PACOP
palliative aged care
outcomes program

PACOP data dictionary

Outcomes and Profile Collections

With data items & guide for use

Version 1.0

PACOP is funded by the Australian Government Department of Health & Aged Care

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PACOP wishes to acknowledge Aboriginal & Torres Strait Islander people as the traditional custodians of the lands we are working on. We wish to pay our respects to the Elders, past, present, emerging & future.

PACOP is built upon the concepts and resources initially created by the Palliative Care Outcomes Collaboration (PCOC) and wishes to acknowledge their foundational contribution. PACOP is an outcome and benchmarking program which creates a clinical language by embedding validated clinical assessments to systematically measure and improve resident and family/carer outcomes.

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Further information and resources are available at: www.uow.edu.au/ahsri/pacop

PACOP palliative aged care outcomes program

Contents

What is PACOP?

The Palliative Aged Care Outcomes Program (PACOP) is a national palliative aged care program funded by the Australian Government Department of Health that is dedicated to improving the outcomes of all Australians in aged care homes (ACHs) with a particular focus on those who are approaching the end of their life.

PACOP is comprised of two routine collections:

1. **The Profile collection**

The Profile Collection is PACOP's core activity and is focussed on assessing and understanding the palliative care needs of each resident in ACHs. This collection ensures a standardised approach to assessment by all participating ACHs and allows these homes to understand the palliative care needs of their residents and observe the changes in their condition and symptoms.

The Profile Collection assessments are conducted by a health professional or clinical leader when a resident enters an aged care home and from that point onwards, they are conducted routinely, every three months. Additional assessments may be triggered by an observed increase in a resident's needs and/or deterioration in their condition.

All ACHs participating in PACOP will use the Profile Collection.

2. **The Outcomes collection**

The Outcomes Collection is underpinned by point of care assessment of residents' palliative care needs, symptoms and distress, and the use of an evidence-based protocol to support clinicians to respond appropriately. It introduces routine palliative care assessments and a response protocol to guide the care delivered to each resident (and their family/carer) who are approaching the end of their life. Reporting of residents' outcomes in this collection will support benchmarking and a systematic methodology for quality improvement.

The Outcomes Collection involves the daily monitoring of residents' symptom distress by care staff and a framework for escalating elevated levels of symptom distress to clinical staff. At a minimum, residents who are stable will be systematically monitored daily by care staff and weekly by a health professional. Residents demonstrating acute needs, increased symptom distress or who are in a terminal phase will be assessed at least daily by a health professional.

Commencing with the Outcomes Collection

The full benefits of PACOP for residents and ACHs are seen when ACHs participate in both the Profile and Outcomes collections. Therefore, many ACHs participating in PACOP will use the Profile Collection in conjunction the Outcomes Collection. However, some ACHs may choose to first embed the Profile Collection and once they have gained confidence, then commence the Outcomes Collection.

Introduction to the PACOP Data dictionary

The PACOP Data Dictionary Version 1.0 provides a reference for anyone who wishes to use the PACOP dataset for analysis purposes.

This document provides an understanding of the PACOP data items available for analysis, including the clinical application of the data items and how the data items are stored in the database.

If PACOP data is to be used for analysis by ACHs or researchers, they must also comply with the PACOP data policy and have relevant ethics approval required to use the data.

This data dictionary is divided into four (4) sections:

- **Section 1:** An overview of the PACOP data items (tabular format)
- **Section 2:** The PACOP data items and a **Guide for use** of relevant data items
    - This **Guide for use** provides specific instructions (clinical guide or business rule) for each data item to increase the reliability and accuracy of data items captured and ensures there is limited variability in interpretation.
    - If you have any questions or need clarification about the **Guide for use** for any data item, please contact the team at PACOP – pacop@uow.edu.au
- **Section 3:** The PACOP data scoping method
- **Section 4:** Example resident journeys

Note: The data dictionary is not meant to replace the clinical guides for the PACOP Profile and Outcomes collections where detailed descriptions of the tools and their clinical use are provided. For access to the PACOP Profile & Outcomes Collections Clinical Guides please contact PACOP via email pacop@uow.edu.au or contact the PACOP Lead at your aged care home.

Data Transformations information

The code sets presented in the PACOP Data Dictionary Version 1.0 may be different from the code sets presented in the PACOP IT Specifications Version 1.0. This is purposeful as the focus of the data dictionary is using the PACOP data items for analysis. Some code sets have been transformed to aid analysis and consistency across the Australian Health Services Research Institute (AHSRI). For more information on data transformations, please see PACOP Dataset Architecture Version 1.0.

Version 1.0 PACOP dataset

There are two distinct collections that make up the PACOP data set. These are 1. The Profile Collection and 2. The Outcomes Collection.

The Profile collection will have three levels of data – that is 1. Resident, 2. Admission, 3. Profile Assessment

The Outcomes collection will also have three levels of data – that is 1. Resident, 2. Outcomes Episode, 3. Outcomes Assessment.

Level 1: Resident (Both Outcomes and Profile Collections)

The information reported at the resident level relates to the resident demographic characteristics. Resident records act as the reference point for lower levels. There will only be one record for each resident for each ACH. The items collected at the resident level should not change e.g., Date of Birth and Country of Birth.

The Resident level is common across both the Profile and Outcomes Collections as this level relates to resident level items that will not change.

Level 2: Admission (Profile Collection)

The information reported at the Admission level relates to how the resident enters and departs the ACH. A resident can have more than one admission to ACHs (e.g. respite care) and therefore can have one or more Admission records.

Level 3: Profile Assessment (Profile Collection)

The information reported at the Profile Assessment level relates to the assessments that have been documented for the resident while in the Profile Collection. It is expected that a resident will be assessed many times within their admission and there will be many Profile Assessments records for each Admission.

Level 2: Outcomes Episode (Outcomes Collection)

The information reported at the Outcomes Episode level relates to how the resident enters and leaves the Outcomes Collection. A resident can start and end the Outcomes Collection multiple times within the same admission to the ACH and therefore can have one or more Outcomes Episode records within a single Admission.

Level 3: Outcomes Assessment (Outcomes Collection)

The information reported at the Outcomes Assessment level relates to the assessments that have been documented for the resident while in the Outcomes Collection. It is expected that a resident will be assessed many times within their Outcomes Episode and there will be many Outcomes Assessment records for each Outcomes Episode.

Interaction between the profile and outcomes collection

All ACHs registered with PACOP will participate in the Profile Collection. Some registered ACHs will participate in both the Profile Collection and Outcomes Collection.

For ACHs using the Profile Collection only

Upon admission to the ACH, a resident is automatically enrolled in the Profile Collection. The resident will stay enrolled in the Profile Collection until they are discharged from the ACH or die.

These ACHs will not have any data in the Outcomes Collection datasets.

For ACHs using both the Profile Collection and Outcomes Collection

If the ACH is using both the Profile Collection and Outcomes Collection, a resident will automatically be enrolled in the Profile Collection. The resident will have an Admission open for the duration of their stay at the ACH regardless of whether they transition into the Outcome Collection or not.

Any resident that enters the Outcomes Collection will also have an Outcomes Episode created for each episode of care in the Outcomes Collection. Any assessments of the resident while in the outcomes collection will be stored in the Outcomes Assessment dataset.

Any time a resident is admitted to the Outcomes Collection, the Resident Snapshot will be combined with the closest full clinical assessment (within 7 days of assessment) to create a three part clinical profile assessment that will be included within the Profile Collection. The purpose of this transformation is to create a continuation of resident profiles across the Admission which allow for comparisons between ACHs using both the Profile and Outcome Collections when compared with ACHs using the Profile Collection only.

As an artefact of this, some residents will have both an Admission and an Outcomes Episode open at the same time.

Section 1 – Overview of the PACOP data items

This section provides a broad overview of the data items collected at each level of the PACOP Outcome Version 1.0 dataset.

Level 1: Resident (Both Profile Collection and Outcomes Collection)

Item No.	Data item	Code set	Code set description	Definition	Location in database
1.01	**Home identifier**	Not applicable (N/A)	N/A	A four-character alphanumeric code assigned by PACOP that uniquely identifies the ACH providing care.	☒ Resident *Profile:* ☒ Admission ☒ Profile Assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
1.02	**Resident identifier**	N/A	N/A	An identifier assigned by the ACH to a resident that is unique within the ACH providing care.	☒ Resident *Profile:* ☒ Admission ☒ Profile Assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
1.03	**Date of birth**	N/A	N/A	The date on which the resident was born.	☒ Resident *Profile:* ☐ Admission ☐ Profile Assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
1.04	**Statistical linkage key (SLK)**	N/A	N/A	The SLK is used for deterministic linkage of data and enables two or more records belonging to the same individual to be brought together.	☒ Resident *Profile:* ☐ Admission ☐ Profile Assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
1.05	**Sex**	1 2 3 9	Male Female Intersex/indeterminate Not stated/inadequately described	The biological distinction between male, female and intersex for the resident. This item is related to biological sex assigned at birth rather than gender which is a social construct. Source AIHW (Meteor Identifier: 287316)	☒ Resident *Profile:* ☐ Admission ☐ Profile Assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
1.06	**Indigenous status**	1 2 3 4 9	Aboriginal but not Torres Strait Islander Torres Strait Islander but not Aboriginal origin Both Aboriginal and Torres Strait Islander origin Neither Aboriginal nor Torres Strait Islander origin Not stated/inadequately defined	Identifies the resident as being of Aboriginal and/or Torres Strait Islander origin. This item is important for cultural considerations in care. Source AIHW (Meteor Identifier: 602543)	☒ Resident *Profile:* ☐ Admission ☐ Profile Assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
1.07	**Preferred language**	ASCL	4 digit language code as per the Australian Standard Classification of Languages (ASCL), ABS 2016	The language (including sign language) most preferred by the resident for communication. Source AIHW (Meteor Identifier: 659407)	☒ Resident *Profile:* ☐ Admission ☐ Profile Assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment

1.08	**Country of Birth**	SACC	4 digit country code as per the Standard Australian Classification of Countries (SACC), ABS 2016	The country in which the resident was born. Source AIHW (Meteor Identifier: 659454)	☒ Resident *Profile:* ☐ Admission ☐ Profile Assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
1.09	**Date of Death**	N/A	N/A	The date on which the resident died.	☒ Resident *Profile:* ☒ Admission ☐ Profile Assessment *Outcomes:* ☒ Outcomes Episode ☐ Outcomes Assessment
1.10	**Place of Death**	1 2 3 4 9	This aged care home Hospital (including palliative care unit or hospice) Private Residence Other Not stated/Inadequately described	The place in which the resident died.	☒ Resident *Profile:* ☐ Admission ☐ Profile Assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment

Level 2: Admission (Profile Collection only)

Item No.	Data item	Code set	Code set description	Definition	Location in database
P.2.01	**Home identifier**	N/A	N/A	A four-character alphanumeric code assigned by PACOP that uniquely identifies the ACH providing care.	☒ Resident *Profile:* ☒ Admission ☒ Profile assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
P.2.02	**Resident identifier**	N/A	N/A	An identifier assigned by the ACH to a resident that is unique within the ACH providing care.	☒ Resident *Profile:* ☒ Admission ☒ Profile assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
P.2.03	**Admission identifier**	Not applicable (N/A)	N/A	A unique identifier for each Admission to link records to the resident.	☐ Resident *Profile:* ☒ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.2.04	**Profile Start Date**	N/A	N/A	The date for which the resident has commenced the Profile collection.	☐ Resident *Profile:* ☒ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.2.05	**Preadmission details**	1 0	Yes No	Describes if the resident was admitted to the ACH on or after 1 January 2020 for this admission.	☐ Resident *Profile:* ☒ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.2.06	**Admission date**	N/A	N/A	The date the resident was admitted to the ACH for this admission.	☐ Resident *Profile:* ☒ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.2.07	**Admission reason**	1 2 3 4 9	Respite Permanent care Transitional Care Program Other admission reason not described above Not stated/inadequately described	The reason the resident was admitted to the ACH for this admission.	☐ Resident *Profile:* ☒ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.2.08	**Australian Postcode**	N/A	N/A	The postcode of the home address for the resident before this admission to this ACH. Source AIHW (Meteor Identifier: 302040)	☐ Resident *Profile:* ☒ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.2.09	**Admission End Date**	N/A	N/A	The date that the resident is no longer at the ACH.	☐ Resident *Profile:* ☒ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment

P.2.10	**Admission End Reason**	10 20 30 40 90	Death End of residential aged care admission (i.e. end of respite, leaving residential aged care) Transferred to another aged care home Other discharge type not described above Not stated/inadequately described	The reason the resident is no longer at the ACH.	☐ Resident *Profile:* ☒ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment

Level 3: Profile Assessment (Profile Collection only)

Item No.	Data item	Code set	Code set description	Definition	Location in database
P.3.01	**Home identifier**	Not applicable (N/A)	N/A	A four-character alphanumeric code assigned by PACOP that uniquely identifies the ACH providing care.	☒ Resident *Profile:* ☒ Admission ☒ Profile assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
P.3.02	**Resident identifier**	N/A	N/A	An identifier assigned by the ACH to a resident that is unique within the ACH providing care.	☒ Resident *Profile:* ☒ Admission ☒ Profile assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
P.3.03	**Admission identifier**	N/A	N/A	A unique identifier for each Admission to link records to the resident.	☐ Resident *Profile:* ☒ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.04	**Team identifier**	N/A	N/A	A four-character alphanumeric code for each team to link the resident to the team providing care.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.05	**Profile Assessment identifier**	N/A	N/A	A unique identifier for each profile assessment to link records to the resident and the Admission	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.06	**Assessment date and time**	N/A	N/A	The date and time on which the assessment was completed.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.07	**Assessment Type**	1 2	Profile clinical assessment Deteriorating resident assessment	Describes the assessment that has been completed for this date and time.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.08	**SAS: Pain**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to pain over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.09	**SAS: Fatigue**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to fatigue over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

P.3.10	**SAS: Breathing problems**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to breathing problems over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.11	**SAS: Bowel problems**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item relates to distress due to bowel problems over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.12	**SAS: Nausea**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to nausea over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.13	**SAS: Appetite problems**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to appetite problems over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.14	**SAS: Difficulty sleeping**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to difficulty sleeping over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.15	**SAS: Other symptom description**	N/A	25-character text field	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item describes the 'other' symptom item.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.16	**SAS: Other symptom score**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to 'other' symptom over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.17	**Who rated the SAS?**	10 20 30 40 90	Resident Family/unpaid carer Care Worker Healthcare professional Not recorded	The SAS is, wherever possible, a **resident-reported** assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item captures who rated the resident's level of distress for the SAS.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

P.3.18	**PSS: Pain**	0 1 2 3 8 9	Absent Mild Moderate Severe Not recorded Not assessed	The PSS is a four-level clinician rated assessment tool for problem severity. The 'Pain' item reflects the severity of pain over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.19	**PSS: Other symptoms***	0 1 2 3 8 9	Absent Mild Moderate Severe Not recorded Not assessed	The PSS is a four-level clinician rated assessment tool for problem severity. The 'Other symptoms' item reflects the worst severity of all physical symptoms (other than pain) over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.20	**PSS: Psychological/ spiritual***	0 1 2 3 8 9	Absent Mild Moderate Severe Not recorded Not assessed	The PSS is a four-level clinician rated assessment tool for problem severity. The 'Psychological/spiritual problems' item reflects the severity of psychological/spiritual problems affecting the resident over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.21	**PSS: Family/carer^***	0 1 2 3 8 9	Absent Mild Moderate Severe Not recorded Not assessed	The PSS is a four-level clinician rated assessment tool for problem severity. The 'Family/carer problems' item reflects the severity of any problems experienced by the resident's family members or carers <u>in relation to the care the resident is receiving</u> (not including problems experienced by staff) over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.22	**PainChek score**	0…42 97 98 99	PainChek score as completed by the service PainChek not used at the ACH PainChek not used with this resident Not recorded	PainChek® is a clinically proven digital pain assessment tool. Using artificial intelligence, facial recognition and smartphone technology, PainChek® intelligently automates the pain assessment process at the point of care.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

P.3.23	**AKPS**	100 90 80 70 60 50 40 30 20 10 998 999	Normal; no complaints; no evidence of disease Able to carry on normal activity; minor signs or symptoms Normal activity with effort; some signs or symptoms of disease Cares for self; unable to carry on normal activity or to do active work Requires occasional assistance but is able to care for most of their needs Requires considerable assistance and frequent medical care In bed more *[chair]* than 50% of the time Almost completely bedfast *[chairfast]* Totally bedfast and requiring extensive nursing care by professionals and/or family Comatose or barely rousable Not recorded Not assessed	The AKPS is a measure of the resident's current overall performance status across three dimensions of health status – activity, work and self-care.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.24	**RUG-ADL: Bed mobility**	1 3 4 5 8 9	Independent or supervision only Limited physical assistance Other than two persons physical assist Two-person (or more) physical assist Not recorded Not assessed	The RUG-ADL describes the current level of functional dependence. This item reflects the situation and assistance required with repositioning while in bed.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.25	**RUG-ADL: Toileting**	1 3 4 5 8 9	Independent or supervision only Limited physical assistance Other than two persons physical assist Two-person (or more) physical assist Not recorded Not assessed	The RUG-ADL describes the current level of functional dependence. This item reflects the situation and assistance required when using the toilet.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.26	**RUG-ADL: Transfers**	1 3 4 5 8 9	Independent or supervision only Limited physical assistance Other than two persons physical assist Two-person (or more) physical assist Not recorded Not assessed	The RUG-ADL describes the current level of functional dependence. This item reflects the situation and assistance required when the person transfers in and out of bed, from bed to chair and in and out of shower/bathtub.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.27	**RUG-ADL: Eating**	1 2 3 8 9	Independent or supervision only Limited assistance Extensive assistance/total dependence/tube fed Not recorded Not assessed	The RUG-ADL describes the current level of functional dependence. This item reflects the situation and assistance required when the person eats, including the tasks of cutting food, bringing food to mouth and chewing and swallowing food and oral care at end of life.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

P.3.28	**Rockwood Clinical Frailty Scale (RCFS)**	1 2 3 4 5 6 7 8 9 98 99	Very fit Well Managing well Vulnerable Mildly frail Moderately frail Severely frail Very severely frail Terminally ill Not recorded Not assessed	The Rockwood Clinical Frailty Scale is a global measure of a resident's current fitness or frailty incorporating physical and cognitive frailty.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.29	**Resident Communication**	1 2 3 4 9	Yes, very well Yes, a moderate amount Yes, a little No, not at all Not recorded	Describes if the person conducting this assessment has been able to communicate and receive feedback directly from the resident.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.30	**Family Communication**	1 2 3 4 9	Yes, very well Yes, a moderate amount Yes, a little No, not at all Not recorded	Describes if the person conducting this assessment has been able to communicate and receive feedback directly from the resident's family/carer.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.31	**Family Contact**	1 2 3 4 5 6 7 9	Not applicable—recently arrived and been in care <3mths Daily Weekly Monthly Infrequently Never Don't know Not recorded	Describes how frequently the resident has contact with family/carer or close friends since the last assessment.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.32	**Desk top assessment date**	NA	NA	The date on which the desk-top assessment was completed (Part B of the three part clinical assessment).	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.33	**Diagnostic cluster: Advancing frailty associated with old age**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has advancing frailty associated with old age and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

P.3.34	**Diagnostic cluster: Dementia and/or other cognitive impairments**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has dementia and/or other cognitive impairments including delirium and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.35	**Diagnostic cluster: Organ failure**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has a history of organ failure and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.36	**Diagnostic cluster: Neurological conditions**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has a history of neurological conditions and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.37	**Diagnostic cluster: malignancy**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has a history of malignancy and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.38	**Diagnostic cluster: Psychological and/or social**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has a psychological and/or social issues and if it is the main reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.39	**Diagnostic cluster: palliative/end of life care**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident requires palliative and/or end of life care and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.40	**Needs Documented**	1 2 3 9	Yes No Don't know Not recorded	Describes if the resident has their needs, wants and preferences for end of life documented.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.41	**Advance Care Plan in Place**	1 2 9	Yes No Not recorded	Describes if the resident has an advance care plan, advance care directive or similar in place at time of assessment.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.42	**Resident Decision Making**	1 2 9	Yes No Not recorded	Describes if the resident is currently capable of making their own decisions.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

P.3.43	**Advance Care Plan Update**	1 2 3 9	Yes No Don't know Not recorded	Describes if the resident would like to develop and/or update their advance care plan, advance care directive or similar.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.44	**Alternate Decision Maker**	1 2 9	Yes No Not recorded	Describes if the resident has an alternate decision maker.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.45	**Emergency Department Attendance**	1 2 3 4 9	Yes, once Yes, more than once No Don't know Not recorded	Describes if the resident had attended the emergency department in the last three months.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.46	**Unplanned Hospitalisations**	1 2 3 4 9	Yes, once Yes, more than once No Don't know Not recorded	Describes if the resident had any unplanned hospitalisations in the last three months.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.47	**Planned Hospitalisations**	1 2 3 4 9	Yes, once Yes, more than once No Don't know Not recorded	Describes if the resident had any planned hospitalisations in the last three months.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

P.3.48	**AN-ACC class**	1 2 3 4 5 6 7 8 9 10 11 12 13 99	Class 1 – Admit for palliative care Class 2 – Independent without compounding factors (CF) Class 3 – Independent with CF Class 4 – Assisted mobility, high cognition, without CF Class 5 – Assisted mobility, high cognition, with CF Class 6 – Assisted mobility, medium cognition, without CF Class 7 – Assisted mobility, medium cognition, with CF Class 8 – Assisted mobility, low cognition Class 9 – Not mobile, higher function, without CF Class 10 – Not mobile, higher function, with CF Class 11 – Not mobile, lower function, lower pressure sore risk Class 12 – Not mobile, lower function, higher pressure sore risk, without CF Class 13 – Not mobile, lower function, higher pressure sore risk, with CF Not recorded	The externally assessed AN-ACC class item is indicative of the resident's care needs in relation to frailty, mobility, motor function, cognition, behaviour and technical nursing needs.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
P.3.49	**Action plan date**	NA	NA	The date on which the action plan was completed (Part C of the three part clinical assessment).	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.50	**New Admission AN-ACC Class 1**	1 0 9	Yes No Not recorded	Describes if the resident is a new admission, admitted as AN-ACC class 1 – Admit for palliative care.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.51	**New Admission PCU**	1 0 9	Yes No Not recorded	Describes if the resident is a new admission, admitted from a palliative care unit.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.52	**Palliative Care Plan**	1 0 9	Yes No Not recorded	Describes if the resident has a <u>palliative care plan documented</u> by a GP or palliative care health professional/team.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.53	**Palliative Care Needs**	1 0 9	Yes No Not recorded	Describes if the resident has <u>documented palliative care needs</u> by a GP or palliative care health professional/team.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment

P.3.54	**Prognosis less than 3 months**	1 0 9	Yes No Not recorded	Describes if based on the clinician's judgement, the current assessment and all the information available to them, does the clinician believe the resident has a prognosis of less than 3 months.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.55	**Moderate/ Severe score**	1 0 9	Yes No Not recorded	Describes if the resident has one or more moderate/severe symptom distress (SAS) or problem severity score (PSS) for this assessment.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.56	**AKPS of 40 or less**	1 0 9	Yes No Not recorded	Describes if the resident has an AKPS of 40 or less for this assessment.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.57	**Rockwood CFS score 8 or 9**	1 0 9	Yes No Not recorded	Describes if the resident has Rockwood Clinical Frailty Scale (RCFS) score of 8 or 9 for this assessment.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.58	**Clinical Judgement**	1 0 9	Yes No Not recorded	Describes if based on the clinician's judgement, the current assessment and all the information available to them, does the clinician believe the resident would benefit from palliative care.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.59	**Requesting palliative care**	1 0 9	Yes No Not recorded	Describes if the resident and/or family is requesting palliative care.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.60	**Action Plan: No action**	0 1	Unchecked Checked	Describes if no action is required for the resident after assessment using the PACOP Profile collection.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.61	**Action Plan: Internal action**	0 1	Unchecked Checked	Describes if an internal ACH action is required from the aged care home to address care needs.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.62	**Action Plan: External action**	0 1	Unchecked Checked	Describes if an external referral from the aged care home action is required to address care needs.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.63	**Internal Action: family meeting**	0 1	Unchecked Checked	Describes if the resident requires a family meeting to be organised.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment

P.3.64	**Internal Action: Commence Outcomes**	0 1	Unchecked Checked	Describes if the resident needs to commence palliative care using the PACOP Outcomes Collection.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.65	**Internal Action: Palliative/End of life care plan**	0 1	Unchecked Checked	Describes if the resident requires a Palliative/End of life care plan to be developed or revised (includes medication review)	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.66	**Internal Action: Resident care plan**	0 1	Unchecked Checked	Describes if the resident requires a resident care plan to be developed or revised.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.67	**Internal Action: advance care plan**	0 1	Unchecked Checked	Describes if the resident requires an advance care plan to be developed or revised.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.68	**Internal Action: end of life care**	0 1	Unchecked Checked	Describes if the resident requires commencement of end-of-life care/terminal care plan/pathway for the dying person.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.69	**Internal Action: Equipment**	0 1	Unchecked Checked	Describes if the resident requires access to equipment for end-of-life care (e.g. syringe driver, air mattress etc.)	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.70	**Internal Action: Allied health**	0 1	Unchecked Checked	Describes if the resident requires internal allied health and/or psycho-social-spiritual consultation.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.71	**Internal Action: Allied heath description**	NA	25-character free text field	This item describes the 'specify' for the internal allied health and /or psycho-social-spiritual consultation.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.72	**External Action: Palliative Care Consult**	0 1	Unchecked Checked	Describes if the resident requires a consultation with an external specialist palliative care consult team or health professional (e.g., PC specialist physician, SPC team member including clinical nurse or CNC, Inreach, Needs rounds, SPC nurse practitioner, etc.).	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.73	**External Action: GP or Specialist**	0 1	Unchecked Checked	Describes if the resident requires a review by a GP or disease specific specialist external to the aged care home.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment

P.3.74	**External Action: Allied Health**	0 1	Unchecked Checked	Describes if the resident requires external allied health and/or psycho-social spiritual consultation.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.75	**External Action: Allied Health description**	N/A	25-character text field	This item describes the 'specify' for the external allied health and /or psycho-social-spiritual consultation.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.76	**External Action: AN-ACC**	0 1	Unchecked Checked	Describes if the resident requires a new AN-ACC assessment.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.77	**Person who completed Face to Face assessment (Profile Part A)**	1 2 3 4 5 9	ACH Manager Clinical Manager RN/EN Palliative Care CNC/CNS Other Not recorded	Describes the position of the person who completed the face to face assessment.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.78	**Person who completed Desk Top Assessment (Profile Part B)**	1 2 3 4 5 9	ACH Manager Clinical Manager RN/EN Palliative Care CNC/CNS Other Not recorded	Describes the position of the person who completed the desktop assessment.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.79	**Person who completed Action Plan (Profile Part C)**	1 2 3 4 5 9	ACH Manager Clinical Manager RN/EN Palliative Care CNC/CNS Other Not recorded	Describes the position of the person who completed the action plan.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment
P.3.80	**Person who completed Deteriorating resident assessment**	1 2 3 4 5 9	ACH Manager Clinical Manager RN/EN Palliative Care CNC/CNS Other Not recorded	Describes the position of the person who completed the deteriorating resident assessment.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☐ Outcomes Assessment

Level 2: Outcomes Episode (Outcomes Collection only)

Item No.	Data item	Code set	Code set description	Definition	Location in database
O.2.01	**Home identifier**	Not applicable (N/A)	N/A	A four-character alphanumeric code assigned by PACOP that uniquely identifies the ACH providing care.	☒ Resident *Profile:* ☒ Admission ☒ Profile assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
O.2.02	**Resident identifier**	N/A	N/A	An identifier assigned by the ACH to a resident that is unique within the ACH providing care.	☒ Resident *Profile:* ☒ Admission ☒ Profile assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
O.2.03	**Outcomes Episode identifier**	N/A	N/A	A unique identifier assigned by PACOP for each outcomes episode to link records to the resident.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
O.2.04	**Outcomes Episode Start Date & Time**	N/A	N/A	The date and time for which the resident has commenced on the Outcomes collection.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☒ Outcomes Episode ☐ Outcomes Assessment
O.2.05	**Diagnosis**	206 207 213 201 211 203 210 209 204 205 208 213 212 214 280 215 101 102 103 104 105 106	Alzheimer's dementia Other dementia Multiple organ failure Cardiovascular disease Diabetes and its complications End stage kidney disease End stage liver disease Respiratory failure Stroke Motor Neurone Disease Other neurological disease Musculoskeletal Sepsis/infectious/Parasitic COVID-19 Other non-malignancy Advanced frailty associated with old age Bone and soft tissue cancer Breast cancer Central nervous system (CNS) cancer Colorectal cancer Other Gastro-Intestinal (GIT) cancers Haematological cancers	The principal diagnoses trigging the resident's need for palliative care.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☒ Outcomes Episode ☐ Outcomes Assessment

		107 108 109 110 111 112 113 114 115 999	Head and neck cancers Lung cancer Pancreatic cancer Prostate cancer Other urological cancer Gynaecological cancer Skin cancer Unknown primary malignancy Other malignancy Not stated/inadequately described		
O.2.06	**Outcomes Episode End Date**	N/A	N/A	The date that the resident has ceased being part of the Outcomes collection.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☒ Outcomes Episode ☐ Outcomes Assessment
O.2.07	**Outcomes Episode End Reason**	10 20 30 40 50 60 90	Death End of residential aged care admission (i.e. end of respite, leaving residential aged care) Transferred to another aged care home Other discharge type not described above The resident/family no longer want to participate in the Outcomes collection – recommence the Profile collection The resident no longer requires palliative care – recommence the Profile collection Not stated/inadequately described	The reason the resident has ceased being part of the Outcomes collection.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☒ Outcomes Episode ☐ Outcomes Assessment

Level 3: Outcomes Assessment (Outcomes Collection only)

Item No.	Data item	Code set	Code set description	Definition	Location in database
O.3.01	**Home identifier**	Not applicable (N/A)	N/A	A four-character alphanumeric code assigned by PACOP that uniquely identifies the ACH providing care.	☒ Resident *Profile:* ☒ Admission ☒ Profile assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
O.3.02	**Resident identifier**	N/A	N/A	An identifier assigned by the ACH to a resident that is unique within the ACH providing care.	☒ Resident *Profile:* ☒ Admission ☒ Profile assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
O.3.03	**Outcomes Episode identifier**	N/A	N/A	A unique identifier assigned by PACOP for each Outcomes episode to link records to the resident.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☒ Outcomes Episode ☒ Outcomes Assessment
O.3.04	**Team identifier**	N/A	N/A	A four-character alphanumeric code assigned by PACOP for each team to link the resident to the team providing care.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.05	**Outcomes Assessment identifier**	N/A	N/A	A unique identifier assigned by PACOP for each Outcomes assessment to link records to the resident and the Outcomes episode.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.06	**Assessment date and time**	N/A	N/A	The date and time on which the assessment was completed.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.07	**Assessment Type**	3 4 5 6 7	Daily SAS Outcome FULL clinical assessment Resident Snapshot Start of leave End of leave	Describes the assessment that has been completed for this date and time.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.08	**SAS: Pain**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to pain over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

O.3.09	**SAS: Fatigue**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to fatigue over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.10	**SAS: Breathing problems**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to breathing problems over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.11	**SAS: Bowel problems**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item relates to distress due to bowel problems over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.12	**SAS: Nausea**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to nausea over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.13	**SAS: Appetite problems**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to appetite problems over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.14	**SAS: Difficulty sleeping**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to difficulty sleeping over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.15	**SAS: Other symptom description**	N/A	25-character text field	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item describes the 'other' symptom item.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.16	**SAS: Other symptom**	0..10 98 99	Absent or no distress ... Worst possible distress Not recorded Not assessed	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item reflects the level of distress due to 'other' symptom over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

O.3.17	**Who rated the SAS?**	10 20 30 40 90	Resident Family or unpaid carer Care Worker Registered Healthcare professional Not recorded	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item captures who rated the resident's level of distress for the SAS.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.18	**PSS: Pain**	0 1 2 3 8 9	Absent Mild Moderate Severe Not recorded Not assessed	The PSS is a four-level clinician rated assessment tool for problem severity. The 'Pain' item reflects the severity of pain over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.19	**PSS: Other symptoms***	0 1 2 3 8 9	Absent Mild Moderate Severe Not recorded Not assessed	The PSS is a four-level clinician rated assessment tool for problem severity. The 'Other symptoms' item reflects the worst severity of all physical symptoms (other than pain) over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.20	**PSS: Psychological/ spiritual***	0 1 2 3 8 9	Absent Mild Moderate Severe Not recorded Not assessed	The PSS is a four-level clinician rated assessment tool for problem severity. The 'Psychological/spiritual problems' item reflects the severity of psychological/spiritual problems affecting the resident over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.21	**PSS: Family/carer*^**	0 1 2 3 8 9	Absent Mild Moderate Severe Not recorded Not assessed	The PSS is a four-level clinician rated assessment tool for problem severity. The 'Family/carer problems' item reflects the severity of any problems experienced by the resident's family members or carers in relation to the care the resident is receiving (not including problems experienced by staff) over the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.22	**PainChek score**	0…42 97 98 99	PainChek score as completed by the service PainChek not used at the ACH PainChek not used with this resident Not recorded	PainChek® is a clinically proven digital pain assessment tool. Using artificial intelligence, facial recognition and smartphone technology, PainChek® intelligently automates the pain assessment process at the point of care.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

O.3.23	**AKPS**	100 90 80 70 60 50 40 30 20 10 998 999	Normal; no complaints; no evidence of disease Able to carry on normal activity; minor signs or symptoms Normal activity with effort; some signs or symptoms of disease Cares for self; unable to carry on normal activity or to do active work Requires occasional assistance but is able to care for most of their needs Requires considerable assistance and frequent medical care In bed [chair] more than 50% of the time Almost completely bedfast [chairfast] Totally bedfast and requiring extensive nursing care by professionals and/or family Comatose or barely rousable Not recorded Not assessed	The AKPS is a measure of the resident's current overall performance status across three dimensions of health status – activity, work and self-care.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.24	**RUG-ADL: Bed mobility**	1 3 4 5 8 9	Independent or supervision only Limited physical assistance Other than two persons physical assist Two-person (or more) physical assist Not recorded Not assessed	The RUG-ADL describes the current level of functional dependence. This item reflects the situation and assistance required with repositioning while in bed.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.25	**RUG-ADL: Toileting**	1 3 4 5 8 9	Independent or supervision only Limited physical assistance Other than two persons physical assist Two-person (or more) physical assist Not recorded Not assessed	The RUG-ADL describes the current level of functional dependence. This item reflects the situation and assistance required when using the toilet.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.26	**RUG-ADL: Transfers**	1 3 4 5 8 9	Independent or supervision only Limited physical assistance Other than two persons physical assist Two-person (or more) physical assist Not recorded Not assessed	The RUG-ADL describes the current level of functional dependence. This item reflects the situation and assistance required when the person transfers in and out of bed, from bed to chair and in and out of shower/bathtub.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.27	**RUG-ADL: Eating**	1 2 3 8 9	Independent or supervision only Limited assistance Extensive assistance/total dependence/tube fed Not recorded Not assessed	The RUG-ADL describes the current level of functional dependence. This item reflects the situation and assistance required when the person eats, including the tasks of cutting food, bringing food to mouth and chewing and swallowing food and oral care at end of life.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

O.3.28	**Palliative Care Phase**	1 2 3 4 8 9	Stable Unstable Deteriorating Terminal Not recorded Not Assessed	The Palliative Care Phase (PHASE) is an assessment tool that identifies the clinical meaningful period of the residents and their family/carer condition.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.29	**Specialist Palliative Care (SPC) Consult**	1 0 9	Yes No Not recorded	Describes if a SPC consult was carried out by a SPC consult team or SPC health professional (e.g., PC specialist physician, SPC team member including clinical nurse or CNC, SPC nurse practitioner, etc.) in the last 24 hours.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.30	**Rockwood Clinical Frailty Scale (RCFS)**	1 2 3 4 5 6 7 8 9 98 99	Very fit Well Managing well Vulnerable Mildly frail Moderately frail Severely frail Very severely frail Terminally ill Not recorded Not assessed	The Rockwood Clinical Frailty Scale is a global measure of a resident's current fitness or frailty incorporating physical and cognitive frailty.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.31	**Resident Communication**	1 2 3 4 9	Yes, very well Yes, a moderate amount Yes, a little No, not at all Not recorded	Describes if the person conducting this assessment has been able to communicate and receive feedback directly from the resident.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.32	**Family Communication**	1 2 3 4 9	Yes, very well Yes, a moderate amount Yes, a little No, not at all Not recorded	Describes if the person conducting this assessment has been able to communicate and receive feedback directly from the resident's family/carer.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.33	**Family Contact**	1 2 3 4 5 6 7 9	Not applicable—recently arrived and been in care <3mths Daily Weekly Monthly Infrequently Never Don't know Not recorded	Describes how frequently the resident has contact with family or close friends since the last assessment.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

O.3.34	**Diagnostic cluster: Advancing frailty associated with old age**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has advancing frailty associated with old age and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.35	**Diagnostic cluster: Dementia and/or other cognitive impairments**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has dementia and/or other cognitive impairments including delirium and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.36	**Diagnostic cluster: Organ failure**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has a history of organ failure and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.37	**Diagnostic cluster: Neurological conditions**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has a history of neurological conditions and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.38	**Diagnostic cluster: malignancy**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has a history of malignancy and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.39	**Diagnostic cluster: Psychological and/or social**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident has a psychological and/or social issues and if it is the main reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.40	**Diagnostic cluster: palliative/end of life care**	1 2 3 9	This is the MAIN Reason the resident needs care This is A REASON (but not the main reason) the resident needed care This is NOT a reason the resident needs care Not recorded	Describes if the resident requires palliative and/or end of life care and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.41	**Needs Documented**	1 2 3 9	Yes No Don't know Not recorded	Describes if the resident has their needs, wants and preferences for end of life documented.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

O.3.42	**Advance Care Plan in Place**	1 2 9	Yes No Not recorded	Describes if the resident has an advance care plan, advance care directive or similar in place at time of assessment.	☐ Resident *Profile:* *Outcomes:* ☐ Admission ☐ Outcomes Episode ☒ Profile assessment ☒ Outcomes Assessment
O.3.43	**Resident Decision Making**	1 2 9	Yes No Not recorded	Describes if the resident is currently capable of making their own decisions.	☐ Resident *Profile:* *Outcomes:* ☐ Admission ☐ Outcomes Episode ☒ Profile assessment ☒ Outcomes Assessment
O.3.44	**Advance Care Plan Update**	1 2 3 9	Yes No Don't know Not recorded	Describes if the resident would like to develop and/or update their advance care plan, advance care directive or similar.	☐ Resident *Profile:* *Outcomes:* ☐ Admission ☐ Outcomes Episode ☒ Profile assessment ☒ Outcomes Assessment
O.3.45	**Alternate Decision Maker**	1 2 9	Yes No Not recorded	Describes if the resident has an alternate decision maker.	☐ Resident *Profile:* *Outcomes:* ☐ Admission ☐ Outcomes Episode ☒ Profile assessment ☒ Outcomes Assessment
O.3.46	**Emergency Department Attendance**	1 2 3 4 9	Yes, once Yes, more than once No Don't know Not recorded	Describes if the resident has attended the emergency department in the last three months.	☐ Resident *Profile:* *Outcomes:* ☐ Admission ☐ Outcomes Episode ☒ Profile assessment ☒ Outcomes Assessment
O.3.47	**Unplanned Hospitalisations**	1 2 3 4 9	Yes, once Yes, more than once No Don't know Not recorded	Describes if the resident had any unplanned hospitalisations in the last three months.	☐ Resident *Profile:* *Outcomes:* ☐ Admission ☐ Outcomes Episode ☒ Profile assessment ☒ Outcomes Assessment
O.3.48	**Planned Hospitalisations**	1 2 3 4 9	Yes, once Yes, more than once No Don't know Not recorded	Describes if the resident had any planned hospitalisations in the last three months.	☐ Resident *Profile:* *Outcomes:* ☐ Admission ☐ Outcomes Episode ☒ Profile assessment ☒ Outcomes Assessment

O.3.49	**AN-ACC class**	1 2 3 4 5 6 7 8 9 10 11 12 13 99	Class 1 – Admit for palliative care Class 2 – Independent without compounding factors (CF) Class 3 – Independent with CF Class 4 – Assisted mobility, high cognition, without CF Class 5 – Assisted mobility, high cognition, with CF Class 6 – Assisted mobility, medium cognition, without CF Class 7 – Assisted mobility, medium cognition, with CF Class 8 – Assisted mobility, low cognition Class 9 – Not mobile, higher function, without CF Class 10 – Not mobile, higher function, with CF Class 11 – Not mobile, lower function, lower pressure sore risk Class 12 – Not mobile, lower function, higher pressure sore risk, without CF Class 13 – Not mobile, lower function, higher pressure sore risk, with CF Not recorded	The externally assessed AN-ACC class item is indicative of the resident's care needs in relation to frailty, mobility, motor function, cognition, behaviour and technical nursing needs.	☐ Resident *Profile:* ☐ Admission ☒ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.50	**Person who completed assessment**	1 2 3 4 5 9	ACH Manager Clinical Manager RN/EN Palliative Care CNC/CNS Other Not recorded	Describes the position of the person who completed the assessment.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment
O.3.51	**Leave Type**	1 2 9	Hospital Other Not stated/inadequately described	Describes the leave the resident is taking.	☐ Resident *Profile:* ☐ Admission ☐ Profile assessment *Outcomes:* ☐ Outcomes Episode ☒ Outcomes Assessment

Section 2 – PACOP data items with 'Guide for use'

Level 1: Resident items (Both Profile Collection and Outcomes Collection)

1.01 Home identifier

Definition	A four-character alphanumeric code assigned by PACOP that uniquely identifies the ACH providing care.		
Variable name	Home_ID	**Field size**	4 characters
Variable type	Categorical (Nominal)	**Layout**	NNNN to AAAA
Variable coding in Database	String		
Location in database	☒ Resident ☒ Admission ☒Profile assessment	☒ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	Unique identifier which is assigned by PACOP. This is used to ensure each ACH can be uniquely identified.		
Analysis Usage	PACOP uses this item to uniquely identify individual ACHs.		
Validation rules	Mandatory item. Home identifier must not be NULL.		
Source	PACOP 2022		

1.02 Resident identifier

Definition	An identifier assigned by the ACH to a resident that is unique within the ACH providing care. This is usually a resident record/unit record number which is generated for each resident within the ACH. This number must be used at all times when recording resident information for PACOP.		
Variable name	Resident_ID	**Field size**	1-12 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAAAAAAAAAA
Variable coding in Database	String		
Location in database	☒ Resident ☒ Admission ☒Profile assessment	☒ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	This identifier is assigned by the ACH and must be used at all times when recording resident information for PACOP. This allows unique identification of each resident and ensures their assessments are mapped to them.		
Analysis Usage	The unique identification of a resident: the Resident identifier ensures that information recorded at each level of information can be associated with that individual which allows for tracking of the resident care at the ACH.		
Validation rules	Mandatory item. Resident identifier must not be NULL. Value must be unique within the Resident database table for the ACH. Value in Admission database table, Profile Assessment database table, Outcome Episode database table and Outcome Assessment database table must match to a record in the Resident database table.		
Source	PACOP 2022		

1.03 Date of birth

Definition	The date on which the resident was born.		
Variable name	DateOfBirth	**Field size**	10 characters
Variable type	Date	**Layout**	dd/mm/yyyy
Variable coding in Database	String		
Location in database	☒ Resident ☐ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Record the date on which the resident was born. If Date of Birth not provided or not known, leave this field blank.		
Analysis Usage	This item is used to derive age for PACOP demographic analyses.		
Validation rules	The date of birth must be less than the current date. Hence, the following situation causes a critical error: *Critical Error if [Date of Birth] > [Current Date (Today)]* The resident must be less than 150 years of age. Hence, the following situation causes a critical error: *Critical Error if [Date of Birth] < [Current Date (Today)] – 150 years* It is unlikely that The Date of Birth would place the resident's age less than 18 years of age. The following would be considered a warning error: *Warning if [Date of Birth] <= [Current Date (Today)] - 18 years*		
Source	National Health Data Dictionary (Meteor Identifier 287007)		

1.04 Statistical linkage key (SLK)

Definition	The SLK is used for deterministic linkage of data and enables two or more records belonging to the same individual to be brought together. It provides the option for resident data to be linked to different datasets in future to enable a more accurate picture of resident care and service usage. The SLK preserves the anonymity of resident data collected by ACHs. The SLK is derived by joining the 'letters of name' (2nd, 3rd and 5th letters of the family name/surname, and 2nd and 3rd letters of the first given name), 'date of birth', and 'sex' to create a 14-character identifier.		
Variable name	StatisticalLinkageKey	**Field size**	14 characters
Variable type	Categorical (Nominal)	**Layout**	XXXXXDDMMYYYYN
Variable coding in Database	Alphanumeric string		
Location in database	☒ Resident ☐ Admission ☐Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	XXXXX is the 2nd, 3rd and 5th letters of the family name and the 2nd and 3rd letters of the first name. For example, John Smith becomes 'MIHOH'. Non-alphabetic characters in a person's name, such as spaces and hyphens ("-"), are ignored (not included in the character count) when deriving the key. If a family name or first name is too short to extract a character, substitute the number 2. If a resident is missing a surname or has a single name only, 999 is substituted for the family name/surname component. DDMMYYYY is the resident's date of birth. N is the number representing the resident's sex. **Note:** This item should be derived by the IT system rather than manual data entry by users.		
Analysis Usage	The SLK is used for deterministic linkage. It is not a unique identifier and is designed for the purposes of statistical analysis. The linkage key is designed to enable a more accurate picture of a resident's care needs and patterns of assistance by linking the record to other sources of information.		
Validation rules	This item should be derived in the back end of the IT system using the resident's first name, last name, date of birth and sex. This item should not be routinely entered by the user.		
Source	National Health Data Dictionary (METeOR Identifier 750410)		

1.05 Sex

Definition	The biological distinction between male, female and intersex for the resident. This item is related to biological sex assigned at birth rather than gender as a social construct.		
Variable name	Sex	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☒ Resident ☐ Admission ☐Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Male
2	Female
3	Intersex/indeterminate
9	Not stated / inadequately described

Guide for use

Record the biological sex of the resident at the ACH. This is related to the biological sex assigned at birth. It is *not* asking for gender (the social construct).

9 Not stated / inadequately described should only be used in data entry when the resident declines to share their sex or they describe it in a way that is inadequate to determine a code above.

Analysis Usage

This item allows for analysis based on the different biological and physiological characteristics of males and females defined by genetic and chromosomal differences.

This item will be used in demographic analysis and may assist to analyse care utilisation and care needs.

Validation rules None

Source National Health Data Dictionary (Meteor Identifier 287316)

1.06 Indigenous status

Definition	Identifies the resident as being of Aboriginal and/or Torres Strait Islander origin. This item is important for cultural considerations in care.		
Variable name	IndigenousStatus	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☒ Resident ☐ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Aboriginal but not Torres Strait Islander origin
2	Torres Strait Islander but not Aboriginal origin
3	Both Aboriginal and Torres Strait Islander origin
4	Neither Aboriginal nor Torres Strait Islander origin
9	Not stated / inadequately described

Guide for use

Record how the resident identifies their Indigenous status. Recording this item follows national best practice guidelines for recording of Indigenous status for all people in healthcare (AIHW). Recording this item is important for facilitating culturally appropriate care.

9 Not stated/inadequately described should only be used in data entry when the resident declines to share their origin or they describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item is used to inform care in ACHs, ensuring care provided to Aboriginal and Torres Strait Islander peoples is culturally appropriate and for demographic analysis.

Validation rules

None

Source

National Health Data Dictionary (Meteor Identifier 602543)

1.07 Preferred language

Definition	The language (including sign language) most preferred by the resident for communication.		
Variable name	PreferredLanguage	**Field size**	4
Variable type	Categorical (Nominal)	**Layout**	NNNN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☒ Resident ☐ Admission ☐Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	4 digit language code as per the Australian Standard Classification of Languages (ASCL), ABS 2016		
Guide for use	Record the language (including sign language) that the person most prefers for communication. Recording this item can enhance communication with the resident which can facilitate better care.		
Analysis Usage	This item will be used in demographic analysis as well as assists in the planning and provision of multilingual services and facilitates care for residents and family/carers from culturally and linguistically diverse backgrounds.		
Validation rules	None		
Source	National Health Data Dictionary (METeOR Identifier 659407) Australian Standard Classification of Languages (ASCL), Australian Bureau of Statistics 2016 (ABS cat. no. 1267.0)		

1.08 Country of birth

Definition	The country in which the resident was born.		
Variable name	CountryOfBirth	**Field size**	4
Variable type	Categorical (Nominal)	**Layout**	NNNN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☒ Resident ☐ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	4-digit country code as per the Standard Australian Classification of Countries (SACC), ABS 2016		
Guide for use	Record the country in which the person was born.		
Analysis Usage	This item is used to facilitate analysis related to access to palliative aged care by different population subgroups. This item will be used in demographic analysis as well as assists in the planning and provision of services and facilitates care for residents and family/carers from culturally and linguistically diverse backgrounds.		
Validation rules	None		
Source	National Health Data Dictionary (METeOR Identifier 659454) Australian Standard Classification of Countries (ASCC), Australian Bureau of Statistics 2016 (ABS cat. no. 1269.0)		

1.09 Date of death

Definition	The date on which the resident died.		
Variable name	DateofDeath	**Field size**	10
Variable type	Date	**Layout**	dd/mm/yyyy
Variable coding in Database	String		
Location in database	☒ Resident ☐ Admission ☐Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Record the date on which the resident died.		
Analysis Usage	This item can be used for survival analysis, to inform epidemiology studies, and duration of the resident's care.		
Validation rules	Date of death must not be greater than the current date *[Date of death] <= [Current Date (Today)]* Item is only recorded for residents that have died. Date of death can only be recorded once for each resident.		
Source	PACOP 2022		

1.10 Place of death

Definition	The place in which the resident died.		
Variable name	PlaceOfDeath	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☒ Resident ☐ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	This aged care home
2	Hospital (including palliative care unit or hospice)
3	Private Residence
4	Other
9	Not stated/Inadequately described

Guide for use

Record where the resident died. Reporting a resident's place of death allows for analysis to determine if goals of care were met.

9 Not stated/Inadequately described should only be used in data entry when the place the resident has died is not recorded or described in a way that is in adequate to determine a code above.

Analysis Usage

This item can inform care whether provision needs were met in the ACH.

Validation rules

Item is only recorded for residents that have died.

Place of death can only be recorded once for each resident.

Source

PACOP 2022

Level 2: Admission (Profile Collection only)

P.2.01 Home identifier

Definition	A four-character alphanumeric code assigned by PACOP that uniquely identifies the ACH providing care.		
Variable name	Home_ID	**Field size**	4 characters
Variable type	Categorical (Nominal)	**Layout**	NNNN to AAAA
Variable coding in Database	String		
Location in database	☒ Resident ☒ Admission ☒Profile assessment	☒ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	Unique identifier assigned by PACOP. This is used to ensure each ACH can be uniquely identified.		
Analysis Usage	PACOP uses this item to uniquely identify individual ACHs.		
Validation rules	Mandatory item. Home identifier must not be NULL.		
Source	PACOP 2022		

P.2.02 Resident identifier

Definition	An identifier assigned by the ACH to a resident that is unique within the ACH providing care. This is usually a resident record/unit record number which is generated for each resident within the ACH. This number must be used at all times when recording resident information for PACOP.		
Variable name	Resident_ID	**Field size**	1-12 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAAAAAAAAAA
Variable coding in Database	String		
Location in database	☒ Resident ☒ Admission ☒Profile assessment	☒ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	This identifier assigned by the ACH must be used at all times when recording resident information for PACOP.		
Analysis Usage	The unique identification of a resident: the Resident identifier ensures that information recorded at each level of information can be associated with that individual which allows for tracking of the resident care at the ACH.		
Validation rules	Mandatory item. Resident identifier must not be NULL. Value must be unique within the Resident database table for the ACH. Value in Admission database table, Profile Assessment database table, Outcome Episode database table and Outcome Assessment database table must match to a record in the Resident database table.		
Source	PACOP 2022		

P.2.03 Admission identifier

Definition	A unique identifier assigned by PACOP for each Admission to link records to the resident.		
Variable name	Admission_ID	**Field size**	1-12 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAAAAAAAAAA
Variable coding in Database	Alphanumeric string		
Location in database	☐ Resident ☒ Admission ☒Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	This field is automatically generated by the PACOP data management system and enables PACOP to link records.		
Analysis Usage	This item is used to link assessments to a specific episode and track when a resident has entered and exited an ACH.		
Validation rules	Admission identifier must be unique relative to the resident, within the ACH organisation providing care. One resident must not have two or more Admission records with the same Admission identifier. Admission Identifier must not be NULL. Value in Profile Assessment database table must match to a record in the Admission database table.		
Source	PACOP 2022		

P.2.04 Profile Start date

Definition	The date for which the resident has commenced the profile collection.		
Variable name	ProfileStartDate	**Field size**	10
Variable type	Date	**Layout**	dd/mm/yyyy
Variable coding in Database	String		
Location in database	☐ Resident ☒ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Document the day the resident has commenced with the PACOP profile collection. **Note**: According to the PACOP protocol it is best practice to complete Profile Clinical assessment within 24 hours of admission to the Profile Collection as this three part holistic assessment facilitates comprehensive care planning. For ACHs commencing with PACOP, this may or may not be the admission date. For ACHs established using PACOP, the Profile Start Data and Admission Date should be the same date.		
Analysis Usage	This date is required to determine length of time the resident has been in PACOP.		
Validation rules	Profile start date must not be greater than the current date *[Profile Start Date] <= [Current Date (Today)]*		
Source	PACOP 2022		

P.2.05 Pre-admission details

Definition	Describes if the resident was admitted to the ACH on or after 1 January 2020 for this admission.		
Variable name	PreadmissionDetails	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☒ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No

Guide for use	If the resident was admitted on or after 1 January 2020, record **Yes**. This is an inclusion for this version of the dataset, , This item w is used for analysis of the two cohorts. If the resident was admitted before 1 January 2020, record **No.**
Analysis Usage	This item will be used to describe two different cohorts based on admission date.
Validation rules	None
Source	PACOP 2022

P.2.06 Admission date

Definition	The date the resident was admitted to the ACH for this admission.		
Variable name	AdmissionDate	**Field size**	10
Variable type	Date	**Layout**	dd/mm/yyyy
Variable coding in Database	String		
Location in database	☐ Resident ☒ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Record the date on which the resident was admitted to the aged care home. This item should be completed only if the resident was admitted on or after 1 Jan 2020.		
Analysis Usage	This date is used to determine length of stay for the resident.		
Validation rules	Admission date must not be greater than the current date *[Admission Date] <= [Current Date (Today)]* An admission must not be earlier than 1 January 2020 *[Admission Date] >= [01 January 2020]* Admission date must be on or after the resident's date of birth plus 18 years *[Admission date] >= [Date Of Birth] +18 years* This item should only be completed if Preadmission details = 1		
Source	PACOP 2022		

P.2.07 Admission reason

Definition	The reason the resident was admitted to the ACH for this admission.		
Variable name	AdmissionReason	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☒ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Respite
2	Permanent care
3	Transitional Care Program
4	Other admission type not described above
9	Not stated/Inadequately described

Guide for use	Record the reason that best describes the residents care associated with this admission. **Code 99 Not stated/inadequately described** should only be used for data entry purposes in circumstances where the form is incomplete or they describe it in a way that is in adequate to determine a code above.
Analysis Usage	This item is used to analyse the care provided for the varying reasons for admission to an ACH and allows for analysis among the various admitted cohorts.
Validation rules	None
Source	PACOP 2022

P.2.08 Australian Postcode

Definition	The postcode of the home address for the resident before this admission to this aged care home.		
Variable name	AustralianPostCode	**Field size**	4
Variable type	Categorical (Nominal)	**Layout**	NNNN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☒ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Record the numerical postcode for the place where the resident usually resided before this admission to the aged care home. This item allows for proximity analysis. Leave blank if not residing in Australia before entering the aged care home.		
Analysis Usage	This item allows analysis of distance from usual place of residence to care provision in aged care.		
Validation rules	None		
Source	National Health Data Dictionary (METeOR Identifier 302040)		

P.2.09 Admission End date

Definition	The date that the resident is no longer at the ACH.		
Variable name	AdmissionEndDate	**Field size**	10
Variable type	Date	**Layout**	dd/mm/yyyy
Variable coding in Database	String		
Location in database	☐ Resident ☒ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Document the day the resident ceased being assessed with the PACOP Profile collection. This date will correspond to the resident either being discharged from the ACH or their death, as all residents in participating ACHs will be admitted into the Profile collection.		
Analysis Usage	This date is required to determine length of time the resident has been in PACOP.		
Validation rules	Admission End Date must not be greater than the current date *[Admission End Date] <= [Current Date (Today)]* Admission End Date not be earlier than the Profile Start Date *[Admission End Date] >= [Profile Start Date]* Item is only recorded for residents that are no longer at the ACH.		
Source	PACOP 2022		

P.2.10 Admission End reason

Definition	The reason the resident is no longer at the ACH.		
Variable name	AdmissionEndReason	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☒ Admission ☐ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
10	Death
20	End of residential aged care admission (i.e. end of respite, leaving residential aged care)
30	Transferred to another aged care home
40	Other discharge type not described above
99	Not stated/inadequately described

Guide for use

Record the end reason that best describes why the resident is no longer part of the PACOP Profile collection.

Record **99 Not stated/inadequately described** should only be used for data entry purposes in circumstances where the form is incomplete, or they describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item allows for analysis of how residents are exiting ACHs.

Validation rules

Item is only recorded for residents that also have an Admission End Date recorded.

Source

PACOP 2022

Level 2: Outcomes Episode (Outcomes Collection only)

O.2.01 Home identifier

Definition	A four-character alphanumeric code assigned by PACOP that uniquely identifies the ACH providing care.		
Variable name	Home_ID	**Field size**	4 characters
Variable type	Categorical (Nominal)	**Layout**	NNNN to AAAA
Variable coding in Database	String		
Location in database	☒ Resident ☒ Admission ☒Profile assessment	☒ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	Unique identifier assigned by PACOP. This is used to ensure each ACH can be uniquely identified.		
Analysis Usage	PACOP uses this item to uniquely identify individual ACHs.		
Validation rules	Mandatory item. Home identifier must not be NULL.		
Source	PACOP 2022		

O.2.02 Resident identifier

Definition	An identifier assigned by the ACH to a resident that is unique within the ACH providing care. This is usually a resident record/unit record number which is generated for each resident within the ACH. This number must be used at all times when recording resident information for PACOP.		
Variable name	Resident_ID	**Field size**	1-12 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAAAAAAAAAA
Variable coding in Database	String		
Location in database	☒ Resident ☒ Admission ☒Profile assessment	☒ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	This identifier assigned by the ACH must be used at all times when recording resident information for PACOP.		
Analysis Usage	The unique identification of a resident: the Resident identifier ensures that information recorded at each level of information can be associated with that individual which allows for tracking of the resident care at the ACH.		
Validation rules	Mandatory item. Resident identifier must not be NULL. Value must be unique within the Resident database table for the ACH. Value in Admission database table, Profile Assessment database table, Outcome Episode database table and Outcome Assessment database table must match to a record in the Resident database table.		
Source	PACOP 2022		

O.2.03 Outcomes Episode identifier

Definition	A unique identifier assigned by PACOP for each Outcomes episode to link records to the resident.		
Variable name	OutcomesEpisode_ID	**Field size**	1-12 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAAAAAAAAAA
Variable coding in Database	Alphanumeric string		
Location in database	☐ Resident ☐ Admission ☐Profile assessment	☒ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	This field is automatically generated by the PACOP data management system to link records.		
Analysis Usage	This item is used to link assessments to a specific episode and track when a resident has entered and exited the outcomes collection.		
Validation rules	Outcomes Episode identifier must be unique relative to the resident, within the ACH organisation providing care. One resident must not have two or more Outcomes episode records with the same Outcomes Episode identifier. Outcomes Episode Identifier must not be NULL. Value in Outcomes Assessment database table must match to a record in the Outcomes Episode database table.		
Source	PACOP 2022		

O.2.04 Outcomes Episode Start date

Definition	The date the resident commenced the Outcomes collection.		
Variable name	OutcomesEpisodeStartDate	**Field size**	10
Variable type	Date	**Layout**	dd/mm/yyyy
Variable coding in Database	String		
Location in database	☐ Resident ☐ Admission ☐ Profile assessment	☒ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Record the date on which the resident commenced the PACOP Outcomes collection. This will be the start of a resident's palliative care episode.		
Analysis Usage	This item identifies the period in which a resident has been part of outcomes collection and can be used to calculate the length of time in the outcomes collection.		
Validation rules	Outcomes start date must not be greater than the current date *[Outcome Start Date] <= [Current Date (Today)]* Outcomes start date must be the same as or after the admission date *[Outcome Start Date] >= [Admission Date]*		
Source	PACOP 2022		

O.2.05 Diagnosis

Definition	The principal diagnosis trigging the resident's need for palliative care.		
Variable name	Diagnosis	**Field size**	3
Variable type	Categorical (Nominal)	**Layout**	ANN
Variable coding in Database	Alphanumeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☐ Profile assessment	☒ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
206	Alzheimer's dementia
207	Other dementia
213	Multiple organ failure
201	Cardiovascular disease
211	Diabetes and its complications
203	End stage kidney disease
210	End stage liver disease
209	Respiratory failure
204	Stroke
205	Motor Neurone Disease
208	Other neurological disease
213	Musculoskeletal
212	Sepsis/infectious/Parasitic
214	COVID-19
280	Other non-malignancy
215	Advanced frailty associated with old age
101	Bone and soft tissue cancer
102	Breast cancer
103	Central nervous system (CNS) cancer
104	Colorectal cancer
105	Other Gastro-Intestinal (GIT) cancers
106	Haematological cancers
107	Head and neck cancers
108	Lung cancer
109	Pancreatic cancer
110	Prostate cancer
111	Other urological cancer
112	Gynaecological cancer
113	Skin cancer
114	Unknown primary malignancy
115	Other malignancy
999	Not stated/inadequately described

Guide for use

Record the diagnosis that best describes what is trigging the resident's need for palliative care. This diagnosis may differ from their admitted diagnosis as it is the one triggering the need for palliative care.

	Code 999 Not stated/inadequately described should only be used for data entry purposes in circumstances where the form is incomplete, or they describe it in a way that is in adequate to determine a code above.
Analysis Usage	This item is used for prognosis analysis and in epidemiology studies. Using this diagnosis allows for analysis of which specific diagnoses are triggering the need for palliative care in aged care.
Validation rules	None
Source	PACOP 2022

O.2.06 Outcomes Episode End date

Definition	The date that the resident ceased being part of the Outcomes collection.		
Variable name	OutcomesEpisodeEndDate	**Field size**	10
Variable type	Date	**Layout**	dd/mm/yyyy
Variable coding in Database	String		
Location in database	☐ Resident ☐ Admission ☐ Profile assessment	☒ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Document the day the resident ceased being assessed with the PACOP Outcomes collection.		
Analysis Usage	This date is required to determine length of time the resident has been in the outcomes collection.		
Validation rules	Outcome end date must not be greater than the current date *[Outcomes End Date] <= [Current Date (Today)]* Outcome end date must be the same as or after the Outcomes episode start date *[Outcomes Episode End Date] >= [Outcomes Episode Start Date]*		
Source	PACOP 2022		

O.2.07 Outcomes Episode End reason

Definition	The reason the resident ceased being part of the Outcomes collection.		
Variable name	OutcomesEpisodeEndReason	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☐ Profile assessment	☒ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
10	Death
20	End of residential aged care admission (i.e. end of respite, leaving residential aged care)
30	Transferred to another aged care home
40	Other discharge type not described above
50	The resident/family no longer want to participate in the Outcomes collection – recommence the profile collection
60	The resident no longer requires palliative care – recommence the profile collection
99	Not stated/inadequately described

Guide for use

Record the end reason that best describes the way the resident has left the PACOP Outcomes collection.

Note: if the 'cease' reason is not death or discharge from the ACH, the resident must be returned to routine care using the Profile collection.

Record **99 Not stated/inadequately described** should only be used for data entry purposes in circumstances where the form is incomplete or they describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item allows for analysis of how residents are exiting the outcomes collection.

Validation rules

Item is only recorded for residents that also have an Outcomes Episode End Date recorded.

Source

PACOP 2022

Level 3: Assessment items

***Note**: The Profile Assessments (Profile Collection [3-Part] Clinical Assessment Tool & Deteriorating Resident Tool) and Outcomes Assessments (Outcomes Collection Daily SAS, Outcomes FULL Clinical Assessment, 3 monthly Resident Snapshot) have been added into this single level to avoid duplications within the document due to their shared assessments/items.*

*This is indicated in the 'Location in database' field e.g., which items will be attached to which collections as well as the 'Item number'. If the item number starts with a **P**, it is included in the **Profile** Collection, if the item number starts with an **O**, it is included in the **Outcomes** collection. If an item is in both the Profile and Outcomes Collections, both item numbers are included in the heading.*

P.3.01, O.3.01 Home identifier

Definition	A four-character alphanumeric code assigned by PACOP that uniquely identifies the ACH providing care.		
Variable name	Home_ID	**Field size**	4 characters
Variable type	Categorical (Nominal)	**Layout**	NNNN to AAAA
Variable coding in Database	String		
Location in database	☒ Resident ☒ Admission ☒Profile assessment	☒ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	Unique ACH identifier assigned by PACOP.		
Analysis Usage	PACOP uses this item to uniquely identify individual ACHs.		
Validation rules	Mandatory item. Home identifier must not be NULL.		
Source	PACOP 2022		

P.3.02, O.3.02 Resident identifier

Definition	An identifier assigned by the ACH to a resident that is unique within the ACH providing care. This is usually a resident record/unit record number which is generated for each resident within the ACH. This number must be used at all times when recording resident information for PACOP.		
Variable name	Resident_ID	**Field size**	1-12 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAAAAAAAAAA
Variable coding in Database	String		
Location in database	☒ Resident ☒ Admission ☒Profile assessment	☒ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	This identifier is assigned by the ACH and must be used at all times when recording resident information for PACOP.		
Analysis Usage	The unique identification of a resident: the Resident identifier ensures that information recorded at each level of information can be associated with that individual which allows for tracking of the resident care at the ACH.		
Validation rules	Mandatory item. Resident identifier must not be NULL. Value must be unique within the Resident database table for the ACH. Value in Admission database table, Profile Assessment database table, Outcome Episode database table and Outcome Assessment database table must match to a record in the Resident database table.		
Source	PACOP 2022		

P.3.03 Admission identifier

Definition	A unique identifier assigned by PACOP for each admission to link records to the resident.		
Variable name	AdmissionEpisode_ID	**Field size**	1-12 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAAAAAAAAAA
Variable coding in Database	Alphanumeric string		
Location in database	☐ Resident ☒ Admission ☒Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	This field is automatically generated by the PACOP data management system to link records.		
Analysis Usage	This item is used to link assessments to a specific episode and track when a resident has entered and exited an ACH.		
Validation rules	Admission identifier must be unique relative to the resident, within the ACH organisation providing care. One resident must not have two or more Admission records with the same Admission identifier. Admission Identifier must not be NULL. Value in Profile Assessment database table must match to a record in the Admission database table.		
Source	PACOP 2022		

P.3.04, O.3.04 Team identifier

Definition	A four-character alphanumeric assigned by PACOP code for each team to link the resident to the team providing care.		
Variable name	Team_ID	**Field size**	1-4 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAA
Variable coding in Database	Alphanumeric string		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	Unique identifier assigned by ACHs to link a resident to a team. This can facilitate knowledge of care provided within various 'Teams' within an ACH. ***Note**: Please contact PACOP to learn more about 'Teams' to determine if they are suitable for your ACH.*		
Analysis Usage	This item is used to link assessments to a specific team and track how a team provides care to residents in an ACH.		
Validation rules	None		
Source	PACOP 2022		

P.3.05 Profile assessment identifier

Definition	A unique identifier assigned by PACOP for each Profile assessment to link records to the resident and the Admission.		
Variable name	ProfileAssessment_ID	**Field size**	1-12 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAAAAAAAAAA
Variable coding in Database	Alphanumeric string		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	This field is automatically generated by the PACOP data management system to link records.		
Analysis Usage	This item is unique to each resident within a home and will allow linking of repeated Profile data collected for trend analysis.		
Validation rules	Profile identifier must be unique relative to the resident and Admission. One Admission must not have two or more assessment records with the same Profile assessment identifier. Profile Assessment identifier must not be NULL. Value in Profile Assessment database table must match to a record in the Admission database table.		
Source	PACOP 2022		

O.3.03 Outcomes Episode identifier

Definition	A unique identifier assigned by PACOP for each Outcomes episode to link records to the resident.		
Variable name	OutcomesEpisode_ID	**Field size**	1-12 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAAAAAAAAAA
Variable coding in Database	Alphanumeric string		
Location in database	☐ Resident ☐ Admission ☐ Profile assessment	☒ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	This field is automatically generated by the PACOP data management system to link records.		
Analysis Usage	This item is used to link assessments to a specific episode and track when a resident has entered and exited the outcomes collection.		
Validation rules	Outcomes Episode identifier must be unique relative to the resident, within the ACH organisation providing care. One resident must not have two or more Outcomes episode records with the same Outcomes Episode identifier. Outcomes Episode Identifier must not be NULL. Value in Outcomes Assessment database table must match to a record in the Outcomes Episode database table.		
Source	PACOP 2022		

O.3.05 Outcomes assessment identifier

Definition	A unique identifier assigned by PACOP for each Outcome assessment to link records to the resident and the outcomes episode.		
Variable name	OutcomesAssessment_ID	**Field size**	1-12 characters
Variable type	Categorical (Nominal)	**Layout**	N to AAAAAAAAAAAA
Variable coding in Database	Alphanumeric string		
Location in database	☐ Resident ☐ Admission ☐Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	This field is automatically generated by the PACOP data management system to link records.		
Analysis Usage	This item is unique to each resident within a home and will allow linking of repeated outcome data collected for trend analysis.		
Validation rules	Outcome Assessment identifier must be unique relative to the resident and Outcomes Episode. One Outcomes Episode must not have two or more assessment records with the same Outcomes Assessment identifier Outcomes Assessment identifier must not be NULL. Value in Outcomes Assessment database table must match to a record in the Outcomes Episode database table.		
Source	PACOP 2022		

P.3.06, O.3.06 Assessment date and time

Definition	The date and time on which the assessment was completed.		
Variable name	AssessmentDateTime	**Field size**	16
Variable type	Date time	**Layout**	dd/mm/yyyy:hh:mm | Time: 24 hour
Variable coding in Database	String		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	Record the date and time on which the assessment was performed. ***Note**: For the Profile assessment this is the face to face assessment date.*		
Analysis Usage	This item will assist ACHs to determine if current residents are being assessed routinely as per the PACOP clinical recommendations and will allow for trend analysis by resident.		
Validation rules	Assessment date must not be greater than the current date *[Assessment date] <= [Current Date (Today)]* Assessment date must be constrained by the admission. *[Profile start date] <= [Assessment date] <= [Admission end date]*		
Source	PACOP 2022		

P.3.07 Assessment Type (**Profile** Collection only)

Definition	Describes the assessment that has been completed for this date and time.		
Variable name	AssessmentType	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description (Assessment types 1 & 2)
1	Profile clinical assessment
2	Deteriorating resident assessment

Guide for use

Record the assessment type that is being entered into the system.

PACOP Profile Collection – clinical assessment protocol		
On admission to ACH or Profile Collection	**Complete every 3 months**	**Complete upon any concern**
• Profile 3-Part clinical assessment (Part A, B, C)	• Profile 3-Part clinical assessment (Part A, B, C)	• Deteriorating resident assessment (Tool)
Note: For resident's receiving care within the Profile collection, it can be beneficial (although not essential) to complete a Profile 3-Part clinical assessment prior to leave or upon return from leave, in particular hospital leave to inform transfer of care and/or ongoing care planning.		

Analysis Usage

This item will assist ACHs to determine if current residents are being assessed routinely as per the PACOP clinical assessment protocol. I.E Profile 3-Part Clinical Assessment completed upon admission and at a minimum every 3 months. The Deteriorating Resident Assessment (Tool) is completed at any time there is concern about the resident.

Validation rules None

Source PACOP 2022

O.3.07 Assessment Type (**Outcomes** Collection only)

Definition	Describes the assessment that has been completed for this date and time.		
Variable name	AssessmentType	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☐ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description (Assessment types 3, 4 & 5)
3	Daily SAS
4	Outcomes FULL clinical assessment
5	Resident snapshot
6	Start of leave (also a status)
7	End of leave (also a status)

Guide for use

Record the assessment type that is being entered into the system.

PACOP Outcomes Collection – clinical assessment protocol		
Complete daily	**Complete weekly**	**Complete every 3 months**
• SAS • Outcomes FULL clinical assessment where the resident's PHASE is ***Unstable*** *or* ***Terminal***	• Outcomes FULL clinical assessment where the resident's PHASE is ***Stable*** *or* ***Deteriorating***	• 3 monthly Resident Snapshot – completed when the resident's routine 3 monthly assessment is due. (enables a continuum for a resident's Profile).
Note: For residents receiving care in the Outcomes collection, it is highly recommended that an Outcomes FULL clinical assessment is completed before and after leave to inform transfer of care and/or ongoing care planning.		

Analysis Usage	This item will assist ACHs to determine if current residents are being assessed routinely as per the PACOP clinical assessment protocol.
Validation rules	None
Source	PACOP 2022

P.3.08, O.3.08 SAS: Pain

Definition	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom. This item reflects the level of distress due to **pain** over the last 24 hours.		
Variable name	SASPain	**Field size**	1-2
Variable type	Categorical (Ordinal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent or no distress
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	Worst possible distress
98	Not recorded
99	Not assessed

Guide for use

Remember the SAS measures ***distress*** that symptoms are causing the resident over the ***last 24 hours***. The gold standard is that it is ***resident rated***. There are 11 levels in the response options. The response options range from 'absent' (score of 0) to 'worst ever possible' distress (score of 10). A score of zero (0) indicates that the symptom was assessed and the resident has no distress. Scores >0 identify the level of distress experienced by the resident if the symptom caused distress.

Note: Only use a zero (0) score if the symptom was assessed and the resident has NO distress. To assist residents to discriminate choose between these multiple (11) response options, the PCOC SAS has been grouped into four intensity categories (absent 0, mild 1-3, moderate 4-7, severe 8-10). Each category has corresponding descriptors, colours and facial expressions.

Code 99 Not assessed should only be used in data entry when a clinical assessment of this item was not undertaken. **Code 98 Not recorded** should only be used for data entry purposes in circumstances where the form is incomplete, or they describe it in a way that is inadequate to determine a code above.

Analysis Usage	This item is used to track distress from pain for the resident.
Validation rules	Item is only recorded when Assessment Type is 1, 2, 3 or 4.

Source	Daveson et al. (2021) The PCOC Symptom Assessment Scale (SAS): A valid measure for daily use at point of care and in palliative care programs. PLoS ONE 16(3): e0247250. https://doi.org/10.1371/journal.pone.0247250

P.3.09, O.3.09 SAS: Fatigue

Definition	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom. This item reflects the level of distress due to **fatigue** (or feelings of tiredness) over the last 24 hours.		
Variable name	SASFatigue	**Field size**	1-2
Variable type	Categorical (Ordinal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent or no distress
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	Worst possible distress
98	Not recorded
99	Not assessed

Guide for use

Remember the SAS measures ***distress*** that symptoms are causing the resident over the ***last 24 hours***. The gold standard is that it is ***resident rated***. There are 11 levels in the response options. The response options range from 'absent' (score of 0) to 'worst ever possible' distress (score of 10). A score of zero (0) indicates that the symptom was assessed and the resident has no distress. Scores >0 identify the level of distress experienced by the resident if the symptom caused distress.

Note: Only use a zero (0) score if the symptom was assessed and the resident has NO distress. To assist residents to discriminate choose between these multiple (11) response options, the PCOC SAS has been grouped into four intensity categories (absent 0, mild 1-3, moderate 4-7, severe 8-10). Each category has corresponding descriptors, colours and facial expressions.

Code 99 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 98 Not recorded** should be used for data entry purposes in circumstances where the form is incomplete or they describe it in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to track distress from fatigue for the resident.

Validation rules	Item is only recorded when Assessment Type is 1, 2, 3 or 4.
Source	Daveson et al. (2021) The PCOC Symptom Assessment Scale (SAS): A valid measure for daily use at point of care and in palliative care programs. PLoS ONE 16(3): e0247250. https://doi.org/10.1371/journal.pone.0247250

P.3.10, O.3.10 SAS: Breathing problems

Definition	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom. This item reflects the level of distress due to **breathing problems** over the last 24 hours.		
Variable name	SASBreathing	**Field size**	1-2
Variable type	Categorical (Ordinal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent or no distress
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	Worst possible distress
98	Not recorded
99	Not assessed

Guide for use

Remember the SAS measures ***distress*** that symptoms are causing the resident over the ***last 24 hours***. The gold standard is that it is ***resident rated***. There are 11 levels in the response options. The response options range from 'absent' (score of 0) to 'worst ever possible' distress (score of 10). A score of zero (0) indicates that the symptom was assessed and the resident has no distress. Scores >0 identify the level of distress experienced by the resident if the symptom caused distress.

Note: Only use a zero (0) score if the symptom was assessed and the resident has NO distress. To assist residents to discriminate choose between these multiple (11) response options, the PCOC SAS has been grouped into four intensity categories (absent 0, mild 1-3, moderate 4-7, severe 8-10). Each category has corresponding descriptors, colours and facial expressions.

Code 99 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 98 Not recorded** should be used for data entry purposes in circumstances where the form is incomplete or they describe it in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to track distress from breathing problems for the resident.

Validation rules	Item is only recorded when Assessment Type is 1, 2, 3 or 4.
Source	Daveson et al. (2021) The PCOC Symptom Assessment Scale (SAS): A valid measure for daily use at point of care and in palliative care programs. PLoS ONE 16(3): e0247250. https://doi.org/10.1371/journal.pone.0247250

P.3.11, O.3.11 SAS: Bowel problems

Definition	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom. This item reflects the level of distress due to **bowel problems** over the last 24 hours.		
Variable name	SASBowels	**Field size**	1-2
Variable type	Categorical (Ordinal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent or no distress
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	Worst possible distress
98	Not recorded
99	Not assessed

Guide for use

Remember the SAS measures ***distress*** that symptoms are causing the resident over the ***last 24 hours***. The gold standard is that it is ***resident rated***. There are 11 levels in the response options. The response options range from 'absent' (score of 0) to 'worst ever possible' distress (score of 10). A score of zero (0) indicates that the symptom was assessed and the resident has no distress. Scores >0 identify the level of distress experienced by the resident if the symptom caused distress.

Note: Only use a zero (0) score if the symptom was assessed and the resident has NO distress. To assist residents to discriminate choose between these multiple (11) response options, the PCOC SAS has been grouped into four intensity categories (absent 0, mild 1-3, moderate 4-7, severe 8-10). Each category has corresponding descriptors, colours and facial expressions.

Code 99 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 98 Not recorded** should be used for data entry purposes in circumstances where the form is incomplete or they describe it in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to track distress from bowel problems for the resident.

Validation rules

Item is only recorded when Assessment Type is 1, 2, 3 or 4.

Source	Daveson et al. (2021) The PCOC Symptom Assessment Scale (SAS): A valid measure for daily use at point of care and in palliative care programs. PLoS ONE 16(3): e0247250. https://doi.org/10.1371/journal.pone.0247250

P.3.12, O.3.12 SAS: Nausea

Definition	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom. This item reflects the level of distress due to **nausea** (or feelings of being sick) over the last 24 hours.		
Variable name	SASNausea	**Field size**	1-2
Variable type	Categorical (Ordinal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent or no distress
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	Worst possible distress
98	Not recorded
99	Not assessed

Guide for use

Remember the SAS measures ***distress*** that symptoms are causing the resident over the ***last 24 hours***. The gold standard is that it is ***resident rated***. There are 11 levels in the response options. The response options range from 'absent' (score of 0) to 'worst ever possible' distress (score of 10). A score of zero (0) indicates that the symptom was assessed and the resident has no distress. Scores >0 identify the level of distress experienced by the resident if the symptom caused distress.

Note: Only use a zero (0) score if the symptom was assessed and the resident has NO distress. To assist residents to discriminate choose between these multiple (11) response options, the PCOC SAS has been grouped into four intensity categories (absent 0, mild 1-3, moderate 4-7, severe 8-10). Each category has corresponding descriptors, colours and facial expressions.

Code 99 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 98 Not recorded** should be used for data entry purposes in circumstances where the form is incomplete or they describe it in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to track distress from nausea for the resident.

Validation rules	Item is only recorded when Assessment Type is 1, 2, 3 or 4.
Source	Daveson et al. (2021) The PCOC Symptom Assessment Scale (SAS): A valid measure for daily use at point of care and in palliative care programs. PLoS ONE 16(3): e0247250. https://doi.org/10.1371/journal.pone.0247250

P.3.13, O.3.13 SAS: Appetite Problems

Definition	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom. This item reflects the level of distress due to **appetite problems** over the last 24 hours.		
Variable name	SASAppetite	**Field size**	1-2
Variable type	Categorical (Ordinal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent or no distress
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	Worst possible distress
98	Not recorded
99	Not assessed

Guide for use

Remember the SAS measures ***distress*** that symptoms are causing the resident over the ***last 24 hours***. The gold standard is that it is ***resident rated***. There are 11 levels in the response options. The response options range from 'absent' (score of 0) to 'worst ever possible' distress (score of 10). A score of zero (0) indicates that the symptom was assessed and the resident has no distress. Scores >0 identify the level of distress experienced by the resident if the symptom caused distress.

Note: Only use a zero (0) score if the symptom was assessed and the resident has NO distress. To assist residents to discriminate choose between these multiple (11) response options, the PCOC SAS has been grouped into four intensity categories (absent 0, mild 1-3, moderate 4-7, severe 8-10). Each category has corresponding descriptors, colours and facial expressions.

Code 99 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 98 Not recorded** should be used for data entry purposes in circumstances where the form is incomplete or they describe it in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to track distress from appetite problems for the resident.

Validation rules	Item is only recorded when Assessment Type is 1, 2, 3 or 4.
Source	Daveson et al. (2021) The PCOC Symptom Assessment Scale (SAS): A valid measure for daily use at point of care and in palliative care programs. PLoS ONE 16(3): e0247250. https://doi.org/10.1371/journal.pone.0247250

P.3.14, O.3.14 SAS: Difficulty sleeping

Definition	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom. This item reflects the level of distress due to **sleeping difficulties** (or insomnia) over the last 24 hours.		
Variable name	SASInsomnia	**Field size**	1-2
Variable type	Categorical (Ordinal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent or no distress
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	Worst possible distress
98	Not recorded
99	Not assessed

Guide for use

Remember the SAS measures ***distress*** that symptoms are causing the resident over the ***last 24 hours***. The gold standard is that it is ***resident rated***. There are 11 levels in the response options. The response options range from 'absent' (score of 0) to 'worst ever possible' distress (score of 10). A score of zero (0) indicates that the symptom was assessed and the resident has no distress. Scores >0 identify the level of distress experienced by the resident if the symptom caused distress.

Note: Only use a zero (0) score if the symptom was assessed and the resident has NO distress. To assist residents to discriminate choose between these multiple (11) response options, the PCOC SAS has been grouped into four intensity categories (absent 0, mild 1-3, moderate 4-7, severe 8-10). Each category has corresponding descriptors, colours and facial expressions.

Code 99 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 98 Not recorded** should be used for data entry purposes in circumstances where the form is incomplete or they describe it in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to track distress from difficulty sleeping for the resident.

Validation rules	Item is only recorded when Assessment Type is 1, 2, 3 or 4.
Source	Daveson et al. (2021) The PCOC Symptom Assessment Scale (SAS): A valid measure for daily use at point of care and in palliative care programs. PLoS ONE 16(3): e0247250. https://doi.org/10.1371/journal.pone.0247250

P.3.15, O.3.15 SAS: Other symptom description

Definition	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom*. This item reflects the level of distress due to **another symptom** (i.e., NOT difficulty sleeping, appetite, nausea, bowels, breathing, fatigue or pain). **A symptom is a distressing physical or mental sensation/experience felt by the person.*		
Variable name	SASOtherDescription	**Field size**	25 characters
Variable type	Categorical (Nominal)	**Layout**	NA
Variable coding in Database	Text field		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	
Code set	N/A		
Guide for use	Document the 'other symptom' that has been rated in the PCOC SAS. **Note**: If you asked the resident whether they have any 'other' symptoms that are distressing to them and they state NO then leave this field blank and score zero (0) see P.3.16 & O.3.16. **Note**: If more than one 'other symptom' is causing distress for the resident, enter the most distressing description here and document all others in the resident's notes.		
Analysis Usage	This item is used to track distress from 'other' symptoms and its/their management for the resident.		
Validation rules	Item is only recorded when Assessment Type is 1, 2, 3 or 4. Item only recorded is SAS: Other symptom is also recorded.		
Source	PACOP 2022		

P.3.16, O.3.16 SAS: Other symptom score

Definition	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom*. This item reflects the level of distress due to another symptom (i.e., not difficulty sleeping, appetite, nausea, bowels, breathing, fatigue or pain) over the last 24 hours. **A symptom is a distressing physical or mental sensation/experience felt by the person.*		
Variable name	SASOther	**Field size**	1-2
Variable type	Categorical (Ordinal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent or no distress
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	Worst possible distress
98	Not recorded
99	Not assessed

Guide for use

Remember the SAS measures ***distress*** that symptoms are causing the resident over the ***last 24 hours***. The gold standard is that it is ***resident rated***. There are 11 levels in the response options. The response options range from 'absent' (score of 0) to 'worst ever possible' distress (score of 10). A score of 0 indicates that the symptom was assessed and the resident has no distress. Scores >0 identify the level of distress experienced by the resident if the symptom caused distress.

Note: Only use a zero (0) score if the resident was asked about any 'other' distressing symptoms they may have and they stated there was NO distress from 'other' symptoms. To assist residents to discriminate choose between these multiple (11) response options, the PCOC SAS has been grouped into four intensity categories (absent 0, mild 1-3, moderate 4-7, severe 8-10). Each category has corresponding descriptors, colours and facial expressions.

***Note**: If more than one 'other symptom' is causing distress for the resident, score the most distressing and document all other scores in the resident's notes.*

Code 99 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 98 Not recorded** should be used for data entry

	purposes in circumstances where the form is incomplete or they describe it in a way that is inadequate to determine a code above.
Analysis Usage	This item is used to track distress from 'other' symptoms and its/their management for the resident.
Validation rules	Item is only recorded when Assessment Type is 1, 2, 3 or 4. Item only recorded if SAS: Other symptom description is also recorded.
Source	Daveson et al. (2021) The PCOC Symptom Assessment Scale (SAS): A valid measure for daily use at point of care and in palliative care programs. PLoS ONE 16(3): e0247250. https://doi.org/10.1371/journal.pone.0247250

P.3.17, O.3.17 Who rated the SAS?

Definition	The SAS is, wherever possible, a resident-reported assessment of the level of distress caused by seven common symptoms, and an additional 'other' symptom'. This item captures who rated the resident's level of distress for the SAS.		
Variable name	WhoRatedSAS	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
10	Resident
20	Family or unpaid carer
30	Care Worker
40	Registered Healthcare professional
99	Not recorded

Guide for use

This item identifies who rated the SAS. The gold standard is that the SAS is resident rated, so wherever possible encourage and assist the resident to tell you about their distress.

***Note**: If the resident told you their scores but you wrote them down this is still a resident rated SAS.*

Code 99 Not assessed should only be used in data entry when the value for this item is missing.

Analysis Usage

This item is ACHs identify the proportion of SAS assessments completed by residents.

Validation rules

Item is only recorded when Assessment Type is 1, 2, 3 or 4.

Source

PACOP 2022

P.3.18, O.3.18 PSS: Pain

Definition	The PSS is a four-level clinician rated assessment tool for problem severity. It comprises four important palliative care domains. The 'Pain' item reflects the severity of pain over the last 24 hours.		
Variable name	PSSPain	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
8	Not recorded
9	Not assessed

Guide for use

Rate and document the severity of pain over the last 24 hours. The overall severity of problems relating to pain is assessed by the clinician through discussion with the resident and family/carer and through observations.

Note: Only score zero (0) if the domain was assessed and problems were absent.

Code 9 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 8** Not recorded should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to track the severity of problems from pain and its management for the resident.

Validation rules

Item is only recorded when Assessment Type is 1, 2 or 4.

Source

Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong

P.3.19, O.3.19 PSS: Other symptoms

Definition	The PSS is a four-level clinician rated assessment tool for problem severity. It comprises four important palliative care domains. The 'Other symptoms*' item reflects the worst severity of all physical symptoms (other than pain) over the last 24 hours. **A symptom is a distressing physical or mental sensation/experience felt by the person.*		
Variable name	PSSOtherSymptoms	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
8	Not recorded
9	Not assessed

Guide for use

Rate and document the severity of 'other symptoms' over the last 24 hours. The overall severity of problems relating to other symptoms is assessed by the clinician through discussion with the resident and family/carer and through observations.

Note: If more than one 'other' symptom, score the most severe and document all others in the resident's notes. Only score zero (0) if the domain was assessed and no 'other' problems were identified.

Code 9 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 8** Not recorded should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to track the severity of problems from any 'other' symptoms other than pain and its management for the resident.

Validation rules

Item is only recorded when Assessment Type is 1, 2 or 4.

Source

Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong

P.3.20, O.3.20 PSS: Psychological/spiritual

Definition	The PSS is a four-level clinician rated assessment tool for problem severity. It comprises four important palliative care domains. The 'Psychological/spiritual problems' item reflects the severity of psychological/spiritual problems affecting the resident over the last 24 hours.		
Variable name	PSSPsychological	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
8	Not recorded
9	Not assessed

Guide for use

Rate and document the severity of psychological/spiritual problems over the last 24 hours. The overall severity of problems relating to psychological/spiritual is assessed by the clinician through discussion with the resident and family/carer and through observations.

Note: If more than one 'psychological/spiritual problem', score the most severe and document all others in the resident's notes. Only score zero (0) if the domain was assessed and problems were absent.

Code 9 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 8** Not recorded should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to track the severity of problems relating to psychological/spiritual and its management for the resident.

Validation rules

Item is only recorded when Assessment Type is 1, 2 or 4.

Source

Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong

P.3.21, O.3.21 PSS: Family/carer

Definition	The PSS is a four-level clinician rated assessment tool for problem severity. It comprises four important palliative care domains. The 'Family/carer problems' item reflects the severity of any problems experienced by the resident's family members or carers (not including problems experienced by staff) over the last 24 hours.		
Variable name	PSSPsychological	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
0	Absent
1	Mild
2	Moderate
3	Severe
8	Not recorded
9	**Not assessed****

Guide for use

Rate and document the severity of Family/carer problems in relation to the family's ability to contribute to support/care for the resident over the last 24 hours. The overall severity of problems relating to family/carer is assessed by the clinician through discussion with the resident and family/carer and through observations.

Note: If more than one 'family/carer problem', score the most severe and document all others in the resident's notes. Only score zero (0) if the domain was assessed and problems were absent.

Example family/carer problems: decision making, family interactions, financial, travel, visitation, emotional support, grief, loss, physical, legal, cultural, communication, denial, unrealistic goals, conflict, anxiety and stress.

Note***If resident has NO family/carer* ***OR*** *their family/carer cannot be contacted to determine if any problems exist as outlined above, select* ***'9' not assessed (see below)****.*

Code 9 Not assessed should be used in data entry when a clinical assessment of this item was not undertaken. **Code 8** Not recorded should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to track the severity of problems relating to family/carer ability to contribute to support/care for the resident.

Validation rules

Item is only recorded when Assessment Type is 1, 2 or 4.

Source	Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong

P.3.22, O.3.22 PainChek score

Definition	PainChek® is a clinically proven digital pain assessment tool. Using artificial intelligence, facial recognition and smartphone technology, PainChek® intelligently automates the pain assessment process at the point of care. PainChek® is not a mandatory assessment tool and will only be included by ACHs if they are already using this assessment tool.		
Variable name	PainChek	**Field size**	1-2
Variable type	Categorical (Ordinal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Numerical rating between 0 to 42 or one of the not recorded/not used codes

Code	Description
0 to 42	PainChek score
97	PainChek not used at the ACH
98	PainChek not used with this resident
99	Not recorded

Guide for use

Rate and document the PainChek score for the resident only if PainChek is in use at the ACH.

Total PainChek range = 0-42. Categories: 0-6 no pain, 7-11 mild pain, 12-15 moderate pain and 16-42 severe pain.

Note: If your ACH uses PainChek, you can transfer the PainChek score/category into to the SAS for pain (if proxy scoring) and PSS for the pain domain using the table below.

Category	PainChek	SAS	PSS
Absent	0-6	Zero (0)	Zero (0)
Mild	7 8-9 10	1 2 3	1
Moderate	12 13 14 15	4 5 6 7	2
Severe	16 17-41 42	8 9 10	3

Code 97 PainChek not used at the ACH should be selected if the ACH doesn't use the PainChek tool.

Code 98 PainChek not used with this resident should be selected if the PainChek tool is used at the ACH, but it was not used for this resident.

	Code 99 Not Recorded should only be used in data entry when a clinical assessment of this item was not undertaken and no other option was selected.
Analysis Usage	This item is used to monitor pain severity and its management for the resident.
Validation rules	Item is only recorded when Assessment Type is 1, 2 or 4.
Source	Babicova, I., Cross, A., Forman, D. *et al.* Evaluation of the Psychometric Properties of PainChek® in UK Aged Care Residents with advanced dementia. *BMC Geriatr* **21,** 337 (2021). https://doi.org/10.1186/s12877-021-02280-0

P.3.23, O.3.23 Australia-Modified Karnofsky Performance Status (AKPS)

Definition	The AKPS is a measure of the resident's current overall performance status across three dimensions of health – activity, work and self-care.		
Variable name	AKPS	**Field size**	2-3
Variable type	Categorical (Ordinal)	**Layout**	NN or NNN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
100	Normal; no complaints; no evidence of disease
90	Able to carry on normal activity; minor signs or symptoms
80	Normal activity with effort; some signs or symptoms of disease
70	Cares for self; unable to carry on normal activity or to do active work
60	Requires occasional assistance but is able to care for most of his needs
50	Requires considerable assistance and frequent medical care
40	In bed [chair] more than 50% of the time
30	Almost completely bedfast [chairfast]
20	Totally bedfast and requiring extensive nursing care by professionals and/or family
10	Comatose or barely rousable
998	Not recorded
999	Not Assessed

Guide for use

Select the value that best describes the resident's current performance across the dimensions of activity, work and self-care.

Code 999 Not assessed should only be used in data entry when a clinical assessment of this item was not undertaken. **Code 998 Not recorded** should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to monitor deterioration and describe care needs for residents over time.

Validation rules

Item is only recorded when Assessment Type is 1, 2 or 4.

Source

Abernethy, A. P., Shelby-James, T., Fazekas, B. S., Woods, D., & Currow, D. C. (2005). The Australia-modified Karnofsky Performance Status (AKPS) scale: a revised scale for contemporary palliative care clinical practice [Electronic Version]. BioMed Central Palliative Care, 4, 1-12.

P.3.24, O.3.24 RUG-ADL: Bed mobility

Definition	The RUG-ADL describes the current level of functional dependence. It is a four-item scale measuring motor function with activities of bed mobility, toileting, transfers and eating. This item reflects the situation and assistance required with repositioning while in bed.		
Variable name	RUGMobility	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Independent or supervision only
3	Limited physical assistance
4	Other than two persons physical assist
5	Two-person (or more) physical assist
8	Not recorded
9	Not assessed

Guide for use

Select the value that best describes the resident's current performance across the domain of bed mobility.

Record **code 1** if the resident:

- is able to readjust position in bed, perform own pressure area relief, through spontaneous movement around bed or with prompting from carer.
- No hands-on assistance required
- May be independent with the use of a device

Record **code 3** if the resident:

- is able to readjust position in bed, and perform own pressure area relief
- requires the assistance of one person

Record **code 4** if the resident:

- requires the use of a hoist or other assistive device to readjust position in bed and provide pressure relief.
- requires the assistance of one person for task

Record **code 5** if the resident:

- requires two or more assistants to readjust position in bed, and perform pressure area relief

Code 9 Not assessed should only be used in data entry when a clinical assessment of this item was not undertaken. **Code 8** Not recorded should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Code 2 is not used for this domain.

Analysis Usage	This item is used to monitor deterioration and describe care and resource needs for residents.
Validation rules	Code 2 is not used for this domain. Item is only recorded when Assessment Type is 1 or 4.
Source	Fries, B. E., Scheider, D.P., Foley, W. J., Gavazzi, M., Burke, R., Cornelius, E. (1994). Refining a Case-Mix Measure for Nursing Homes: Resource Utilization Groups (RUG-III). Medical Care 32(7): 668-685.

P.3.25, O.3.25 RUG-ADL: Toileting

Definition	The RUG-ADL describes the current level of functional dependence. It is a four-item scale measuring motor function with activities of bed mobility, toileting, transfers and eating. This item reflects the situation and assistance required when using the toilet.		
Variable name	RUGToileting	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Independent or supervision only
3	Limited physical assistance
4	Other than two persons physical assist
5	Two-person (or more) physical assist
8	Not recorded
9	Not assessed

Guide for use

Select the value that best describes the resident's current performance across the domain of toileting.

Considering the tasks of mobilising to the toilet, adjusting clothing, self cleaning. And considering whether the resident has incontinence and is able to avoid soiling clothing:

Record **code 1** if the resident:

- performs all tasks independently or with prompting from carer
- does not require hands-on assistance required
- is independent with the use of a device

Record **code 3** if the resident:

- requires hands-on assistance of one person for one or more of the tasks

Record **code 4** if the resident:

- requires the use of a catheter/uridome/urinal
- requires the use of colostomy/bedpan/commode chair
- requires insertion of enema/ suppository
- requires assistance of one person for management of the device

Record **code 5** if the resident:

- requires two or more assistants to perform any step of the task

Code 9 Not assessed should only be used in data entry when a clinical assessment of this item was not undertaken. **Code 8** Not recorded should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Code 2 is not used for this domain.

Analysis Usage	This item is used to monitor deterioration and describe care and resource needs for residents.
Validation rules	Code 2 is not used for this domain. Item is only recorded when Assessment Type is 1 or 4.
Source	Fries, B. E., Scheider, D.P., Foley, W. J., Gavazzi, M., Burke, R., Cornelius, E. (1994). Refining a Case-Mix Measure for Nursing Homes: Resource Utilization Groups (RUG-III). Medical Care 32(7): 668-685.

P.3.26, O.3.26 RUG-ADL: Transfers

Definition	The RUG-ADL describes the current level of functional dependence. It is a four-item scale measuring motor function with activities of bed mobility, toileting, transfers and eating. This item reflects the situation and assistance required when the person transfers in and out of bed, from bed to chair and in and out of shower/bathtub.		
Variable name	RUGTransfer	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Independent or supervision only
3	Limited physical assistance
4	Other than two persons physical assist
5	Two-person (or more) physical assist
8	Not recorded
9	Not assessed

Guide for use

Select the value that best describes the resident's current performance across the domain of transfers. Record the lowest performance of the day/night.
Record **code 1** if the resident:

- is able to perform all transfers independently or with prompting of carer
- does not require hands-on assistance required
- is independent with the use of a device

Record **code 3** if the resident:

- requires the hands-on assistance of one person to perform any transfer of the day/night

Record **code 4** if the resident:

- requires use of a device for any of the transfers performed in the day/night
- requires only one person plus a device to perform the task

Record **code 5** if the resident:

- requires two or more assistants to perform any transfer of the day/night

Code 9 Not assessed should only be used in data entry when a clinical assessment of this item was not undertaken. **Code 8** Not recorded should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Code 2 is not used for this domain.

Analysis Usage	This item is used to monitor deterioration and describe care and resource needs for residents.
Validation rules	Code 2 is not used for this domain. Item is only recorded when Assessment Type is 1 or 4.
Source	Fries, B. E., Scheider, D.P., Foley, W. J., Gavazzi, M., Burke, R., Cornelius, E. (1994). Refining a Case-Mix Measure for Nursing Homes: Resource Utilization Groups (RUG-III). Medical Care 32(7): 668-685.

P.3.27, O.3.27 RUG-ADL: Eating

Definition	The RUG-ADL describes the current level of functional dependence. It is a four-item scale measuring motor function with activities of bed mobility, toileting, transfers and eating. This item reflects the situation and assistance required when the person eats/drinks, including the tasks of cutting food, bringing food/drink to mouth and chewing and swallowing food/drink.		
Variable name	RUGEating	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Independent or supervision only
2	Limited physical assistance
3	Extensive assistance/total dependence/tube fed
8	Not recorded
9	Not assessed

Guide for use

Select the value that best describes the resident's current performance across the domain of eating.

Record **code 1** if the resident:

- is able to cut, chew and swallow food, or drink independently or with supervision, once a meal has been presented in the customary fashion
- does not require hands-on assistance for eating/drinking
- The resident relies on self-administered parenteral or gastrostomy feeding

Record **code 2** if the resident:

- requires hands on assistance of one person to set up or assist in bringing food/drink to the mouth
- requires food/drink to be modified (soft or staged diet)

Record **code 3** if the resident:

- needs to be fed food or drink by assistant,
- requires oral care at end of life,
- does not eat or drink full meals by mouth but relies on parenteral/gastrostomy feeding and does not administer feeds by him/herself

Code 9 Not assessed should only be used in data entry when a clinical assessment of this item was not undertaken. **Code 8** Not recorded should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to monitor deterioration and describe care and resource needs for residents.

Validation rules	Item is only recorded when Assessment Type is 1 or 4.
Source	Fries, B. E., Scheider, D.P., Foley, W. J., Gavazzi, M., Burke, R., Cornelius, E. (1994). Refining a Case-Mix Measure for Nursing Homes: Resource Utilization Groups (RUG-III). Medical Care 32(7): 668-685.

O.3.28 Palliative Care Phase (PHASE)

Definition

The Palliative Care Phase (PHASE) is an assessment tool that identifies the clinical meaningful period associated with the palliative care needs of the residents and their family/carer. Each of the four Phase Types (Stable, Unstable, Deteriorating and Terminal) have a definition linked to the plan and goals of care.

Variable name	PhaseType	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☐Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Stable
2	Unstable
3	Deteriorating
4	Terminal
8	Not recorded
9	Not assessed

Guide for use

Record the PHASE type (see table below) that best described the clinical situation of the resident at the time of the assessment.

Note: PHASE should be allocated after all other assessments are complete. All residents cared for in the Outcomes Collection must have a PHASE allocated at all times to determine ongoing assessment frequency.

A resident's PHASE is related to care planning requirements and is therefore not necessarily sequential. See table below for a guide.

Stable	Deteriorating	Unstable	Terminal
Care plan is currently addressing all resident needs	Care plan is addressing needs but requires a timely review	Urgent changes required to care plan to address resident needs	Death is likely within days - terminal care plan required

Code 9 Not assessed should only be used in data entry when a clinical assessment of this item was not undertaken. **Code 8** Not recorded should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to identify when the residents care plan changes or needs to be changed and track a resident's trajectory over time.

Validation rules

Item is only recorded when Assessment Type is 4.

Source

Eagar K. et al (1997) The Australian National Sub-Acute and Non-Acute Patient Classification (AN-SNAP): Report of the National Sub-Acute and Non-Acute Casemix Classification Study. Centre for Health Service Development, University of Wollongong.

O.3.29 Specialist Palliative Care (SPC) Consult

Definition	Describes if a SPC consult was carried out by a SPC consult team or SPC health professional (e.g., PC specialist physician, SPC team member including clinical nurse or CNC, SPC nurse practitioner, etc.) **in the last 24 hours**.		
Variable name	SPCConsult	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☐Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	
Code set	**Code** / **Description** 1 / Yes 0 / No 9 / Not recorded		
Guide for use	Record **code 1** if the resident has received an SPC consult in the last 24 hours of the specified date. Record **code 0** if the resident has not had a SPC consult in the last 24 hours of the specified date.		
Analysis Usage	This item is used to monitor if the resident has been seen by a palliative care consultant.		
Validation rules	Item is only recorded when Assessment Type is 4.		
Source	PACOP 2022		

P.3.28, O.3.30 Rockwood Clinical Frailty Scale (RCFS)

Definition	The Rockwood Clinical Frailty Scale is a global measure of a resident's current fitness or frailty incorporating physical and cognitive frailty.		
Variable name	RCFS	**Field size**	1-2
Variable type	Categorical (Ordinal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Very fit
2	Well
3	Managing well
4	Vulnerable
5	Mildly frail
6	Moderately frail
7	Severely frail
8	Very severely frail
9	Terminally ill*
98	Not recorded
99	Not assessed

Guide for use

Select the value that best describes the resident's current fitness or frailty at the time of assessment according to the descriptors within the RCFS.

Note**: RCFS Level 9 (Terminally ill) is for those who will likely die in within 6 months who are ***NOT otherwise frail. This level often applies to those with an advanced cancer diagnosis. Most residents who are terminally ill in aged care homes will be RCFS Level 8 (Very severely frail) as they will generally have associated frailty.

Code 99 Not assessed should only be used in data entry when a clinical assessment of this item was not undertaken. **Code 98 Not recorded** should be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item is used to monitor deterioration and describe care and resource needs for residents in relation to physical and cognitive fitness or frailty.

Validation rules

Item is only recorded when Assessment Type is 1, 2 or 5.

Source

Rockwood K, Theou O. Using the Clinical Frailty Scale in Allocating Scarce Health Care Resources. Canadian Geriatrics Journal. 2020;23(3): 210-215. doi: 10.5771/cgj.23.463

P.3.29, O.3.31 Resident communication

Definition	Describes if the person conducting this assessment has been able to communicate and receive feedback directly from the resident.		
Variable name	ResidentCommunication	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes assessment	

Code set

Code	Description
1	Yes, very well
2	Yes, a moderate amount
3	Yes, a little
4	No, not at all
9	Not recorded

Guide for use	Document the value that best describes the resident's ability to communicate and directly feedback information about the assessments. **Code 9 Not Recorded** should only be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.
Analysis Usage	This item is used to inform comprehensive care planning for the resident.
Validation rules	Item is only recorded when Assessment Type is 1 or 5.
Source	PACOP 2022

P.3.30, O.3.32 Family communication

Definition	Describes if the person conducting this assessment has been able to communicate and receive feedback directly from the resident's family/carer.		
Variable name	FamilyCommunication	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Yes, very well
2	Yes, a moderate amount
3	Yes, a little
4	No, not at all
9	Not recorded

Guide for use

Document the value that best describes the resident's family and/or carer ability and availability to communicate and directly feedback information about the assessments.

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Code 9 is also used where the resident has no family/carer OR contact with the resident's family/carer could not be made.

Analysis Usage

This item is used to inform comprehensive care planning for the resident.

Validation rules

Item is only recorded when Assessment Type is 1 or 5.

Source

PACOP 2022

P.3.31, O.3.33 Family contact

Definition	Describes how frequently the resident has contact with family/carer or close friends since the last assessment.		
Variable name	FamilyContact	**Field size**	1
Variable type	Categorical (Ordinal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Not applicable—recently arrived and been in care <3mths
2	Daily
3	Weekly
4	Monthly
5	Infrequently
6	Never
7	Don't know
9	Not recorded

Guide for use

Document the value that best describes the resident's contact with family/carer and/or close friends since the last assessment was completed.

Note: Family/carer or close friends refers to any visitors that are **NOT** paid and/or contracted by the aged care home to interact with residents.

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage: This item is used to inform the psychosocial care needs of residents.

Validation rules: Item is only recorded when Assessment Type is 1 or 5.

Source: PACOP 2022

P.3.32 Desk-top assessment date

Definition	The date on which the desk-top assessment was completed (Part B of the Profile clinical assessment).		
Variable name	DeskTopAssessmentDate	**Field size**	10
Variable type	Date	**Layout**	dd/mm/yyyy
Variable coding in Database	String		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Record the date on which the Profile clinical assessment (Part B) Desk-top assessment was performed.		
Analysis Usage	This item will assist ACHs to determine if current residents are being assessed routinely as per the PACOP clinical recommendations and will allow for analysis of trends in individual residents.		
Validation rules	Item is only recorded when Assessment Type is 1. Desk top assessment date must not be greater than the current date *[Desk top assessment date] <= [Current Date (Today)]* Desk top assessment date must be constrained by the admission. *[Profile start date] <= [Desk top assessment date] <= [Admission end date]*		
Source	PACOP 2022		

P.3.33, O.3.34 Diagnostic cluster: Advancing frailty associated with old age

Definition	Describes if the resident has advancing frailty associated with old age and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.		
Variable name	DCFrailty	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	This is the MAIN reason the resident needs care
2	This is A REASON but not the main reason the resident needs care
3	This is NOT a reason the resident needs care
9	Not recorded

Guide for use

Document the value that best describes the resident's advancing frailty associated with old age for this assessment. **Note**: There can only be one (1) MAIN reason.

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item will be used to determine the diagnostic clusters responsible for resident care needs in ACHs and track changes over time.

Validation rules

Item is only recorded when Assessment Type is 1 or 5.

Only one Diagnostic Cluster can have Code = 1 for each assessment record.

[Diagnostic cluster: Advancing frailty associated with old age] *OR*
[Diagnostic cluster: Dementia and/or other cognitive impairments] *OR*
[Diagnostic cluster: Organ failure] *OR*
[Diagnostic cluster: Neurological conditions] *OR*
[Diagnostic cluster: Malignancy] *OR*
[Diagnostic cluster: Psychological and/or social] *OR*
[Diagnostic cluster: Palliative/end of life care] *=1*

Source

PACOP 2022

P.3.34, O.3.35 Diagnostic cluster: Dementia and/or other cognitive impairments

Definition	Describes if the resident has dementia and/or other cognitive impairments including delirium and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.		
Variable name	DCDementia	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	This is the MAIN reason the resident needs care
2	This is A REASON but not the main reason the resident needs care
3	This is NOT a reason the resident needs care
9	Not recorded

Guide for use

Document the value that best describes the resident's dementia and/or other cognitive impairments including delirium for this assessment. **Note**: There can only be one (1) MAIN reason.

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item will be used to determine the diagnostic clusters responsible for resident care needs in ACHs and track changes over time.

Validation rules

Item is only recorded when Assessment Type is 1 or 5.

Only one Diagnostic Cluster can have Code = 1 for each assessment record.

[Diagnostic cluster: Advancing frailty associated with old age] *OR*
[Diagnostic cluster: Dementia and/or other cognitive impairments] *OR*
[Diagnostic cluster: Organ failure] *OR*
[Diagnostic cluster: Neurological conditions] *OR*
[Diagnostic cluster: Malignancy] *OR*
[Diagnostic cluster: Psychological and/or social] *OR*
[Diagnostic cluster: Palliative/end of life care] *=1*

Source PACOP 2022

P.3.35, O.3.36 Diagnostic cluster: Organ failure

Definition	Describes if the resident has a history of organ failure and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.		
Variable name	DCOrgan	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	This is the MAIN reason the resident needs care
2	This is A REASON but not the main reason the resident needs care
3	This is NOT a reason the resident needs care
9	Not recorded

Guide for use

Document the value that best describes the resident's history of organ failure for this assessment. This includes items such as heart failure, respiratory failure, renal failure and diabetes. **Note**: There can only be one (1) MAIN reason.

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item will be used to determine the diagnostic clusters responsible for resident care needs in ACHs and track changes over time.

Validation rules

Item is only recorded when Assessment Type is 1 or 5.

Only one Diagnostic Cluster can have Code = 1 for each assessment record.

[Diagnostic cluster: Advancing frailty associated with old age] *OR*
[Diagnostic cluster: Dementia and/or other cognitive impairments] *OR*
[Diagnostic cluster: Organ failure] *OR*
[Diagnostic cluster: Neurological conditions] *OR*
[Diagnostic cluster: Malignancy] *OR*
[Diagnostic cluster: Psychological and/or social] *OR*
[Diagnostic cluster: Palliative/end of life care] *=1*

Source PACOP 2022

P.3.36, O.3.37 Diagnostic cluster: Neurological conditions

Definition	Describes if the resident has a history of neurological conditions and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.		
Variable name	DCNeurological	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	This is the MAIN reason the resident needs care
2	This is A REASON but not the main reason the resident needs care
3	This is NOT a reason the resident needs care
9	Not recorded

Guide for use

Document the value that best describes the resident's history of neurological conditions for this assessment. This includes items such as multiple sclerosis, motor neurone disease, Parkinson's disease and stroke. **Note**: There can only be one (1) MAIN reason.

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item will be used to determine the diagnostic clusters responsible for resident care needs in ACHs and track changes over time.

Validation rules

Item is only recorded when Assessment Type is 1 or 5.

Only one Diagnostic Cluster can have Code = 1 for each assessment record.

[Diagnostic cluster: Advancing frailty associated with old age] *OR*
[Diagnostic cluster: Dementia and/or other cognitive impairments] *OR*
[Diagnostic cluster: Organ failure] *OR*
[Diagnostic cluster: Neurological conditions] *OR*
[Diagnostic cluster: Malignancy] *OR*
[Diagnostic cluster: Psychological and/or social] *OR*
[Diagnostic cluster: Palliative/end of life care] *=1*

Source

PACOP 2022

P.3.37, O.3.38 Diagnostic cluster: Malignancy

Definition	Describes if the resident has a history of malignancy and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.		
Variable name	DCMalignancy	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	This is the MAIN reason the resident needs care
2	This is A REASON but not the main reason the resident needs care
3	This is NOT a reason the resident needs care
9	Not recorded

Guide for use

Document the value that best describes the resident's history of malignancy for this assessment. **Note**: There can only be one (1) MAIN reason.

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item will be used to determine the diagnostic clusters responsible for resident care needs in ACHs and track changes over time.

Validation rules

Item is only recorded when Assessment Type is 1 or 5.

Only one Diagnostic Cluster can have Code = 1 for each assessment record.

[Diagnostic cluster: Advancing frailty associated with old age] *OR*
[Diagnostic cluster: Dementia and/or other cognitive impairments] *OR*
[Diagnostic cluster: Organ failure] *OR*
[Diagnostic cluster: Neurological conditions] *OR*
[Diagnostic cluster: Malignancy] *OR*
[Diagnostic cluster: Psychological and/or social] *OR*
[Diagnostic cluster: Palliative/end of life care] *=1*

Source PACOP 2022

P.3.38, O.3.39 Diagnostic cluster: Psychological and/or social issues

Definition	Describes if the resident has a psychological and/or social issues and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.		
Variable name	DCPsychological	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	This is the MAIN reason the resident needs care
2	This is A REASON but not the main reason the resident needs care
3	This is NOT a reason the resident needs care
9	Not recorded

Guide for use

Document the value that best describes the resident's psychological and/or social issues for this assessment. **Note**: There can only be one (1) MAIN reason.

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item will be used to determine the diagnostic clusters responsible for resident care needs in ACHs and track changes over time.

Validation rules

Item is only recorded when Assessment Type is 1 or 5.

Only one Diagnostic Cluster can have Code = 1 for each assessment record.

[Diagnostic cluster: Advancing frailty associated with old age] *OR*
[Diagnostic cluster: Dementia and/or other cognitive impairments] *OR*
[Diagnostic cluster: Organ failure] *OR*
[Diagnostic cluster: Neurological conditions] *OR*
[Diagnostic cluster: Malignancy] *OR*
[Diagnostic cluster: Psychological and/or social] *OR*
[Diagnostic cluster: Palliative/end of life care] *=1*

Source PACOP 2022

P.3.39, O.3.40 Diagnostic cluster: Palliative/end of life care

Definition	Describes if the resident requires palliative and/or end of life care and if it is the main reason for care, a secondary reason for care or not a reason for care during the last week.		
Variable name	DCPalliative	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	This is the MAIN reason the resident needs care
2	This is A REASON but not the main reason the resident needs care
3	This is NOT a reason the resident needs care
9	Not recorded

Guide for use

Document the value that best describes the resident's palliative and/or end of life care needs for this assessment. **Note**: There can only be one (1) MAIN reason.

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.

Analysis Usage

This item will be used to determine the diagnostic clusters responsible for resident care needs in ACHs and track changes over time.

Validation rules

Item is only recorded when Assessment Type is 1 or 5.

Only one Diagnostic Cluster can have Code = 1 for each assessment record.

[Diagnostic cluster: Advancing frailty associated with old age] *OR*
[Diagnostic cluster: Dementia and/or other cognitive impairments] *OR*
[Diagnostic cluster: Organ failure] *OR*
[Diagnostic cluster: Neurological conditions] *OR*
[Diagnostic cluster: Malignancy] *OR*
[Diagnostic cluster: Psychological and/or social] *OR*
[Diagnostic cluster: Palliative/end of life care] *=1*

Source

PACOP 2022

P.3.40, O.3.41 Needs Documented

Definition	Describes if the resident has their needs, wants and preferences for end of life documented.		
Variable name	NeedsDocumented	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Yes
2	No
3	Don't know
9	Not recorded

Guide for use	Document the value that best describes if the resident has their needs, wants and preferences for end of life documented. **Code 9 Not Recorded** should only be used for data entry purposes in circumstances where the form is incomplete or it is described in a way that is inadequate to determine a code above.
Analysis Usage	This item is used to inform best practice for comprehensive care planning for the resident.
Validation rules	Item is only recorded when Assessment Type is 1 or 5.
Source	PACOP 2022

P.3.41, O.3.42 Advance care plan in place

Definition	Describes if the resident has an advance care plan, advance care directive or similar in place at time of assessment.		
Variable name	AdvanceCareInPlace	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Yes
2	No
9	Not recorded

Guide for use	Document the value that best describes if the resident has an advance care plan, advance care directive or similar in place. **Code 9 Not Recorded** should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.
Analysis Usage	This item is used to inform best practice for comprehensive care planning for the resident.
Validation rules	Item is only recorded when Assessment Type is 1 or 5.
Source	PACOP 2022

P.3.42, O.3.43 Resident decision making

Definition	Describes if the resident is currently capable of making their own decisions.		
Variable name	ResidentDecisionMaking	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Yes
2	No
9	Not recorded

Guide for use	Document the value that best describes if the resident is currently capable of making their own decisions. **Code 9 Not Recorded** should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.
Analysis Usage	This item is used to inform best practice for comprehensive care planning for the resident.
Validation rules	Item is only recorded when Assessment Type is 1 or 5.
Source	PACOP 2022

P.3.43, O.3.44 Advance care plan update

Definition	Describes if the resident would like to develop and/or update their advance care plan, advance care directive or similar.		
Variable name	AdvanceCareUpdate	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Yes
2	No
3	Don't know
9	Not recorded

Guide for use	Document the value that best describes if the resident would like to update their advanced care plan, advanced care directive or similar. **Code 9 Not Recorded** should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.
Analysis Usage	This item is used to inform best practice for comprehensive care planning for the resident.
Validation rules	Item is only recorded when Assessment Type is 1 or 5.
Source	PACOP 2022

P.3.44, O.3.45 Alternate decision maker

Definition	Describes if the resident has an alternate decision maker.		
Variable name	AlternateDecisionMaker	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Yes
2	No
3	Don't know
9	Not recorded

Guide for use	Document the value that best describes if the resident has an alternate decision maker nominated. **Code 9 Not Recorded** should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.
Analysis Usage	This item is used to inform best practice for comprehensive care planning for the resident.
Validation rules	Item is only recorded when Assessment Type is 1 or 5.
Source	PACOP 2022

P.3.45, O.3.46 Emergency Department attendance

Definition	Describes if the resident has attended the emergency department in the last three months.		
Variable name	EDAttendance	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Yes, once
2	Yes, more than once
3	No
4	Don't know
9	Not recorded

Guide for use	Document the value that best describes if the resident has attended the emergency department in the last three months. **Code 9 Not Recorded** should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.
Analysis Usage	This item is used to inform best practices around anticipatory care for residents.
Validation rules	Item is only recorded when Assessment Type is 1 or 5.
Source	PACOP 2022

P.3.46, O.3.47 Unplanned Hospitalisations

Definition	Describes if the resident had any unplanned hospitalisations in the last three months.		
Variable name	UnplannedHospitalisations	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Yes, once
2	Yes, more than once
3	No
4	Don't know
9	Not recorded

Guide for use	Document the value that best describes if the resident had any unplanned hospitalisations in the last three months. **Code 9 Not Recorded** should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.
Analysis Usage	This item is used to inform best practices around anticipatory care for residents.
Validation rules	Item is only recorded when Assessment Type is 1 or 5.
Source	PACOP 2022

P.3.47, O.3.48 Planned Hospitalisations

Definition	Describes if the resident had any planned hospitalisations in the last three months.		
Variable name	PlannedHosptialisations	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Yes, once
2	Yes, more than once
3	No
4	Don't know
9	Not recorded

Guide for use	Document the value that best describes if the resident had any planned hospitalisations in the last three months. **Code 9 Not Recorded** should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.
Analysis Usage	This item is used to inform best practices around anticipatory care for residents.
Validation rules	Item is only recorded when Assessment Type is 1 or 5.
Source	PACOP 2022

P.3.48, O.3.49 AN-ACC class

Definition	The externally assessed AN-ACC class item is indicative of the resident's care needs in relation to frailty, mobility, motor function, cognition, behaviour and technical nursing needs.		
Variable name	ANACC	**Field size**	1-2
Variable type	Categorical (Nominal)	**Layout**	N or NN
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☒ Outcomes Assessment	

Code set

Code	Description
1	Class 1 – Admit for palliative care
2	Class 2 – Independent mobility without compounding factors (CF)
3	Class 3 – Independent mobility with CF
4	Class 4 – Assisted mobility, higher cognitive ability, without CF
5	Class 5 – Assisted mobility, higher cognitive ability, with CF
6	Class 6 – Assisted mobility, medium cognitive ability, without CF
7	Class 7 – Assisted mobility, medium cognitive ability, with CF
8	Class 8 – Assisted mobility, low cognitive ability
9	Class 9 – Not mobile, higher function, without CF
10	Class 10 – Not mobile, higher function, with CF
11	Class 11 – Not mobile, lower function, lower pressure sore risk
12	Class 12 – Not mobile, lower function, higher pressure sore risk, without CF
13	Class 13 – Not mobile, lower function, higher pressure sore risk, with CF
99	Not recorded

Guide for use

Document the Australian National Aged Care Classification (AN-ACC) class for the resident. **Note:** This is the residents current AN-ACC class (if known).

Code 99 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above. This item should also be used if the item is unknown or still under ACFI.

Analysis Usage

This item is used to identify care needs of the resident in relation to frailty, mobility, motor function, cognition, behaviour and technical nursing needs.

Validation rules

Item is only recorded when Assessment Type is 1 or 5.

Source

Eagar K, Gordon R, Snoek M, Loggie C, Westera A, Samsa P, Kobel C (2020 The Australian National Aged Care Classification (AN-ACC): a new casemix classification for residential aged care. Med J Aust 2020; 213 (8): 359-363. doi: 10.5694/mja2.50703

P.3.49 Action plan date

Definition	The date which the action plan was completed (Part C of the Profile clinical assessment).		
Variable name	ActionPlanDate	**Field size**	10
Variable type	Date	**Layout**	dd/mm/yyyy
Variable coding in Database	String		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Record the date on which the action plan (Part C – Profile clinical assessment) was completed.		
Analysis Usage	This item will assist ACHs to determine if current residents are being assessed routinely as per the PACOP clinical recommendations and will allow for trend analysis by resident.		
Validation rules	Item is only recorded when Assessment Type is 1. Action plan date must not be greater than the current date *[Action plan date] <= [Current Date (Today)]* Action plan date must be constrained by the admission. *[Profile start date] <= [Action plan date] <= [Admission end date]*		
Source	PACOP 2022		

P.3.50 New Admission AN-ACC Class 1

Definition	Describes if the resident is a new admission, admitted as AN-ACC class 1 – Admit for palliative care.		
Variable name	NewAdmissionANACC1	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No
9	Not recorded

Guide for use

Document if the resident is a new admission and is admitted as AN-ACC Class 1-Admitted for palliative care.

If YES: *For participating aged care homes, this resident should be commenced in the Outcomes collection for comprehensive palliative care.*

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item is used to identify if a resident needs palliative care.

Validation rules

Item is only recorded when Assessment Type is 1.

Source

PACOP 2022

P.3.51 New Admission from a Palliative Care Unit

Definition	Describes if the resident is a new admission, admitted from a palliative care unit (PCU).		
Variable name	NewAdmissionPCU	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No
9	Not recorded

Guide for use

Document if the resident is a new admission **and** is admitted from a palliative care unit.

If YES: *For participating aged care homes, this resident should be commenced in the Outcomes collection for comprehensive palliative care.*

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item is used to identify if a resident needs palliative care.

Validation rules

Item is only recorded when Assessment Type is 1.

Source

PACOP 2022

P.3.52 Palliative Care Plan

Definition	Describes if the resident has a palliative care plan developed and documented by a GP or palliative care health professional/team.		
Variable name	PalliativeCarePlan	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No
9	Not recorded

Guide for use

Document if the resident has a palliative care plan developed and documented by a GP or palliative care health professional/team.

If YES: *For participating aged care homes, this resident should be commenced in the Outcomes collection for comprehensive palliative care.*

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item is used to identify if a resident needs palliative care.

Validation rules

Item is only recorded when Assessment Type is 1.

Source

PACOP 2022

P.3.53 Palliative Care Needs

Definition	Describes if the resident has documented palliative care needs completed by a GP or palliative care health professional/team.		
Variable name	PalliativeCareNeeds	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No
9	Not recorded

Guide for use

Document if the resident has their palliative care needs developed and documented by a GP or palliative care health professional/team.

If YES: *For participating aged care homes, this resident should be commenced in the Outcomes collection for comprehensive palliative care.*

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item is used to identify if a resident needs palliative care.

Validation rules

Item is only recorded when Assessment Type is 1.

Source

PACOP 2022

P.3.54 Prognosis less than 3 months

Definition	Describes if based on the clinician's judgement, the current assessment and all the information available to them, does the clinician believe the resident has a prognosis of less than 3 months.		
Variable name	LessThan3Months	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No
9	Not recorded

Guide for use

Document if based on clinical judgement, the current assessment and all the information available, it is believed the resident has a prognosis of less than 3 months.

Note: This question should be completed by taking into account the current assessment using the PACOP Profile assessment or Deteriorating resident tools and all other sources of information available to you, for example clinical handover from a previous shift, family/carer concern, a new diagnosis or simply your long term knowledge of the condition of the resident in question.

If YES: *For participating aged care homes, this resident should be commenced in the Outcomes collection for comprehensive palliative care.*

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.

Analysis Usage	This item is used to identify if a resident needs palliative care.
Validation rules	Item is only recorded when Assessment Type is 1 or 2.
Source	PACOP 2022

P.3.55 Moderate/Severe score

Definition	Describes if the resident has one or more moderate/severe symptom distress (SAS) or problem severity score (PSS) for this assessment.		
Variable name	ModerateSevereScore	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No
9	Not recorded

Guide for use

Document if the resident has one or more of moderate or severe score for either symptom distress (SAS) or problem severity (PSS).

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item is used to identify if a resident needs palliative care.

Validation rules

Item is only recorded when Assessment Type is 1 or 2.

Source

PACOP 2022

P.3.56 AKPS of 40 or less

Definition	Describes if the resident has an AKPS of 40 or less for this assessment.		
Variable name	AKPS40orLess	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No
9	Not recorded

Guide for use

Document if the resident has an AKPS of 40 or less.

***If YES**: For participating aged care homes, this resident could be considered for commencement in the Outcomes collection for comprehensive palliative care.*

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item is used to identify if a resident needs palliative care.

Validation rules

Item is only recorded when Assessment Type is 1 or 2.

Source

PACOP 2022

P.3.57 RCFS score 8 or 9

Definition	Describes if the resident has Rockwood Clinical Frailty Scale (RCFS) score of 8 or 9 for this assessment.		
Variable name	RCFSof8or9	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No
9	Not recorded

Guide for use

Document if the resident has a Rockwood Clinical Frailty Scale (RCFS) score of 8 or 9.

***If YES**: For participating aged care homes, this resident could be considered for commencement in the Outcomes collection for comprehensive palliative care.*

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item is used to identify if a resident needs palliative care.

Validation rules

Item is only recorded when Assessment Type is 1 or 2.

Source

PACOP 2022

P.3.58 Clinical Judgement

Definition	Describes if based on the clinician's judgement, the current assessment and all the information available to them, does the clinician believe the resident would benefit from palliative care.		
Variable name	ClinicalJudgement	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No
9	Not recorded

Guide for use

Document if based on clinical judgement, the current assessment and all the information available, it is believed that the patient would benefit from palliative care.

If YES: *For participating aged care homes, this resident should be commenced in the Outcomes collection for comprehensive palliative care.*

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.

Analysis Usage	This item is used to identify if a resident needs palliative care.
Validation rules	Item is only recorded when Assessment Type is 2.
Source	PACOP 2022

P.3.59 Requesting palliative care

Definition	Describes if the resident and/or family is requesting palliative care.		
Variable name	RequestingPalliativeCare	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Yes
0	No
9	Not recorded

Guide for use

Document if the resident and/or family is requesting palliative care.

If YES: *For participating aged care homes, this resident should be commenced in the Outcomes collection for comprehensive palliative care.*

Code 9 Not Recorded should only be used for data entry purposes in circumstances where the form is incomplete or describe it in a way that is in adequate to determine a code above.

Analysis Usage

This item is used to identify if a resident needs palliative care.

Validation rules

Item is only recorded when Assessment Type is 2.

Source

PACOP 2022

P.3.60 Action Plan: No action

Definition	Describes if no action is required for the resident after assessment using the PACOP Profile collection. Continue to monitor the resident using PACOP profile collection if this item is checked.		
Variable name	AP_NoAction	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	Document if the resident requires no further action. Selecting this item means the resident's care plan is addressing all of their care needs. **Note:** No other actions can be selected if this item is checked.		
Analysis Usage	This item is used to demonstrate the responsiveness of ACHs to developing an action plan to address resident needs post assessment.		
Validation rules	Item is only recorded when Assessment Type is 1. This can only be completed if there are no actions to be completed. *Warning if [Action Plan: No Action] = 1 and [Action Plan: Internal Action] = 1* *Warning if [Action Plan: No Action] = 1 and [Action Plan: External Action] = 1*		
Source	PACOP 2022		

P.3.61 Action Plan: Internal action

Definition	Describes if an internal ACH action is required.		
Variable name	AP_ InternalAction	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	Document if the resident requires an internal aged care home action to address care needs.		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Can only be completed if 'Action Plan: No Action' is not ticked. *Warning if [Action Plan: No Action] = 1 and [Action Plan: Internal Action] = 1*		
Source	PACOP 2022		

P.3.62 Action Plan: External action

Definition	Describes if an external referral from the aged care home action is required to address care needs.		
Variable name	AP_ExternalAction	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
0	Unchecked
1	Checked

Guide for use	Document if the resident requires an external referral to address care needs.
Analysis Usage	This item is used to identify if an action is required by the ACHs.
Validation rules	Item is only recorded when Assessment Type is 1. Can only be completed if 'Action Plan: No Action' is also not ticked. *Warning if [Action Plan: No Action] = 1 and [Action Plan: External Action] = 1*
Source	PACOP 2022

P.3.63 Internal action: Family meeting

Definition	Describes if the resident requires a family meeting to be organised.		
Variable name	IA_FamilyMeeting	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	Document if the resident requires a family meeting to be organised.		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: Internal action is 1.		
Source	PACOP 2022		

P.3.64 Internal action: Commence PACOP Outcomes Collection

Definition	Describes if the resident needs to commence palliative care using the PACOP Outcomes Collection.		
Variable name	IA_CommenceOutcome	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	For participating homes, document if the resident is required to commence the PACOP Outcomes collection (i.e. palliative care). Commence Outcomes collection for comprehensive palliative care.		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: Internal action is 1.		
Source	PACOP 2022		

P.3.65 Internal action: Palliative/End of life care plan

Definition	Describes if the resident requires a Palliative/End of life care plan to be developed or revised.		
Variable name	IA_Palliative	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
0	Unchecked
1	Checked

Guide for use

Document if the resident requires a Palliative/End of life care plan to be developed or revised.

***Note**: For participating ACHs, these residents should also be commenced in the Outcomes collection.*

Analysis Usage

This item is used to identify if an action is required by the ACHs.

Validation rules

Item is only recorded when Assessment Type is 1.

Item is only recorded when Action plan: Internal action is 1.

Source

PACOP 2022

P.3.66 Internal action: Resident care plan

Definition	Describes if the resident requires a resident care plan to be developed or revised.		
Variable name	IA_ ResidentCarePlan	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	Document if the resident requires a resident care plan to be developed or revised.		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: Internal action is 1.		
Source	PACOP 2022		

P.3.67 Internal action: Advance care plan

Definition	Describes if the resident requires an advance care plan to be developed or revised.		
Variable name	IA_ AdvanceCarePlan	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	Document if the resident requires an advanced care plan to be developed or revised.		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: Internal action is 1.		
Source	PACOP 2022		

P.3.68 Internal action: End of life plan

Definition	Describes if the resident requires commencement of end-of-life care/terminal care plan/pathway for the dying person.		
Variable name	IA_ EndOfLifeCare	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	Document if the resident requires commencement of end-of-life care/terminal care plan/pathway for the dying person. ***Note**: For participating ACHs this resident should also be commenced on the Outcomes Collection.*		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: Internal action is 1.		
Source	PACOP 2022		

P.3.69 Internal action: Equipment

Definition	Describes if the resident requires access to equipment for end-of-life care.		
Variable name	IA_ Equipment	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	Document if the resident requires access to equipment for end-of-life care (e.g. syringe driver, air mattress etc.). ***Note**: For participating ACHs this resident should also be commenced on the Outcomes Collection.*		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: Internal action is 1.		
Source	PACOP 2022		

P.3.70 Internal action: Allied health

Definition	Describes if the resident requires internal allied health and/or psycho-social-spiritual consultation.		
Variable name	IA_ AlliedHealth	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	Document if the resident requires internal allied health and/or psycho-social-spiritual consultation.		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: Internal action is 1.		
Source	PACOP 2022		

P.3.71 Internal action: Allied health description

Definition	This item describes the 'specify' for the internal allied health and/or psycho-social-spiritual consultation.		
Variable name	IA_AlliedHealthDescription	**Field size**	25 characters
Variable type	Categorical (Nominal)	**Layout**	NA
Variable coding in Database	Text field		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Document the 'specify' that has been recorded for the 'allied health and/or psycho-social-spiritual' item in the internal action plan.		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: Internal action is 1. Special characters and carriage returns are not allowed to be entered in field.		
Source	PACOP 2022		

P.3.72 External action: Palliative care consult

Definition	Describes if the resident requires an external consultation with a specialist palliative care consult team or health professional (e.g., PC specialist physician, SPC team member including clinical nurse or CNC, SPC nurse practitioner, etc.).		
Variable name	EA_PalliativeCareConsult	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	Document if the resident requires an external consultation with a specialist palliative care consult team or health professional. ***Note**: For participating ACHs this resident should also be considered for commencement on the Outcomes Collection.*		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: External action is 1.		
Source	PACOP 2022		

P.3.73 External action: GP or specialist

Definition	Describes if the resident requires an external consultation with a GP or disease specific specialist.		
Variable name	EA_GP	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
0	Unchecked
1	Checked

Guide for use	Document if the resident requires an external consultation with a GP or disease specific specialist.
Analysis Usage	This item is used to identify if an action is required by the ACHs.
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: External action is 1.
Source	PACOP 2022

P.3.74 External action: Allied Health

Definition	Describes if the resident requires external allied health and/or psycho-social spiritual consultation.		
Variable name	EA_ AlliedHealth	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	**Code** / **Description** 0 / Unchecked 1 / Checked		
Guide for use	Document if the resident requires external allied health and/or psycho-social spiritual consultation.		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: External action is 1.		
Source	PACOP 2022		

P.3.75 External action: Allied health description

Definition	This item describes the 'specify' for the external allied health and /or psycho-social-spiritual consultation		
Variable name	EA_AlliedHealthDescription	**Field size**	25 characters
Variable type	Categorical (Nominal)	**Layout**	NA
Variable coding in Database	Text field		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	
Code set	N/A		
Guide for use	Document the 'specify' that has been recorded for the 'allied health and/or psycho-social-spiritual' item in the external action plan.		
Analysis Usage	This item is used to identify if an action is required by the ACHs.		
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: External action is 1. Special characters and carriage returns are not allowed to be entered in field.		
Source	PACOP 2022		

P.3.76 External action: AN-ACC

Definition	Describes if the resident requires a new AN-ACC assessment.		
Variable name	EA_ ANACC	**Field size**	1
Variable type	Categorical (Dichotomous)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
0	Unchecked
1	Checked

Guide for use	Document if the resident requires a new AN-ACC assessment. **Note**: Resident is due for a new external AN-ACC assessment **OR** resident needs have increased sufficiently to request one.
Analysis Usage	This item is used to identify if an action is required by the ACHs.
Validation rules	Item is only recorded when Assessment Type is 1. Item is only recorded when Action plan: External action is 1.
Source	PACOP 2022

P.3.77 Person who completed the Face to Face assessment

Definition	Describes the position of the person who completed the Profile collection (Part B) Face to Face assessment.		
Variable name	WhoAssessed_Face2Face	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	ACH Manager
2	Clinical Manager
3	RN/EN
4	Palliative Care CNC/CNS
5	Other
9	Not recorded

Guide for use	Document if who completed the Profile collection (Part B) Face to Face assessment.
Analysis Usage	This item is used to identify trends in who has completed the assessment.
Validation rules	Item is only recorded when Assessment Type is 1.
Source	PACOP 2022

P.3.78 Person who completed the Desk-top assessment

Definition	Describes the position of the person who completed the Profile collection (Part B) Desk-top assessment.		
Variable name	WhoAssessed_ DeskTop	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	ACH Manager
2	Clinical Manager
3	RN/EN
4	Palliative Care CNC/CNS
5	Other
9	Not recorded

Guide for use	Document if who completed the Profile collection (Part B) Desk-top assessment.
Analysis Usage	This item is used to identify trends in who has completed the assessment.
Validation rules	Item is only recorded when Assessment Type is 1.
Source	PACOP 2022

P.3.79 Person who completed the Action plan

Definition	Describes the position of the person who completed the Profile collection (Part C) Action plan.		
Variable name	WhoAssessed_ ActionPlan	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	ACH Manager
2	Clinical Manager
3	RN/EN
4	Palliative Care CNC/CNS
5	Other
9	Not recorded

Guide for use	Document who completed the Profile collection (Part C) Action plan.
Analysis Usage	This item is used to identify trends in who has completed the assessment.
Validation rules	Item is only recorded when Assessment Type is 1.
Source	PACOP 2022

P.3.80 Person who completed Deteriorating resident assessment

Definition	Describes the position of the person who completed the Profile collection, Deteriorating resident assessment.		
Variable name	WhoAssessed_Deteriorating	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☒ Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	ACH Manager
2	Clinical Manager
3	RN/EN
4	Palliative Care CNC/CNS
5	Other
9	Not recorded

Guide for use	Document who completed the Profile collection, Deteriorating resident assessment.
Analysis Usage	This item is used to identify trends in who has completed the assessment.
Validation rules	Item is only recorded when Assessment Type is 1.
Source	PACOP 2022

O.3.50 Person who completed assessment

Definition	Describes the position of the person who completed the assessment for the Outcomes collection.		
Variable name	WhoAssessed_Outcomes	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☐Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	ACH Manager
2	Clinical Manager
3	RN/EN
4	Palliative Care CNC/CNS
5	Other
9	Not recorded

Guide for use	Document who completed the Outcomes collection assessment.
Analysis Usage	This item is used to identify trends in who has completed the assessment.
Validation rules	None
Source	PACOP 2022

O.3.51 Leave type

Definition	Describes the leave the resident is taking.		
Variable name	LeaveType	**Field size**	1
Variable type	Categorical (Nominal)	**Layout**	N
Variable coding in Database	Numeric (with labels as below)		
Location in database	☐ Resident ☐ Admission ☐Profile assessment	☐ Outcomes Episode ☐ Outcomes Assessment	

Code set

Code	Description
1	Hospital
2	Other
9	Not stated/inadequately described

Guide for use	Document the type of leave the resident is taking. **Note:** Leave is a resident status item.
Analysis Usage	This item is used to identify gaps in assessments and allow for this in analysis of trends.
Validation rules	Item is only recorded when Assessment Type is 6.
Source	PACOP 2022

Section 3 – Data scoping method

Data will be scoped into the six-monthly reporting period based on if the resident has had an assessment within that reporting period.

Profile report scoping

If a resident has been assessed by any of the following assessments within the six-monthly reporting period, they will be included in the profile report:

- Profile three part clinical assessment tool
- Deteriorating resident tool
- 3 monthly resident snapshot

Any resident assessment that qualifies for being 'in-scope' by the above criteria will also have their associated Admission record deemed as 'in-scope' and included for reporting purposes.

Any resident assessment that qualifies for being 'in-scope' by the above criteria will also have their associated Resident record deemed as 'in-scope' and included for reporting purposes.

Outcome report scoping

If a resident has been assessed by any of the following assessments within the six-monthly reporting period, they will be included in the outcome report:

- Daily Symptom assessment
- Full clinical assessment tool
- 3 monthly resident snapshot

Any resident assessment that qualifies for being 'in-scope' by the above criteria will also have their associated Outcomes Episode record deemed as 'in-scope' and included for reporting purposes.

Any resident assessment that qualifies for being 'in-scope' by the above criteria will also have their associated Resident record deemed as 'in-scope' and included for reporting purposes.

It is expected that some ACH residents will have very long Admissions due to the nature of an ACH being the resident's home. As a by-product of this model, some Admission information will also be very old. To account for this, when reporting on Admission information at start of admission, only admissions that have occurred within the six-monthly reporting period will be included (i.e., they will be 'new admissions' to the ACH within the six month reporting period). Any table or figure in reports where this is occurring will be footnoted.

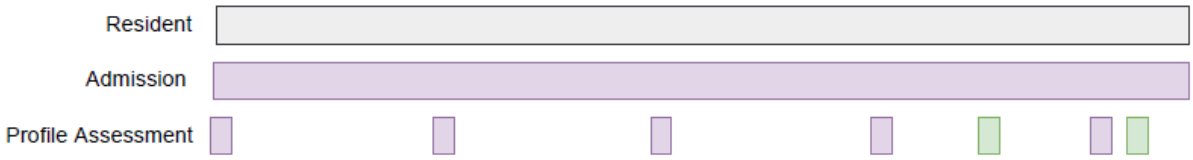
Section 4 – Example residents

The following examples provide an overview of how ACH residents interact with the PACOP dataset. This is not an exhaustive list of resident journeys while in ACHs, it is included to demonstrate visually the information contained in this document.

Please use the key below to interpret the different types of assessments for each resident.

Resident 1: Profile Collection only from admission to death

Profile Collection:



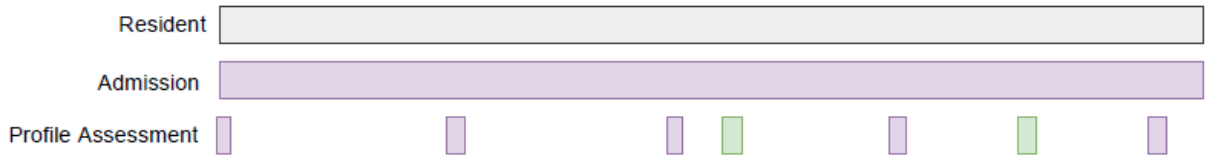
Outcomes Collection:

No data

Resident 1 has one Resident level record, one Admission record and seven Profile assessment records.

Resident 2: Profile Collection only from admission to discharge

Profile Collection:



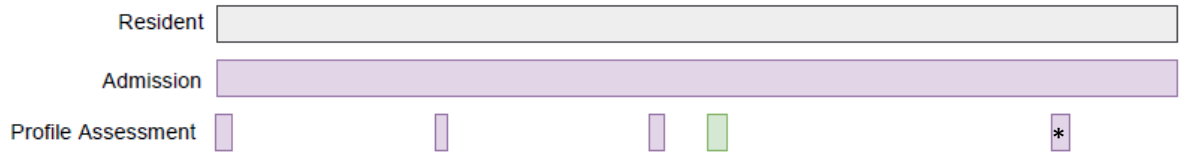
Outcomes Collection:

No data

Resident 2 has one Resident level record, one Admission record and seven Profile assessment records.

Resident 3: Profile and Outcomes Collection ending in death

Profile Collection:



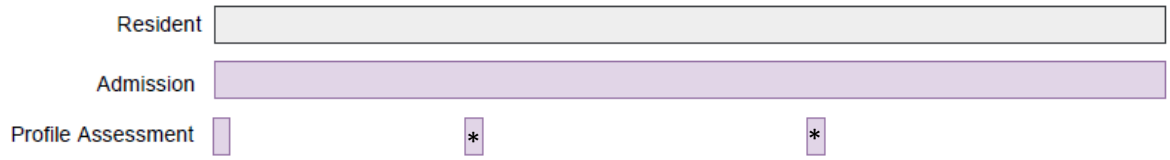
*This assessment is Resident Snapshot in the outcomes collection that has been converted to a profile assessment.

Outcomes Collection:

Resident 3 has one Resident level record that is used for both the Outcomes Collection and the Profile Collection. Resident 3 has one Admission record and five Profile assessment records in the Profile Collection. For the Outcome Collection, Resident 3 has one Outcomes episode and 22 Outcome assessment records. The resident has two additional records at the Outcome assessment level, one for start of leave and one for end of leave. The resident died while in the Outcomes Collection

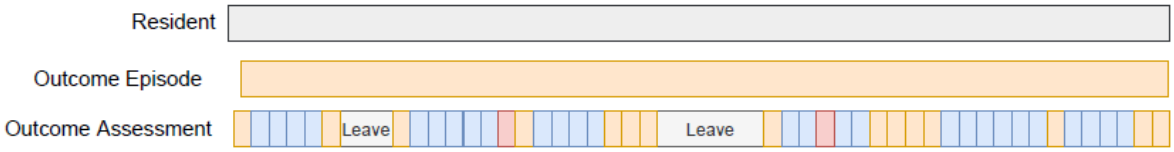
Resident 4: AN-ACC Class 1 admission Profile & Outcomes Collection resident ending in death

Profile Collection:



*This assessment is Resident Snapshot in the outcomes collection that has been converted to a profile assessment.

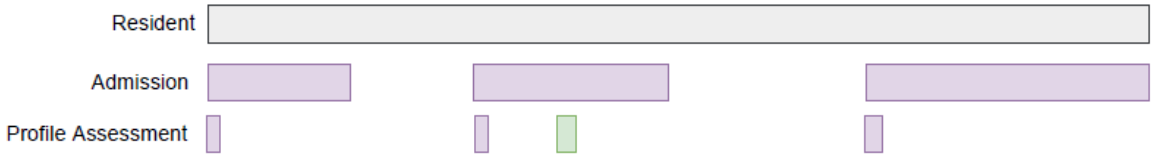
Outcomes Collection:



Resident 4 has one Resident level record that is used for both the Outcomes Collection and the Profile Collection. Resident 4 has one Admission record and three Profile assessment records in the Profile Collection. For the Outcomes Collection, Resident 4 has one Outcomes episode and 44 Outcome assessment records. The resident has four additional records at the Outcome assessment level, two for start of leave and two for end of leave. The resident died while in the Outcomes Collection.

Resident 5: Respite resident with multiple admissions

Profile Collection:

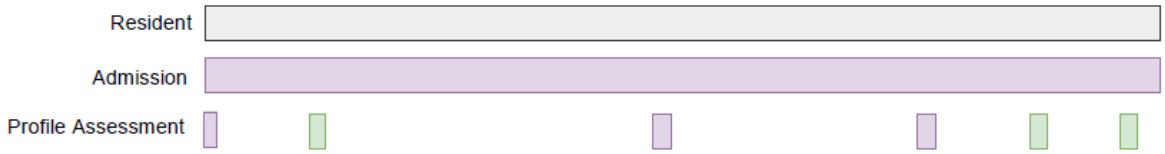


Outcomes Collection:

Resident 5 has one resident level record that is used for both the Outcomes Collection and the Profile Collection. Resident 5 has three Admission records. The first admission record has one Profile assessment record, the second Admission record has two Profile assessment records and the third Admission record has one Profile assessment. For the Outcomes Collection, Resident 5 has one Outcomes episode and 16 Outcome assessment records. The admission ended while the resident was in the Outcomes Collection

Resident 6: Multiple Outcomes admissions ending in death in Profile

Profile Collection:

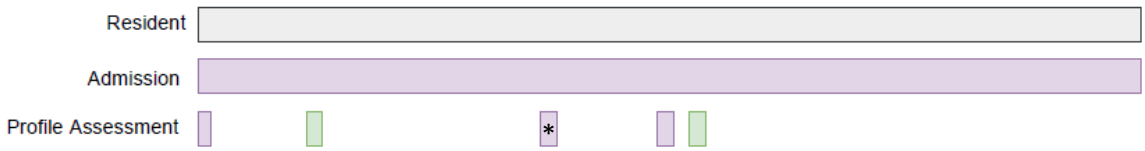


Outcomes Collection:

Resident 6 has one Resident level record that is used for both the Outcomes Collection and the Profile Collection. Resident 6 has one Admission record and six Profile assessment records in the Profile Collection. For the Outcome Collection, Resident 6 has two Outcomes episodes. The first Outcomes episode has 10 Outcome assessment records and the second Outcomes episode has 12 Outcomes assessment records. The resident died in the Profile Collection.

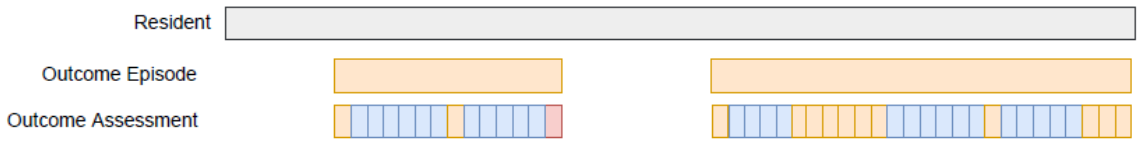
Resident 7: Multiple Outcomes admissions ending in death in Outcomes

Profile collection:



*This assessment is Resident Snapshot in the outcomes collection that has been converted to a profile assessment.

Outcomes collection:

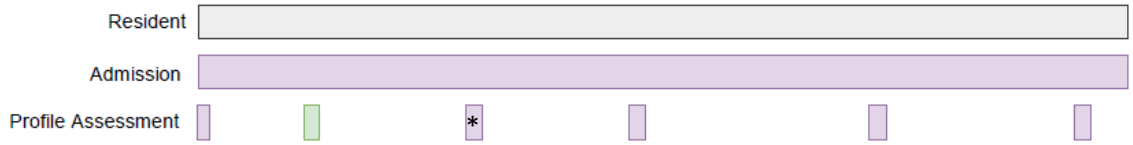


Resident 7 has one resident level record that is used for both the Outcomes Collection and the Profile Collection. Resident 7 has one Admission record and 5 Profile assessment records in the Profile Collection. For the outcome collection, Resident 7 has two Outcomes episodes. The first Outcomes episode has 14 outcome assessment records and the second outcome episode has 26 outcome assessment records. The resident died while in the Outcomes Collection.

Resident 8: Both Profile and Outcomes Collections ending in discharge

How the data are used for reporting:

Profile collection:



*This assessment is Resident Snapshot in the outcomes collection that has been converted to a profile assessment.

Outcomes collection:

Resident 8 has one resident level record that is used for both the Outcomes Collection and the Profile Collection. Resident 8 has one Admission record and 6 Profile assessment records in the Profile Collection. For the Outcome Collection, Resident 8 has one Outcomes episode and 10 Outcome assessment records.