Goal of care code NN

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Goal of care code NN

Identifying and definitional attributes

Metadata item type:	Value Domain
METEOR identifier:	270783
Registration status:	Health, Standard 01/03/2005
Definition:	A code set representing the expected outcome of a plan of care.

Representational attributes

Representation class:	Code
Data type:	String
Format:	NN
Maximum character length:	2

	Value	Meaning
Permissible values:	01	Well person for preventative/maintenance/health promotion program
	02	Person will make a complete recovery
	03	Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required
	04	Person has a long-term care need and the goal is aimed at on-going support to maintain at home
	05	Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die
	06	Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time
	07	For assessment only/not applicable

Collection and usage attributes

Guide for use:

CODE 01 Well person for preventative/maintenance/health promotion program

Service recipients are those making contact with the health service primarily as a part of a preventative/maintenance health promotion program. This means they are well and do not require care for established health problems. They include well antenatal persons attending or being seen by the service for screening or health education purposes.

CODE 02 Person will make a complete recovery

Describes those persons whose condition is self-limiting and from which complete recovery is anticipated, or those with established or long-term health problems who are normally independent in their management.

Goal 2 service recipient includes:

- post-surgical or acute medical service recipients whose care at home is to facilitate convalescence. Such admissions to home care occur as a result of early discharge from hospital; post-surgical complication such as wound infection; or because the person is at risk during the recovery phase and requires surveillance for a limited period;
- persons recovering from an acute illness and referred from the general

practitioner or other community-based facility;
- persons with **disability** or established health problem normally independent of health services, and currently recovering from an acute condition or illness as above.

CODE 03 Person will not make a complete recovery; but will rehabilitate to a state where formal on-going service is no longer required

Refers to those service recipients whose care plan is aimed at returning them to independent functioning at home either through self-care or with informal assistance, such that formal services will be discontinued. The distinguishing characteristic of this group is that complete recovery is not expected but some functional gain may be possible. Further, the condition is not expected to deteriorate rapidly or otherwise cause the client to be at risk without contact or surveillance from the community service.

CODE 04 Person has a long-term care need and the goal is aimed at on-going support to maintain at home

Refers to those service recipients whose health problem/condition is not expected to resolve and who will require ongoing maintenance care from the nursing service. Such clients are distinguished from those in Goal 3 in that their condition is of an unknown or long-term nature and not expected to cause death in the foreseeable future. They may require therapy for restoration of function initially and intermittently, and may also have intermittent admissions for respite. However, the major part of their care is planned to be at home.

CODE 05 Person in end-stage of illness the goal is aimed at support to stay at home in comfort and dignity and facilitation of choice of where to die

Refers to persons whose focus of care is palliation of symptoms and facilitation of the choice to die at home.

CODE 06 Person is unable to remain at home for extended period and goal is aimed at institutionalisation at a planned and appropriate time

Includes persons who have a limited ability to remain at home because of their intensive care requirements and the inability of formal and informal services to meet these needs. Admission to institutional care is therefore a part of the care planning process and the timing dependent upon the capacity and/or wish to remain at home. The distinguishing feature of this group is that the admission is not planned to be an intermittent event to boost the capacity for home care but is expected to be of a more permanent (or indeterminate) nature.

- Excluded from this group are persons with established health problems or permanent disability, if the contact is related to the condition. For example, persons with diabetes and in a diabetes program would be included in Goal 3; however, such persons would be included in Goal 6 if the contact with the service is not related to an established health problem but is primarily for preventative/maintenance care as described above.

CODE 07 For assessment only/not applicable

Service recipients are those for whom the reason for the visit is to undertake an assessment. This may include clients in receipt of a Domiciliary Nursing Care Benefit (DNCB) for whom the purpose of the visit is to determine ongoing DNCB eligibility and requirements for care. Implicit in this visit is review of the person's health status and circumstances, to ensure that their ongoing support does not place them or their carer at avoidable risk.

Relational attributes

Data elements implementing this value domain:

Community nursing service episode—goal of care, code NN
Health, Standard 01/03/2005