Reason for aged care assessment code N[N]

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Reason for aged care assessment code N[N]

Identifying and definitional attributes

Metadata item type:	Value Domain
METEOR identifier:	775139
Registration status:	Aged Care, Standard 30/06/2023
Definition:	A code set representing the reason why an aged care assessment was undertaken.

Representational attributes

Representation class:	Code
Data type:	Number
Format:	N[N]
Maximum character length:	2

	Value	Meaning
Permissible values:	1	Hospital admission or discharge
	2	Change in medical condition(s)
	3	Change in care needs
	4	Concerns about increasing frailty
	5	Fall(s)
	6	Change in cognitive status
	7	Change in mental health status
	8	Change in caring arrangements
	9	Change in living arrangements
	10	Risk of vulnerability
	20	Other
Supplementary values:	97	Not applicable
	98	Unknown/unable to be determined
	99	Not stated/inadequately described

Collection and usage attributes

Guide for use:

CODE 1 Hospital admission or discharge

This code applies where a recent hospitalisation (within three months) results in the initiation of an aged care assessment. This relates to an inpatient stays or emergency department presentations, not an outpatient visit at e.g., a hospital clinic.

CODE 2 Change in medical conditions

This code applies where a change in the person's medical conditions (including mental health and disability) has led to the initiation of an aged care assessment. The medical conditions impact on the persons need for assistance with activities and can include e.g., changes in pain levels or ability to self-manage the condition(s).

CODE 3 Change in care needs

This code applies where there is a change in care needs, such as the need for

more assistance to complete everyday tasks, that trigger the need for an assessment. Use code 2 if the change in care needs is specific to a particular medical condition.

CODE 4 Concerns about increasing frailty

This code applies if the trigger for assessment relates to concerns about overall worsening health and mobility. Use code 2 if the concerns are specific to a particular medical condition and code 4 if the increasing frailty involves falls.

CODE 5 Fall(s)

This code applies to falls, including slips and trips that lead to the initiation of an assessment.

CODE 6 Change in cognitive status

This code applies where the assessment is triggered by a change in a person's memory and/or cognition. Changes may include declining memory, forgetfulness and confusion, poor judgement and decision-making, and other cognitive changes that impact on every day activities.

CODE 7 Change in mental health status

This code applies where the assessment is triggered by a change in a person's mental health. Changes may include increased symptoms of depression, anxiety, withdrawal or lack of enjoyment that impact on every day activities.

CODE 8 Change in caring arrangement

This code applies where the assessment is triggered by a change in caring arrangements. This includes changes where a co-resident, non-resident carer or informal support network are no longer able to provide care for the person, e.g., due to the carer's death, hospitalisation or moving away.

CODE 9 Change in living arrangement

This code applies where the assessment is triggered by a change in a person's accommodation or housing situation. This includes changes where the person needs to relocate to alternative or new accommodation e.g., due to cost, availability or suitability of housing. Where an assessment is needed because of a change in the carer's living arrangements or loss of a carer, use code 8.

CODE 10 Risk of vulnerability

This code applies where a person has a level of vulnerability that triggers the need for an assessment. It may relate to the person being identified as belonging to an at-risk group. Should a person choose not to disclose information about their situation or lifestyle, this choice should be respected.

CODE 20 Other

This code applies for any triggers which are not categorised or defined in the above and warranted an assessment.

CODE 97 Not applicable

This code is used where the assessment reason is not required.

CODE 98 Unknown/unable to be determined

This code is used where the assessor was not able to determine the reason for the assessment.

CODE 99 Not stated/inadequately described

This code is not to be used on primary collection forms.

Source and reference attributes

Submitting organisation: Department of Health and Aged Care

Relational attributes

Data elements implementing this value domain:

Aged care assessment—reason for assessment, code N[N]
Aged Care, Standard 30/06/2023