports should not be reported as the First Intervention Date.
- Use the eight-digit date i.e. DD/MM/YYYY as noted previously.

18 First face-to-face contact date

Is this item applicable to all clients?
Yes

Definition:
The date on which one or more members of an Aged Care Assessment Team (or their representative) first has face-to-face contact with the client for the purpose of a comprehensive assessment, in response to a particular referral.

Why this is important:
Face-to-face contact is a core element of any ACAT comprehensive assessment. At times, another person may act as an ACAT representative if face-to-face contact with an ACAT member is not possible. This may be particularly relevant in remote areas.

Getting it right:
Record the Date as noted previously, i.e. DD/MM/YYYY.
19 First face-to-face contact setting

Is this item applicable to all clients?
Yes

Definition:
The setting of the first face-to-face contact between the client and an Aged Care Assessment Team member (or their representative) in response to a particular referral for a comprehensive assessment.

Why this is important:
Information about the face-to-face contact setting of an assessment has been identified as a factor influencing the recommended long-term care setting.

Getting it right:
- The code ‘residential aged care service’ includes all government-funded residential aged care services, multi-purpose services or multi-purpose centres and Indigenous flexible pilots, regardless of the level of care received by the client or whether the client is a permanent or respite resident at the first face-to-face contact.
- Code ‘other’ for settings, such as private homes, outpatient clinics, retirement villages, independent living units, Supported Residential Services/Facilities (Victoria and South Australian only) and supported accommodation settings in the community.

Codes
1. Hospital – acute care ward in a public or private hospital.
2. Other inpatient setting – any other hospital setting where the client is receiving overnight care e.g. admission to extended or rehabilitations facilities, or other non-acute wards/beds in a hospital.
3. Residential aged care service – High or low care facilities, Indigenous Flexible Pilots, regardless of the level of care received by the person or whether the person is a permanent or respite resident at time of first face-to-face contact.
4. Other – all other settings, such as, private homes, outpatient clinics, retirement villages, independent living units etc.
These data items recognise the importance of informal carers in maintaining frail older people (and younger people with disabilities) within the community. This data will provide information about the needs of carers and the relationship between informal care and the provision/need for formal services.

20 Carer availability

Is this item applicable to all clients?
No – code only for client who’s accommodate setting – usual is in the community. Code other clients “not applicable.”

Definition:
Whether someone, such as a family member, friend or neighbour, excluding paid or volunteer carers organised by formal services, has been identified as providing regular and sustained care and assistance to the client without payment other than a pension or benefit.

Why this is important:
This item provides information on the extent that carers assist clients to remain living in the community, and contributes to a number of national indicators on the effectiveness and quality of the ACAP.

Getting it right:
- A carer is someone who provides care and/or assistance to the client on a regular and sustained basis, excluding paid workers or volunteers organised by formal services. A carer does not have to live with the client.
- If in doubt, assess whether removal of the level and type of assistance provided by the person would significantly compromise the care available to the client to their detriment. If the client would be compromised, record them as having a carer.
- The code does not reflect the need for a carer, or whether an identified ‘carer’ is considered to be capable of undertaking the caring role.
- Code according to expressed views of the client and/or their carer or significant other.
- Living with someone else does not necessarily define a carer. The data element Living Arrangements records person(s) with whom the client lives.

Codes:
0  Not applicable
1  Has a carer
2  Has no carer
21 Carer co-residency status

Is this item applicable to all clients?
No – code only for client who’s accommodate setting – usual is in the community. Code other clients “not applicable.”

Definition:
Whether or not the carer lives with the person for whom they care.

Why this is important:
This item provides information on the characteristics of carers.

Getting it right:
- If more than one family member or friend are providing care and assistance, record the carer who is identified as providing the most care and assistance.
- A co-resident carer is a person who provides care and assistance on a regular and sustained basis to a person who lives in the same household. A non-resident or visiting carer lives in a different household.
- If a client has both a co-resident (e.g. a spouse) and a visiting carer (e.g. a daughter or son), coding should be related to the carer who provides the most care and assistance related to the client’s capacity to remain living at home. The expressed views of the client and/or their carer(s) or significant other should be used as the basis for determining which carer should be considered to be the primary or principal carer in this regard.

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<td>Non-resident carer</td>
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</table>
22 Relationship of carer to care recipient

Is this item applicable to all clients?

No – code only for client who’s accommodate setting – usual is in the community. Code other clients “not applicable.”

Definition:
The relationship of the carer to the person for whom they care.

Why this is important:
This item provides further information on the characteristics of carers and enables comparisons with national data such as the Survey of Disability, Aging and Carers.

Getting it right:
• This item describes the person coded in Carer availability. However the opportunity to code ‘Paid employee’ may mean that this data item identifies a person who is not coded as a carer in the carer availability item. This is an understood ‘anomaly’. The Private employee code is not a standard code but has been introduced to the ACAP MDS to ‘test’ the prevalence of this type of carer relationship.
• If the ‘private employee’ code is applicable to a client, do not go back and change your response to the Carer Availability item.
• Some people of Aboriginal or Torres Strait Islander origin attach a different cultural meaning to the terms brother, uncle, mother etc. than the purely biological/social meanings that non-Indigenous people use. In these cases the ACAT should record the relationship of the carer according to how the client or carer identifies that relationship.
• As in the previous item, if there is more than one carer, choose the carer who provides the most significant amount and type of care and assistance.

Codes:
0                          Not applicable
1                          Wife/female partner
2                          Husband/male partner
3                          Mother
4                          Father
5                          Daughter
6                          Son
7                          Daughter-in-law
8                          Son-in-law
9                          Other relative—female
10                         Other relative—male
11                         Friend/neighbour—female
12                         Friend/neighbour—male
13                         Private employee (not organised by formal services)
Part 4

Activity limitations and assistance

23 Activity limitations
24a Current assistance with activity
24b Source of current assistance
25 Recommended formal assistance with activities

Program support at assessment

26 Government program support at assessment
27 Respite care use at assessment
23 Activity limitations

Is this item applicable to all clients?
Yes

Definition:
The activities in which the help or supervision of another individual is needed by the client, as assessed by the Aged Care Assessment Team.

Why this is important:
This item gives some indication of the extent and complexity of the needs of ACAT clients and also identifies severe or profound core activity restriction (as defined by the ABS). This information allows comparisons with members of the general population as identified by the ABS Survey of Disability, Ageing and Carers.

A client with a severe or profound core activity restriction is defined as someone who sometimes, or always, needs assistance with one or more of the tasks of self-care, mobility, or communication. The information enables comparisons of assistance needed by ACAT clients with the types of assistance provided by other government funded community care services (e.g. HACC and CACPs).

Getting it right:
- More than one activity can be recorded.
- Code for ALL clients. However, for clients whose usual accommodation setting is in a residential aged care service, hospital or other institutional care setting, codes 8, 9 & 10 (domestic assistance, meals and home maintenance) do not apply. It is assumed that these activities are provided as part of their accommodation setting.
- Record areas of activity that, in your opinion, the client needs the assistance or supervision of another person, from either formal agencies or informal carers; regardless of whether the assistance is available or not; and regardless of whether the client agrees to a referral being made to a relevant agency.
- Take into account use of aids or equipment. That is, if a client independently uses an aid to help them with a particular activity—or could independently use such an aid—they should not be recorded as needing the help or supervision of another individual.
- Report in relation to the usual accommodation setting. For example, if the person is in hospital at assessment, the data should reflect their capabilities in their home environment.

Codes:
1 Self care - Refers to assistance with eating, showering/bathing, dressing, toileting and managing incontinence.
2 Movement activities – refers to activities such as maintaining or changing body position, carrying, moving and manipulating objects, getting in or out of bed or a chair.
3 Moving around places at or away from home – refers to walking and related activities, either around the home or away from home. (excludes needing assistance with transportation.
4 Communication – refers to understanding others, making oneself understood by others. The use of interpreters should not be recorded here.
Health care tasks – refers to taking medication or administering injections, dressing wounds, using medical machinery, manipulating muscles or limbs, taking care of feet (includes a need for home nursing and allied health care, such as physiotherapy and podiatry).

Transport – refers to assistance with using public transport, getting to and from places away from home and driving.

Activities involved in social and community participation – refers to assistance with shopping, banking, participating in recreational, cultural or religious activities, attending day centres, managing finances and writing letters.

Domestic assistance – refers to assistance with household chores such as washing, ironing, cleaning and formal linen services.

Meals – refers to assistance with meals, including delivery of prepared meals, help with meal preparation and managing basic nutrition.

Home maintenance – refers to assistance with repair of the home, garden or yard to keep the home in a safe and habitable condition, e.g. changing light bulbs and basic gardening.

Other – refers to assistance with any other tasks or activities of daily living.

None

Unable to determine.

24a Current assistance with activities

Is this item applicable to all clients?

No – Code only for clients whose accommodation setting – usual is in the community.

Definition:

The activities in which the help or supervision of another individual is used by the client at the time of their comprehensive assessment, in relation to their usual accommodation arrangements.

Why this is important:

Current Assistance with Activities helps to establish a profile of the support used by the client at the time of their comprehensive assessment, from either formal services or informal carers. When analysed in conjunction with Source of Current Assistance with Activities it also provides some indication of the extent of the contribution of informal carers to supporting frail older people living at home.

Getting it right.

- Code only for clients living in the community at assessment. Code ‘Not Applicable’ for clients who are permanent residents in residential care, multi purpose services, Indigenous flexible pilots, hospitals or other institutional settings at the time of assessment.
- Code for assistance given by both formal agencies and informal carers.
- More than one activity can be recorded.
- As with Activity Limitations, code according to usual accommodation setting.
- Health care tasks include home nursing, medication management, and all allied health care such as physiotherapy and podiatry and therapeutic services provided at Day Therapy Centres)

Codes: Same as for Activity Limitations, with additional code, Code 0: Not Applicable.
24b Source of current assistance with activities

*Is this item applicable to all clients?*
   No – Code only for clients whose *accommodation setting – usual* is in the community.

*Definition:*
Whether the help or supervision of another individual currently used by the client at the time of their comprehensive assessment is from formal agencies or family members, friends, or neighbours.

*Getting it right:*
- *Source of Current Assistance* should relate to each activity area identified in *Current Assistance with Activities*.
- More than one source of assistance can be reported.
- Formal agencies can be publicly funded (e.g. HACC, COPs) or private agencies. It is unimportant whether the person providing the assistance is a paid worker or a volunteer.
- Report in relation to the usual accommodation setting.
- Report only for clients who usually live in the community.
- Code ‘Not Applicable’ for clients who are permanent residents in residential care, multi purpose services, Indigenous flexible pilots, hospitals or other institutional settings at the time of assessment and for clients who do not receive assistance with an activity (as coded on the previous item).

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25 Recommended formal assistance with activities

**Is this item applicable to all clients?**
No – Code only for clients whose *recommended long-term accommodation setting* is in the community.

**Definition:**
The activities in which the assistance of formal services is recommended for the person by the Aged Care Assessment Team as part of their care plan.

**Why this is important:**
Comparison of assistance recommended by the ACAT after comprehensive assessment with assistance currently used by the client (as recorded under *Current assistance with activities*) provides some indication of the extent to which the ACAT has linked the client to available formal services.

**Getting it right:**
- Code for all clients whose *Recommended Long Term Care Setting* is ‘community’. This means that interim care plans for people recommended for residential care are not included.
- Code for those clients whose usual accommodation setting is a residential aged care service, etc, but have a *Recommended Long Term Care Setting* in the community.
- This data element relates only to recommended *formal assistance* with activities.
- Formal assistance can be recorded for all activity areas.
- Record those areas of activity where the assistance or supervision of another person are newly recommended by the ACAT or are recommended to be ongoing as part of the care plan.
- A recommended type of assistance takes account of both availability and client preference, and represents a consensus between the client and the ACAT. What the ACAT assesses as needed by the client may not be the same as the ACAT recommendation in all cases.
- Recommendations for the use of aids and equipment to assist with activities should not be recorded here.

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26 Government program support at assessment

Is this item applicable to all clients?
No – Code only for clients whose accommodation setting – usual is in the community.

Definition:
The major national government funded community care program(s) from which the client is receiving support or assistance at the time of their comprehensive assessment.

Why this is important:
This information assists in establishing a profile of the support used by the client at the time of their comprehensive assessment from selected major national government funded community care programs, and assists in tracking the use of identified major national government funded community care programs, particularly Community Aged Care Packages.

Getting it right:

- More than one program can be recorded.
- Code only for clients living in the community at assessment. Code 0: ‘Not Applicable’ for clients who are permanent residents in residential care, multi purpose services, Indigenous flexible pilots, hospitals or other institutional settings at the time of assessment.
- If the client pays the full cost of services it should not be coded. Assistance fully or partially funded by a program should be coded.

Codes:

0 Not applicable
1 Community Aged Care Package (CACP)
2 Extended Aged Care at Home (EACH)
3 Home and Community Care (HACC) (including Community Options/Linkages)
4 Veterans’ Home Care
5 Day Therapy Centre (Commonwealth funded)
6 National Respite for Carers Program (Carer Respite Centre/Resource Centre)
7 Other
8 None
98 Unable to determine
27 Respite care use

Is this item applicable to all clients?
No – Code only for clients whose accommodation setting – usual is in the community.

Definition:
Whether or not the client or their carer has received residential or community based respite care.

Why this is important:
This data element assists in establishing a profile of the assistance received prior to the clients’ comprehensive assessment and identifying the extent that carers have received assistance in their caring role.

Getting it right:
• Record respite care use for the twelve months period prior to the person’s comprehensive assessment.
• More than one code can be recorded, i.e. the client may have used both residential and community-based respite care.
• Code only for clients living in the community at assessment. Code ‘Not Applicable’ for clients who are permanent residents in residential care, multi purpose services, Indigenous flexible pilots, hospitals or other institutional settings at assessment.

Codes:

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Page 4 Part 4 (Cont’d)
28 Health condition
29 Government program support recommended
30 Respite care recommended
31 Recommended long term care setting
32 Reason for ending assessment
28 Health condition

Is this item applicable to all clients?
Yes

Definition:
The diagnosed diseases/disorders, signs or symptoms that have an impact on the client’s need for assistance with activities of daily living and social participation.

Why this is important:
Recording Health Condition provides a basic health profile of clients assessed by ACATs and contributes to an understanding of the complexity of a client’s needs and circumstances. The coding of this item also allows comparisons of ACAP clients with other data such as the ABS Survey of Disability, Ageing and Carers, and other health data sets. This item provides information on incontinence and disorientation.

Getting it right:
- Code for ALL clients
- Coding for this item is based on the ICD-10-AM classification for health conditions (modified for the ACAP) and comparable to the Australian Bureau of Statistics 4 digit code.
- State and territories can choose from a choice of code lists that best suit local needs.
- Up to 10 health conditions may be reported for the client.
- The disease or disorder listed first should be the health condition with the greatest impact on the client’s need for assistance with activities of daily living and social participation.
- Signs and symptoms codes should be used to record certain symptoms that represent important problems in their own right, regardless of whether a related diagnosed disease or disorder is also reported.
- Signs and symptoms allow you to code problems such as ‘incontinence’, or ‘disorientation’ where there is no specific diagnosis.
- Clarification: In the majority of cases this is a formal diagnosis by a medical professional: GP, geriatrician, hospital registrar, etc. If a medically confirmed diagnosis is not available, code ‘signs and symptoms’. In the absence of medical confirmation (eg. in remote areas) team members would need to code a diagnosis.

Codes:
0000 No health condition diagnosed (i.e. no diagnosed disease or signs or symptoms)
9998 No formal diagnosis available (i.e. insufficient information to code a diagnosis or sign or symptom)
29 Government program support recommended

Is this item applicable to all clients?
No – Code only for clients whose recommended long-term accommodation setting is in the community.

Definition:
The major national government funded community care program(s) recommended by the Aged Care Assessment Team as the source of assistance for the client, as identified in their care plan.

Why this is important:
This data element provides information about the referral patterns from ACATs to selected major national government funded community care programs identified by the ACAT as the recommended source of assistance to the client. It identifies the program source of assistance rather than the specific agency to which people may be referred or the specific type of assistance they require from that agency.

Getting it right:
- Record those programs that are newly recommended by the ACAT or are recommended to be ongoing. A recommendation takes account of the availability of the program and reflects a consensus between the person and the ACAT.
- More than one program can be recorded.
- Code for all clients whose Recommended Long Term Care Setting is ‘community’. This means that interim care plans for people recommended for residential care are not included.
- Code for those people whose usual accommodation setting is a residential aged care service, etc, but have a Recommended Long Term Care Setting in the community.
- If the client will be paying the full cost of services, it should not be coded. Assistance fully or partially funded by a program should be coded.

Codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>1</td>
<td>Community Aged Care Package (CACP)</td>
</tr>
<tr>
<td>2</td>
<td>Extended Aged Care at Home (EACH)</td>
</tr>
<tr>
<td>3</td>
<td>Home and Community Care (HACC) (including Community Options/Linkages)</td>
</tr>
<tr>
<td>4</td>
<td>Veterans’ Home Care</td>
</tr>
<tr>
<td>5</td>
<td>Day Therapy Centre (Commonwealth funded)</td>
</tr>
<tr>
<td>6</td>
<td>National Respite for Carers Program (Carer Respite Centre/Resource Centre)</td>
</tr>
<tr>
<td>7</td>
<td>Other</td>
</tr>
<tr>
<td>8</td>
<td>None</td>
</tr>
<tr>
<td>98</td>
<td>Unable to determine</td>
</tr>
</tbody>
</table>
30 Respite care recommended

Is this item applicable to all clients?
No – Code only for clients whose **recommended long-term accommodation setting** is in the community.

Definition:
Whether or not the provision of residential or community-based respite care for the client or their carer has been included in the clients care plan.

Why this is important:
*Respite Care Recommended* after assessment can be compared to what has been received in the previous twelve months (as recorded under *Respite Care Use*) to provide some indication of the extent to which the ACAT has linked the client or their carer to available assistance.

Getting it right:
- Day centre respite is only included if the primary purpose is respite for the carer.
- More than one code can be recorded, i.e. the client may have used both residential and community-based respite care.
- Code for all clients whose **Recommended Long Term Care Setting** is ‘community’. This means that interim care plans for people recommended for residential care are not included.
- Code also for those people whose usual accommodation setting is a residential aged care service, etc, but have a **Recommended Long Term Care Setting** in the community.

Codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>1</td>
<td>Residential respite care</td>
</tr>
<tr>
<td>2</td>
<td>Non-residential respite care</td>
</tr>
<tr>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>98</td>
<td>Unable to determine</td>
</tr>
</tbody>
</table>
31 Recommended long term care setting

Is this item applicable to all clients?

No

Definition:
The living environment considered most appropriate to the long term care needs of the client.

Why this is important:
Together with the other data elements recording the assistance needed by the client, this data element characterises the outcomes of the comprehensive assessment process, and contributes to measuring the effectiveness of the Aged Care Assessment Program.

Getting it right:
- Record at the end of the assessment for all assessments that have ended with the development of a care plan for the client (i.e. Code 1 in the data element Reason for Ending Assessment).
- Coding should reflect the setting that is agreed between the assessor(s) and the client as the most appropriate for their long-term care.
- Leave blank for incomplete assessments because there is no ‘not applicable’ code.
- Only one code should be selected, even if the client is approved for more than one type of care on an Aged Care Application and Approval (‘2624’) form. If more than one type of care is approved on the 2624, code the long-term care setting agreed between the assessor(s) and the client to be the most appropriate for their long-term care.
- This data item is not intended to report on aging-in-place. Code the level of care you are recommending, not the facility type where it is to be delivered.

Codes:

1  Private residence
2  Independent living within a retirement village
3  Supported community accommodation
4  Residential aged care service—low level care
5  Residential aged care service—high level care
6  Hospital
7  Other institutional care
8  Other
32 Reason for ending assessment

*Is this item applicable to all clients?*

Yes

**Definition:**

The situation that signalled the end of the client’s comprehensive assessment.

**Why this is important:**

This data element identifies whether the assessment was complete or incomplete at its conclusion, and the circumstances that led to ending the assessment.

**Getting it right:**

- Code for ALL clients
- All assessments recorded as ending with a care plan (code 1), should also have a record of the *Recommended Long Term Care Setting*.
- Assessment may end because the client died, or moved away, or because the client’s medical condition or functional status is unstable indicating a need for acute care or a period of rehabilitation care before their long term care needs can be comprehensively assessed by the ACAT (Codes 2-6).
- Some assessments, previously ‘held open’ or ‘interrupted’ or ‘suspended’ will now be recorded as ended. A new assessment will be reported when the client is eventually assessed by the ACAT.

**Codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assessment complete - care plan developed to the point of effective referral</td>
</tr>
<tr>
<td>2</td>
<td>Assessment incomplete—client withdrew</td>
</tr>
<tr>
<td>3</td>
<td>Assessment incomplete—client died</td>
</tr>
<tr>
<td>4</td>
<td>Assessment incomplete—client transferred to another ACAT</td>
</tr>
<tr>
<td>5</td>
<td>Assessment incomplete—client’s medical condition unstable</td>
</tr>
<tr>
<td>6</td>
<td>Assessment incomplete—client’s functional status unstable</td>
</tr>
<tr>
<td>7</td>
<td>Other reason</td>
</tr>
</tbody>
</table>
Page 5 Part 4 (Cont’d)

33   Assessment end date

34   Assessor profession

Part 5 – Assessment summary and information for service providers
33 Assessment end date

Is this item applicable to all clients?
Yes

Definition:
The date on which the comprehensive assessment of the client ends.

Why this is important:
This data element records the end of the comprehensive assessment phase of an ACATs work with a client and is the trigger for inclusion of the record of a client’s comprehensive assessment in the ACAP MDS.

Assessment End Date and Referral Date provide a measure of the time taken for the assessment process. This item—with Reason for Ending Assessment—identifies complete and incomplete assessments for analysis.

Getting it right:
- Code for ALL clients
- Record the Assessment End Date as an eight-digit date with day, month and year, i.e. DD/MM/YYYY.
- Use zeros to ensure that days and months less than 10 have the required two digits.
- Record the year in four-digit format.
- Assessment End Date is the date that the ACAT completes the care plan (i.e. makes a recommendation for the client’s long term care setting) or ends the assessment process because of other factors or events.
- Recording and reporting of Assessment End Date does not imply that ACATs will have no further contact with the client.
34 Assessor profession

Is this item applicable to all clients?

Yes

Definition:
The profession of all Aged Care Assessment Team members and non-team members participating in the client’s comprehensive assessment via extensive consultation or discussion of the client’s situation, condition or care needs that contributes to their care plan.

Why this is important:
Recording the range of disciplines contributing to a client’s assessment gives some indication of the extent that the ACAP is providing comprehensive, multidisciplinary assessments of the care needs of frail older people.

Getting it right:
- More than one discipline or area of expertise contributing to the assessment can be recorded.
- This data element is not limited to ACAT members.
- If more than one assessor belongs to the same professional category, record the category only once.

Codes:

5 Other medical practitioners: Includes specialist physicians e.g. neurologists, rehabilitation specialists.

13 Physiotherapist: Includes physical therapists.

18 Other health professional: Includes audiologists, orthoptist, orthotist and health professionals not elsewhere classified.

21 Counsellor: Includes rehabilitation counsellor, drug and alcohol counsellor, family counsellor etc.

23 Other social professional: Includes interpreters and social professionals not elsewhere classified.
Summing up

Where to go next

The following is a flow chart of what action is to be taken once the MDS has been collected and the ACCR form is completed.

Please note that the ACAT must retain a copy of all Parts of the Aged Care Client Record.

WHEN TO USE THE NEW FORMS

ACATS need to commence using the ACCR for ALL clients referred from and including the 1st April 2003.

ACATs will need to use existing Form 2624 and MDS V1.0 recording until this date, and usual reporting instructions are to continue until the April 1st changeover. MDS V1.0 data needs to be forwarded to the EU as soon as possible after the 31st March 2003 to complete the Version 1.0 reports.

From the 1st April 2003 the MDS data is to be sent to the Evaluation on a quarterly basis.

Prepare for Implementation:
- Make sure that you have your own copy of the Condensed data dictionary WA EU 2003.
- Make sure your team has a copy of the MDS Data Dictionary Version 1, AIHW 2002.
- Know your software and how it supports MDS coding.
Where to go for help

When coding if you are not sure how to record an item, check the Data Dictionary. Remember the Data Dictionary contains all the definitions and coding instructions. If you are still not sure, check with your team/clerk. If the situation you need to code appears to be an exception, contact the Evaluation Unit Helpdesk. Any exceptions or other coding instructions will be circulated to all teams as they arise so all teams can code the situations consistently.

Evaluation Unit help desk – 08 6488 1790

Contact:

Dimitris Matsakidis – dimitris@dph.uwa.edu.au
Peter Black – peterb@dph.uwa.edu.au
Georgie Dolphin – georgie@dph.uwa.edu.au

TRAINING REFRESHERS/SITE BASED TRAINING

The EU can be contacted to arrange site-based training or refresher training sessions.

Feedback on training sessions and materials

Please fill out the evaluation sheets provided